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VIRGINIA:

IN THE CIRCUIT COURT FOR THE CITY OF RICHMOND

MARISOL RODRIGUEZ, as Administrator of the Estate of **JEFRY RODRIGUEZ**, deceased,

Plaintiff,

v.

Case No.:

JURY TRIAL DEMANDED

DANIEL N. DAVIDOW, M.D.
[redacted]

DANIEL N. DAVIDOW, P.C.
RA: Michael L. Goodman
Goodman Allen Donnelly, PLLC
4501 Highwoods Parkway, Ste. 210
Glen Allen, VA 23060

CUMBERLAND HOSPITAL, LLC
d/b/a CUMBERLAND HOSPITAL FOR CHILDREN AND ADOLESCENTS
RA: Corporation Service Company
100 Shockoe Slip Fl. 2
Richmond, Virginia 23219

UNIVERSAL HEALTH SERVICES, INC.
Serve: Secretary of Commonwealth

UHS OF DELAWARE, INC.
RA: Corporation Service Company
100 Shockoe Slip Fl. 2
Richmond, Virginia 23219

Defendants.

COMPLAINT

Marisol Rodriguez, as Administrator of the Estate of Jefry Rodriguez, files this Complaint against the Defendants, jointly and severally, for the wrongful death of Jefry Rodriguez, and alleges as follows:

PARTIES

1. Plaintiff Jefry Rodriguez, deceased, was at all times relevant to this suit an infant and a resident of Woodstock, Virginia.

2. Plaintiff Marisol Rodriguez, Jefry's mother, was appointed Administrator of Jefry's Estate in the Circuit Court of Shenandoah County on April 30, 2020. She currently resides in Woodstock, VA.

3. For purposes of damages under the Wrongful Death Act, Va. Code § 8.01-50, *et seq.*, Jefry's statutory beneficiaries are his mother, Marisol Rodriguez, his father, Emmanuel Jose Morales, his two siblings born of his mother, Dominic Gabriel Riley Rodriguez (DOB: 9/18/2010) and Angel Daniel Rodriguez (DOB: 12/11/2012), and his siblings born of his father.

DR. DAVIDOW AND DAVIDOW, P.C.

4. Daniel N. Davidow, M.D. ("Dr. Davidow" or "Davidow") is and was at all times relevant to this action a person licensed to practice medicine in Virginia and the Medical Director of Cumberland Hospital for Children and Adolescents.

5. Dr. Davidow was at all times relevant to this action Board certified in pediatrics.

6. Dr. Davidow was at all times relevant to this action an officer, director, president, agent and/or employee of Daniel N. Davidow, M.D., P.C.

7. Daniel N. Davidow, M.D., P.C. ("Davidow, P.C.") is a Virginia professional corporation with its principal office located in Richmond, Virginia.

8. Dr. Davidow was at all times relevant to this action also an agent, servant and/or employee of Cumberland Hospital, LLC, Universal Health Services, Inc., and UHS of Delaware, Inc.

CUMBERLAND HOSPITAL

9. Cumberland Hospital, LLC d/b/a Cumberland Hospital for Children and Adolescents (hereinafter "Cumberland Hospital") is and has at all times been a Virginia limited liability company with its principal office located in New Kent, Virginia.

10. Cumberland Hospital was at all times relevant to this action an agent, servant and/or employee of Universal Health Services, Inc., ("UHS, Inc.") and/or UHS of Delaware, Inc. ("UHS-D").

11. Cumberland Hospital is owned , managed, and operated, directly or indirectly, by UHS, Inc. and/or UHS-D.

UHS, INC.

12. UHS, Inc. is a Delaware corporation with its principal office located in King of Prussia, Pennsylvania.

13. UHS, Inc. is a for-profit holding company which directly or indirectly owns the assets or stock of its subsidiaries and its inpatient and residential psychiatric and behavioral health facilities, including Cumberland Hospital and other Virginia facilities.

14. UHS, Inc. describes itself as "one of the nation's largest and most respected providers of hospital and healthcare services, has 400 acute care hospitals, behavioral health facilities and ambulatory centers across the U.S."

15. UHS, Inc. acquired Cumberland Hospital as part of its $3.1 billion acquisition of Psychiatric Solutions, Inc. in November 2010.

16. Integration of these newly-acquired facilities included implementation of UHS, Inc. policies and appointment of management and officers, including Cumberland Hospital's CEO and medical director, at UHS, Inc.'s and UHS-D's direction.

17. UHS, Inc. conducts or at all times relevant to this suit conducted substantial business in Virginia.

18. UHS, Inc. does or did at all times relevant to this suit operate, manage, and/or own, directly or indirectly, at least 12 behavioral health facilities in Virginia, including Cumberland Hospital.

19. UHS, Inc. maintains oversight control over management decisions of its subsidiaries and inpatient and residential psychiatric and behavioral health facilities, including UHS-D and Cumberland Hospital.

20. According to UHS, Inc., its corporate officers are employees of UHS-D and serve as officers to both UHS, Inc. and UHS-D.

UHS-D

21. UHS-D is a Delaware corporation with its principal office located in King of Prussia, Pennsylvania.

22. UHS-D is a wholly owned subsidiary of UHS, Inc. and according to UHS, Inc. provides management and administrative services to other subsidiaries of UHS, Inc. including Cumberland Hospital and other facilities in Virginia.

23. At all times relevant to this suit and beginning in 2004 through at least February 2021, UHS-D was authorized to transact business in Virginia and maintained a registered agent in Virginia (Corporation Service Company, 100 Shockoe Slip Fl 2, Richmond, Virginia, 23219).

24. UHS-D's active status with the Virginia State Corporation Commission (SCC) lapsed for failure to pay the annual registration fee in 2021.

25. UHS-D remains eligible for reinstatement with the SCC by paying the fee but has not done so as of the date of filing of this action.

26. UHS-D conducts or at all times relevant to this suit conducted substantial business in Virginia.

27. UHS-D does or did at all times relevant to this suit operate, manage, and/or own, directly or indirectly, at least 12 facilities in Virginia, including Cumberland Hospital.

JURISDICTION

28. This Court has personal jurisdiction over UHS, Inc. and UHS-D pursuant to the Virginia long-arm statute, Va. Code § 8.01-328.1(A), and under constitutional principles because the claims raised in this action arise from and relate to these Defendants' intentional, deliberate, and purposeful availment of the privilege of conducting activities within Virginia.

29. UHS, Inc., either directly or indirectly through its subsidiary UHS-D at all times relevant to this action owned, operated, oversaw, and managed Cumberland Hospital and other Virginia facilities.

30. At all times relevant to this action, UHS, Inc., UHS-D and Cumberland Hospital owned the realty upon which Cumberland Hospital is located. UHS, Inc.'s annual reports confirm this as shown by the following true depiction from 2018:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Crescent Pines	Stockbridge, Georgia	50	Owned
Cumberland Hall (11)	Hopkinsville, Kentucky	64	Owned
Cumberland Hospital (11)	New Kent, Virginia	130	Owned

31. UHS, Inc. transacted substantial business in Virginia directly and through its agents, UHS-D, Cumberland Hospital, Dr. Davidow, and other leadership officials at Cumberland Hospital.

32. UHS, Inc., either directly through its officers or indirectly through its subsidiary UHS-D and its officers, at all times relevant to this action exercised authority over employing, directing, and discharging members of the Cumberland Hospital management team, including CEO Patrice Gay Brooks, Chief Nursing Officer Paula Roberts, and Dr. Davidow, the Medical Director.

33. UHS, Inc. directly hired and continues to hire Cumberland Hospital officers, staff, and other employees. It hired or retained Davidow when it purchased Cumberland Hospital. And it hired Cumberland Hospital's CEO, other managers, therapists, nurses, and behavioral technicians.

34. UHS, Inc., either directly or indirectly through its subsidiary UHS-D, at all times relevant to this action exercised authority over employing, directing, and discharging Cumberland Hospital executives and employees, including managers, physicians, nurses, behavioral technicians, counselors, and administrative staff.

35. UHS, Inc. and UHS-D from at least 2018 through present day solicited and continues to solicit potential management, executive-level, and other employees and staff for vacancies at Cumberland Hospital and its other Virginia facilities, including medical director, nurses, and behavioral technicians, through its website (uhsinc.com or jobs.uhsinc.com), as well as various online platforms (e.g., LinkedIn, Ladders).

36. When one searches the UHS, Inc. website for job postings, he or she must apply directly from the UHS website.

37. After clicking "Apply Now" applicants are redirected to "careers-uhsinc.icims.com" where they set up a profile.

38. UHS, Inc. and UHS-D from at least 2018 through present day marketed, promoted, and controlled services provided by Cumberland Hospital and their other Virginia facilities and substantially profited from all such activities.

39. Employees, officers, and the Board of Directors at UHS, Inc. and UHS-D exercise overall control over Cumberland Hospital and the other Virginia facilities with the goal of maximizing profit by increasing revenue and decreasing costs.

40. UHS, Inc. and UHS-D procured contracts from referring facilities and state and local government agencies to send patients like Jefry to Cumberland Hospital and its other Virginia facilities.

41. UHS, Inc. and UHS-D designed and implemented staffing ratios, billing practices and staff training requirements at Cumberland Hospital and its other Virginia facilities as part of its strategy to increase profits and maximize return to shareholders.

42. UHS, Inc. and UHS-D deliberately and systematically exploited the Virginia market for inpatient and outpatient services in order to get potential patients treated at Cumberland Hospital and its other Virginia facilities.

43. In 2009, UHS, Inc.'s behavioral health revenue made up 25% of its total revenue. By the end of 2019, that grew to 46% of total revenue. In that 10-year period, its total behavioral health revenue grew from $1.3 billion to $5.2 billion.

44. A substantial amount of that behavioral health revenue came from its Virginia facilities.

45. In or around 2019, UHS, Inc. proposed entering into a management agreement with the Virginia Department of Behavioral Health and Developmental Services ("DBHDS") for the operational management of the Commonwealth Center for Children and Adolescents, an acute care mental health facility for youth operated by DBHDS. A true and accurate depiction of the cover of the proposal is below.

Universal Health Services, Inc.
Virginia Regional Facilities

Commonwealth of Virginia - Conceptual Proposal

A Strategic Partnership to Provide Transformative Change for Youth in the Virginia Behavioral Health Care System

46. In it, UHS, Inc. boasted that "[a]s the managing entity, UHS-VA is a [sic] position to leverage its depth, breadth and expertise with child and adolescent services in the Commonwealth to develop a system of care to meet the needs of this vulnerable population."

47. UHS, Inc. described its "qualification and experience" for such an undertaking:

> **1. Qualification and Experience**
>
> A. Our regional Virginia facilities including Kempsville Center for Behavioral Health, Harbor Point Behavioral Health, Cumberland Hospital for Children and Adolescents, Poplar Springs Hospital, The Hughes Center, Liberty Point Behavioral Healthcare, North Springs Behavioral Healthcare, Newport News Behavioral Health Center, and First Home Care (FHC) are under the parent company Universal Health Services, Inc. (UHS). Each facility has their own management agreements and additional information can be provided upon request.
>
> These nine facilities are proud of our past, present and future role in partnership with the Commonwealth of Virginia to meet the behavioral health needs of Virginia's youth. As a large behavioral healthcare player in the Commonwealth, our facilities and services are in a unique position to provide integrative care delivery and offers child and adolescent behavioral health services that will complement a well-coordinated strategy across state agencies. Our UHS inpatient hospitals are well positioned in crisis stabilization and center on family-centered, person-centered care coordination. Many of the RTC facilities include programming for short term residential, including assessment and diagnostic services. The Joint Commission's gold seal of approval on UHS Virginia's website shows that we have demonstrated compliance to the most stringent standards of performance, and we take pride in our accreditation.

UHS, Inc. also described the "project characteristics," which focused on diverting DBHDS patients to UHS, Inc.-owned facilities:

> **2. Project Characteristics**
>
> A. The Virginia regional facilities Kempsville Center for Behavioral Health, Harbor Point Behavioral Health, Cumberland Hospital for Children and Adolescents, Poplar Springs Hospital, The Hughes Center, Liberty Point Behavioral Healthcare, North Springs Behavioral Healthcare, Newport News Behavioral Health Center, and First Home Care, seek to develop a system of care focused on diverting new admissions and current admitted patients from the Commonwealth Center for Children and Adolescents (CCCA). We are working through our network to define how our system of care will evolve and expand to meet this need.

48. Cumberland Hospital CEO Brooks, prior to and including 2018 and 2019, was an employee, agent, and/or servant of UHS, Inc. and UHS-D hired directly by UHS, Inc.

49. Davidow was likewise hired or retained directly by UHS, Inc.

50. CEO Brooks and Dr. Davidow had discretionary authority to act on behalf of UHS, Inc. and UHS-D in their management and operation of Cumberland Hospital, subject to oversight by UHS, Inc. and UHS-D.

51. UHS Inc. confided the day-to-day management of Cumberland Hospital in its leadership team, including Dr. Davidow and CEO Brooks.

52. While acting within the scope of their employment and agency with UHS, Inc. and UHS-D, CEO Brooks submitted annual license applications on behalf of UHS, Inc. and UHS-D to the Virginia Department of Health ("VDH").

53. Each application included an affidavit, which she signed under oath, affirming that the information contained therein was "true and correct, and all federal state and local laws and regulations have been complied with."

54. In each application, CEO Brooks affirmed that "Universal Health Services" was the "owner" of Cumberland Hospital.

55. Each year, VDH issued a general hospital license (No. H 1849) to "Universal Health Services" as the "operator" of Cumberland Hospital.

56. At all times relevant to this action, UHS, Inc. and/or UHS-D, or both, paid for DBHDS and VDH license application renewals for Cumberland Hospital via check.

57. The checks were signed by Debra K. Osteen, UHS, Inc.'s "Executive Vice President" and "president" of its "Behavioral Health Division."

58. At all times relevant to this action, UHS, Inc. and UHS-D submitted financial statements to state agencies evidencing sufficient financial qualifications for licensure in Virginia.

59. At all times relevant to this action, UHS, Inc. and UHS-D funded, profited from, and exercised oversight authority over all operations and activities at Cumberland Hospital.

60. UHS, Inc. dominated UHS-D and Cumberland Hospital to the point that neither had separate corporate interests of their own.

61. UHS-D and Cumberland Hospital were both UHS, Inc.'s alter egos.

62. UHS, Inc.'s and UHS-D's direct and indirect contacts with Virginia are thus pervasive, such that each had more than fair warning that it may be haled into Virginia courts to defend actions based on injuries caused by its facilities.

VENUE

63. Venue is proper in this Court pursuant to Va. Code §§ 8.01-262(1) and -262(2) because Daniel N. Davidow, M.D. and Daniel N. Davidow, P.C. resides and has its principal office in the City of Richmond, and because Cumberland Hospital, LLC and UHS of Delaware, Inc. appointed agents to receive process in the City of Richmond.

UHS, INC./UHS-D & CUMBERLAND HOSPITAL'S UNLICENSED SERVICES

64. UHS, Inc. and its facilities have a long history of repeated and serious violations of state and federal regulatory requirements governing staffing, licensure, supervision, and patient safety.

65. In March 2013, UHS, Inc. CFO Steve Filton spoke at the Annual Cowen Health Care Conference and boasted about how UHS, Inc. "benefit[s]" from patients who are "not in a position" to make decisions about their own care. Levine, Art, Mental Health, Inc., n. 238 (2017).

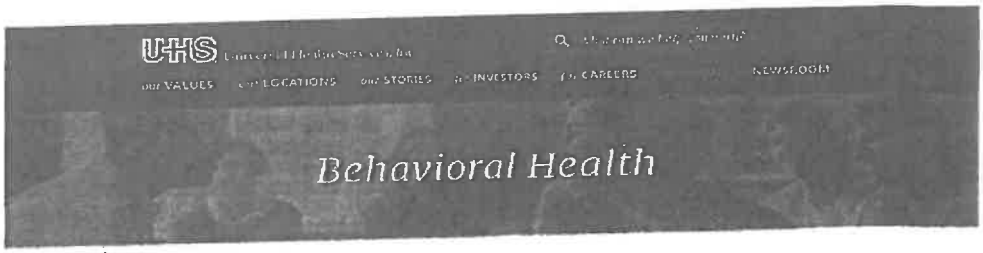
66. In July 2020, Virginia's Attorney General announced that it and 49 other states, territories, and the federal government settled allegations of fraud against UHS, Inc., UHS-D, and its facilities, including Cumberland Hospital.

67. The allegations included that UHS, Inc.'s facilities submitted false claims to Medicare and Medicaid for inpatient behavioral health treatments that were medically unnecessary or not reasonable, and that UHS, Inc. failed to provide appropriate or adequate services for children admitted to its facilities, including staffing, training, and supervision of staff.[1]

68. Cumberland Hospital was at all times relevant to this action a part of UHS, Inc.'s "Behavioral Health Division."

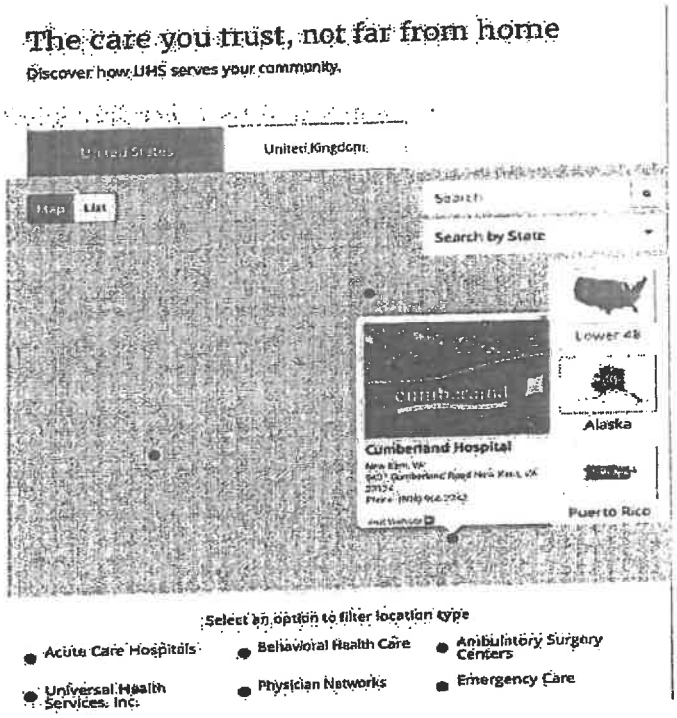
69. A May 2019 web capture of a true depiction of UHS, Inc.'s website describes the Behavioral Health Division and its "responsibility to patients":

[1] *See* https://www.oag.state.va.us/media-center/news-releases/1757-july-14-2020-universal-health-services-inc-and-uhs-of-delaware-inc-to-pay-117-million-to-settle-allegations-involving-improper-admissions-and-discharges-at-its-inpatient-and-residential-psychiatric-and-behavioral-healthcare-facilities. *See also* UHS, Inc.'s Settlement Agreement with U.S Dep't. of Justice, *et al.*, *available at* https://www.sec.gov/Archives/edgar/data/352915/000156459020032190/uhs-ex101_17.htm.



As the largest facility-based behavioral health provider in the country, we recognize our responsibility to patients and their families to provide them with specialized care and treat them with dignity and respect.

70. Another true and accurate May 2019 web capture confirms that Cumberland Hospital was held out by UHS, Inc. as part of its Behavioral Health Division:



71. An April 2018 web capture of a true depiction of the Cumberland Hospital website shows the following:

Neurobehavioral Treatment

At Cumberland Hospital, we understand that children's emotions and behavior can be affected by their medical conditions and developmental status. Our Neurobehavioral Program is designed specifically for youth whose neurological impairments are compounded by behavior issues.

Our team of professionals are experts in childhood development, diseases, injuries and emotional adaptation. We help young people ages two to 22 heal physically and develop emotionally by employing the latest approaches in medical management and through building adaptive skills.

Admission

Upon admission, each child participates in a comprehensive multidisciplinary team assessment from which a master treatment plan is developed that considers the child's unique needs. Because of Cumberland's small size and specialized staff, each child receives personalized treatment in a nurturing environment. Medical assessment and treatment includes consultations from a pediatric neurologist, a pediatric psychiatrist or neuropsychologist as necessary.

72. Cumberland Hospital's website in June 2018 also represented that "[m]ost children who are admitted to the Neurobehavioral Program are medically stable."

73. Cumberland Hospital's "FAQ" section of its website in 2018 showed the following:

What brain injury and neurobehavioral patients do you see?

Typical neurobehavioral diagnoses include low-functioning autism, spinal cord injuries, developmental syndrome, perinatal brain injury, impulse control disorders, fetal alcohol syndrome and seizure disorders. Brain injury diagnoses include TBI, coma recovery, spinal cord injuries and post-surgical rehabilitation.

74. The 2018 Cumberland Hospital website included the following from Dr. Davidow:

A Note From the Medical Director

Thank you for your interest in Cumberland Hospital.

The physicians who started Cumberland in 1983 envisioned a hospital that provides integrated care, combining medical, psychotherapeutic, rehabilitative, behavioral and educational services for young people challenged by both complex medical and emotional needs. As one of those founding physicians, I am proud to say that we continue to be highly successful in accomplishing this mission.

Our community of professionals has helped many young people reach optimum levels of health, independence and improved family relationship by identifying and building on each patient's strengths and abilities. We work as a team to develop goals and plans for treatment in partnership with our patients, families, caregivers and professionals. We are able to share our collective knowledge and expertise through this process, treating both mind and body as a whole because we believe a child's health is impacted by all aspects of his or her life. This integrated approach contributes to the success of our patients.

The location and setting of Cumberland Hospital lend itself to healing. With acres of farmland, trees and waterways surrounding the hospital, we incorporate the outdoors into each patient's daily life. Our goal is to provide an environment that meets every child's need for learning, recreation, peer interaction, socialization and spiritual and emotional growth.

I invite you to visit our hospital campus or community-based group home. You will find a truly unique approach to providing quality medical care to young people. We may just be the breakthrough you've been looking for.

Best wishes for the future.
Daniel Davidow, MD

75. At all times relevant to this suit, Cumberland Hospital was licensed only by VDH to operate a "general hospital" with 94 acute care beds.

76. A "general hospital" means "an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity." 12VAC5-410-10.

77. Licensure as a "general hospital" by VDH does not authorize the provision of "services" that constitute a "residential treatment program" or "inpatient psychiatric" services as defined in the Virginia behavioral health regulations. *See* 12VAC 35-46-10; -105-20.

78. Residential treatment and inpatient psychiatric facilities have different staffing requirements given the typical patient's unique risk levels and supervision needs.

79. DBHDS did not license any providers at or services within the VDH-licensed Cumberland Hospital during the timeframe relevant to this action.

80. DBHDS did license a separate facility on Cumberland Hospital's campus, a 16-bed unit which provided services constituting a residential treatment program. However, that unit was available only to adolescents and young adults, i.e., according to Cumberland Hospital's own website in 2018, people between ages 13-22.

81. The Virginia behavioral health regulations define "residential treatment program" as:

> 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent ***in order to prevent or minimize the need for more intensive inpatient treatment.*** Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive nonmental health special needs including, but not limited to, personal care, habilitation, or academic educational needs of the resident.

12 VAC 35-46-10 (emphasis added).

82. The Virginia behavioral health licensing regulations define "inpatient psychiatric services" as:

> [I]ntensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of such a hospital.

12 VAC 35-105-20. "Mental illness" means

> [A] disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities ***and requires care and treatment for the health, safety, or recovery of the individual*** or for the safety of others.

Id. (emphasis added).

83. The Commissioner of DBHDS is responsible for licensing behavioral health providers operating "residential treatment program" or "inpatient psychiatric" services.

84. Licensure signifies state approval to operate a children's residential or inpatient psychiatric facility and indicates the status of a facility regarding compliance with regulations.

85. DBHDS is authorized to impose sanctions on licensees and to summarily suspend licenses. Its board is required to adopt regulations governing the advertising practices of licensees.

86. To become licensed, a provider must certify compliance with seclusion, time out, and restraint regulations, among other conditions.

87. DBDHS also investigates the "character, reputation, status, and responsibility of the applicant." 12VAC35-46-30.

88. At admission, a licensee must "discuss [with the patient or guardian] and document in the individual's services record, his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstances, if any, the intervention may include seclusion, restraint, or time out." *Id.*

89. "Only residential facilities for children that are licensed under the Regulations for Children's Residential Facilities (12VAC35-46) and inpatient hospitals may use seclusion and only in an emergency." 12VAC35-115-110.

90. "Trained, qualified staff shall monitor the individual's medical and mental condition continuously while the [seclusion, restraint, or time out] is being used." *Id.*

91. "Providers shall not use seclusion, restraint, or time out as a punishment or reprisal or for the convenience of staff." *Id.*

92. "Incidents of seclusion and restraint, including the rationale for and the type and duration of the restraint, shall be reported to the department." *Id.*

93. Use of timeout must be reported to DBHDS for independent review by the local human rights committee. *See* 12VAC35-155-105.

94. DBDHS makes "announced and unannounced reviews during the effective dates of the license. The purpose of these reviews is to monitor compliance with applicable regulations." 12VAC35-46-40.

95. A "helmet" is a "restraint" for "protective purposes." 12VAC35-115-30.

96. "Seclusion" is "the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it." *Id.*

97. "Time out" is "the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior." *Id.*

98. Nurses, behavioral technicians, ("BT") and other staff at Cumberland Hospital who were agents, employees, and servants of UHS, Inc., UHS-D, and Cumberland Hospital, frequently and routinely used restraint, seclusion, and time out for patients, including Jefry, for punishment and for ease and convenience because they were poorly, improperly, and recklessly trained and staffing ratios were wholly inadequate.

99. UHS, Inc., UHS-D, Cumberland Hospital, and their agents, including Dr. Davidow and Cumberland Hospital's CEO Brooks, also had actual and constructive knowledge that Cumberland Hospital and its employees and agents were using restraint, seclusion, and time out without following or being subject DBHDS regulations and reporting requirements.

100. No provider, including Dr. Davidow or Cumberland Hospital, "shall establish, conduct, maintain, or operate or continue to operate in the Commonwealth any service, without being licensed under this article." Code § 37.2-405(A).

101. "No person shall be admitted, placed, treated, maintained, housed, or otherwise kept, voluntarily or involuntarily, by any provider required to be licensed by subsection A, unless and until the provider is licensed by the Commissioner." Code § 37.2-405(C).

102. A violation of that Code section or any applicable regulation is a Class 3 misdemeanor, "and each day, or part thereof, of continuation of any such violation shall constitute a separate offense." Code § 37.2-422.

103. UHS, Inc., UHS-D, Cumberland Hospital, and their agents, including Dr. Davidow and Cumberland Hospital's CEO Brooks, had actual and constructive knowledge throughout at least 2018 and 2019 that Cumberland Hospital and its employees and agents were providing unlicensed services.

104. In fact, in 2019 a Cumberland Hospital patient made a report to DBHDS through the Governor's Office. The Virginia State Police and CPS were involved. The incident took place on Cumberland Hospital's Unit 8. CEO Brooks informed DBHDS that Unit 8 was not licensed by DBDHS. As a result, DBDHS did not formally investigate the complaint.

105. However, VDH and DBHDS conducted a formal investigation of Cumberland Hospital's licensure and services in late 2019 into early 2020.

106. The investigation started because "VDH, DBHDS, and the Virginia Department of Social Services have received numerous complaints, including substantiated allegations of abuse and neglect, related to the provision of services at Cumberland Hospital."

107. "VDH and DBHDS [had] grave concerns for the safety and care of the individuals served at the units of Cumberland Hospital currently licensed by VDH."

108. The DBHDS Commissioner notified CEO Brooks via letter in February 2020 that Cumberland Hospital's Units 2, 6, 7, and 8, as well as its "Autism Unit" were operating child "residential treatment program" and "inpatient psychiatric" services without a license.

109. CEO Brooks acknowledged this truth in a letter to the commissioners of DBHDS and VDH dated March 16, 2020.

110. Officers and agents of UHS, Inc., UHS-D, and Cumberland Hospital directly communicated and met with VDH and DBHDS officials during the investigation.

111. On at least one occasion, officials from UHS, Inc.'s Pennsylvania corporate office met directly with VDH and/or DBHDS officials in Virginia.

112. Kerry Knott, UHS, Inc.'s and UHS-D's Divisional Vice President in charge of the Behavioral Health Division, initiated and coordinated regular contact with VDH and DBHDS officials during the investigation through his "@uhsinc.com" e-mail address.

113. The position of "Divisional Vice President" is classified by UHS, Inc. as among its "Officers and Senior Management."

114. On April 7, 2020, Cheryl Ramagano, UHS, Inc.'s "Senior Vice President and Treasurer" wrote to the Director of DBHDS, "I am authorized to represent that subject

to approval of our investment committee, Universal Health Services, Inc. is committed to fund enhanced services at [Cumberland Hospital]."

115. The position of "Senior Vice President and Treasurer" is classified by UHS, Inc. as a "Corporate Officer."

116. Officers and agents of UHS, Inc. and UHS-D, as well as Cumberland Hospital employees, were directly involved in the planning and process of obtaining proper licensure in response to the VDH and DBHDS investigation, including the transitioning of beds between units and hiring staff at Cumberland Hospital.

117. Dr. Davidow personally oversaw the day-to-day provision of unlicensed services by Cumberland Hospital's other agents, but similarly was not licensed by DBHDS.

118. UHS, Inc. and UHS-D derived substantial income from Cumberland Hospital's and Dr. Davidow's provision of unlicensed services.

119. UHS, Inc., UHS-D, and Cumberland Hospital all represented to the public via their websites and other mediums that Cumberland Hospital was licensed by DBHDS.

120. UHS, Inc., UHS-D, and Cumberland Hospital all represented to the public via their websites and other mediums that Cumberland Hospital was credentialed both as a Hospital and as a Behavioral Health Care organization by The Joint Commission.

121. Credentialing by The Joint Commission and compliance with its standards is necessary for a facility's eligibility to receive Medicare and/or Medicaid reimbursement.

122. Cumberland Hospital received Medicare and/or Medicaid reimbursement and is therefore required to comply with its standards.

123. The ultimate goals of the Joint Commission standards are patient safety and improved quality care.

124. UHS, Inc. touts its facilities' credentialing by The Joint Commission on its website and otherwise in the public domain.

125. A fact sheet available through the UHS, Inc. website shows the following:

UHS Clinical Quality Reputation, Accomplishments and Awards:
We have a longstanding, independently validated and evidence-based record of providing quality healthcare services to patients and their families:

- All UHS hospitals are fully accredited by independent organizations including The Joint Commission (TJC), whose rigorous clinical assessment protocols are widely respected throughout the healthcare industry. In our almost 40-year history, UHS has not had a facility fail to achieve accreditation or re-accreditation by any accrediting body.

126. At all times relevant to this action, Cumberland Hospital did not actually follow The Joint Commission's credentialing standards for Behavioral Health Care.

127. Yet at all times relevant to this action, Cumberland Hospital's website openly displayed The Joint Commission's gold seal.

128. At all times relevant to this action, UHS, Inc., UHS-D, Cumberland Hospital, Davidow, and their employees and agents admitted and attempted to treat children, including Jefry, without appropriate and necessary licenses from DBHDS and VDH.

129. At all times relevant to this action, UHS, Inc., UHS-D, Cumberland Hospital, Davidow, and Davidow, P.C. knowingly, fraudulently, negligently, and with the intent to deceive the public, including Jefry and his mother, as well as referring agencies and entities, held Cumberland Hospital out as a necessarily and appropriately licensed and credentialed facility providing child residential treatment services and inpatient psychiatric services for children.

130. UHS, Inc., UHS-D, Cumberland Hospital, Davidow, and Davidow, P.C. knowingly and negligently made false statements and misrepresentations on their websites and in marketing and advertising material for Cumberland Hospital with the intent to deceive the public, including Jefry and his mother, as well as referring agencies and entities,

that described Cumberland Hospital as a "behavioral health provider" offering "specialized care" when, in fact, the facility was not licensed, credentialed, staffed, equipped, or prepared to provide residential behavioral health or inpatient psychiatric services to any child.

131. UHS, Inc., UHS-D, Cumberland Hospital, Davidow, and Davidow, P.C. knowingly and negligently made false statements and misrepresentations on a now deleted YouTube video promotion for Cumberland Hospital with the intent to deceive the public, including Jefry and his mother, that described the facility as "a medical facility first, behavioral secondary" when, in fact, a majority of individuals at Cumberland Hospital had a primary diagnosis of mental illness and/or developmental disability and the primary reason for admission to Cumberland Hospital was directly related to the individuals' mental illnesses and/or developmental disabilities rather than medical conditions.

132. During the entirety of Jefry's stay at Cumberland Hospital no hospital unit was licensed to provide children's residential treatment program or inpatient psychiatric services.

133. Yet, during the entirety of Jefry's stay, Cumberland Hospital, including its Unit 2 and Unit 8, provided children's residential treatment program and inpatient psychiatric services to Jefry without a license.

134. The knowing and intentional failure to obtain proper licensure by UHS, Inc., UHS-D, Cumberland Hospital, Davidow, and Davidow, P.C. allowed them to escape regulation and enforcement by DBHDS and VDH.

135. Cumberland Hospital's *modus operandi*, ratified by and known to UHS, Inc. UHS-D, and Davidow was and is to accept patients like Jefry who suffer from a primary

diagnosis of mental illness or developmental disability, regardless of severity, and keep them in the general hospital under the guise of medical care.

136. The only medical care Jefry received over his time at Cumberland Hospital, other than prescriptions ordered by Davidow (who lacked any special training in child psychiatry from approved residency programs) was treatment of acute conditions caused by the negligence of Cumberland Hospital and its agents and principals.

JEFRY'S PATH TO CUMBERLAND HOSPITAL

137. Jefry was born on September 21, 2007. He lived at home with his mother, Marisol, and his siblings until his time at Cumberland Hospital.

138. Jefry never attended traditional public school. Instead, he was receiving special education services through Shenandoah County.

139. Jefry suffered from autism spectrum disorder (ASD) and intellectual disability that were diagnosed around the age of three.

140. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association describes ASD as follows:

> Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships. . . .
>
> [ASD] is not a degenerative disorder, and it is typical for learning and compensation to continue throughout life.

141. The DSM-5 bases severity "on social communication impairments and restricted, repetitive patterns of behavior." Level 3, the highest level of severity, requires "very substantial support" and is marked by "severe deficits in verbal and nonverbal social communication skills, "extreme difficulty coping with change," and "great distress/difficulty changing focus or action."

142. Jefry suffered from the most severe level of ASD.

143. Jefry was completely non-verbal and required constant one-on-one adult monitoring for all activities of daily living (ADLs) from personal grooming to toileting.

144. While disruptive behaviors are not included in the DSM-5 diagnostic features, self-injurious behavior (SIB) occurs in a large percentage of individuals with ASD.

145. Lack of verbal communication, deficits in receptive and expressive language, social skills deficits, and sleep disturbances are all associated with an increased risk of SIB.

146. SIB can also be a manifestation of communicating pain and discomfort related to a variety of medical conditions which, when present, can be overlooked if not considered diligently and prudently.

147. Head banging is a common form of SIB in children like Jefry.

148. Jefry began head banging as early as age 5. It was sporadic and varied in severity until Jefry reached age 10.

149. In 2018, Dr. Anthony Neri, Jefry's primary care physician, trialed Jefry on Sertraline (Zoloft) (37.5 mg) to no benefit.

150. In May 2018, Jefry saw Dr. Katheryn Frazier, a developmental behavioral pediatrician at the University of Virginia Developmental Pediatrics Clinic. She noted that Jefry started head banging "again about 2-3 months ago," that it happens at home and at school when his mother or someone else is not by his side, that he wears a helmet, and that he sustained no injuries or bruises.

151. Dr. Frazier "[s]trongly recommend[ed] behavioral therapy to address self-injurious behaviors" and asked a social worker to reach out to Marisol with potential resources.

152. Jefry's IEP with Shenandoah County schools required continuous one-to-one monitoring for his safety.

153. In September 2018, school officials amended his IEP to reflect their discussions "about a specialized residential hospitalized setting (such as Kennedy Kreiger [sic]) where he could have the 24/7 medical and wrap around services."

154. Special education services officials referred Marisol to Cumberland Hospital, which they believed, based upon Cumberland Hospital's affirmative representations to them on this and other occasions, was a licensed children's residential facility on par with Kennedy Krieger equipped to treat and care for children with severe ASD and SIB.

155. Marisol, in turn, was aware of and relied upon Cumberland Hospital's representations that it was a licensed children's residential facility equipped to treat and care for children with severe ASD and SIB on par with Kennedy Krieger.

156. Cumberland Hospital required a letter of medical necessity before admission.

157. In November 2018, school officials worked in conjunction with Dr. Neri to draft a letter of necessity for Jefry's referral.

158. Dr. Neri wrote that Jefry "is in a self-contained classroom for special education services that includes a trained autistic spectrum disorders behavioral specialist. In recent weeks his support has been increased from frequent one-on-one to 2 on 1 support in an effort to prevent serious self-injury."

159. Cumberland Hospital received a copy of Dr. Neri's letter and Jefry's IEP before he was admitted.

160. A representative from Shenandoah County schools personally spoke with a person employed by UHS, Inc., UHS-D, and Cumberland and explained Jefry's condition in detail and emphasized that Jefry needed at least continuous one-to-one monitoring for his safety.

161. Marisol believed that Jefry would receive at least continuous one-to-one monitoring pursuant to his IEP while at Cumberland Hospital.

JEFRY'S FIRST ADMISSION TO CUMBERLAND HOSPITAL

162. Jefry's mother, Marisol, accompanied Jefry throughout the admission process. Marisol speaks and understands Spanish but very little English.

163. There was no Spanish-English interpreter present during the initial admission process.

164. Marisol informed her contact at Shenandoah County of the failure to provide an interpreter. The county relayed this concern via e-mail to Donna Donahue, a Cumberland Hospital Admission Liaison, and Sherry Green-Henry, a Patient Relations Coordinator.

165. Both Donahue and Green-Henry have e-mail addresses with the suffix "@uhsinc.com."

166. Green-Henry referred the matter to Jefry's case manager, Kim Moneyhan, who also had the same e-mail suffix.

167. Moneyhan and Green-Henry dismissed Marisol's concern.

168. Marisol was confused and frustrated by the admission process because the language barrier prevented her from fully understanding Jefry's treatment plan and asking questions of the providers, including Davidow.

169. As Jefry's parent and legal guardian, Marisol was required to sign a number of release forms and policy acknowledgments that were all in English and not available in or otherwise translated to Spanish, including restraint, time out, and seclusion policies and notices.

170. No staff member at Cumberland Hospital that day or after took the time to explain to or ensure Marisol's understanding of the treatment Jefry would receive during his stay.

171. However, Marisol was told directly multiple times at the admission intake with Cumberland Hospital that Jefry would receive one-to-one monitoring for his safety and SIB prevention.

172. UHS Inc., UHS-D, and Cumberland Hospital billed Shenandoah County and other payors for Jefry's stay at a rate reflecting continuous one-to-one care pursuant to his IEP.

173. Marisol was aware of the billing practice and relied upon her knowledge of the services breakdown in assuming Jefry would receive continuous one-to-one care pursuant to his IEP.

174. Dr. Davidow engaged Jefry as his attending physician and conducted Jefry's admission assessment and clinical review on November 19, 2018.

175. Dr. Davidow is not now and was never a psychologist, psychiatrist, or neurologist.

176. Davidow has no specialized training in treating or medicating children with severe ASD.

177. At admission, Davidow estimated Jefry's duration of stay to be 100 days.

178. Davidow noted under diagnosis "Autism Spectrum Disorder (IQ<50), Self-Injurious Behavior, Cognitive/Language Delay, Aggressive."

179. Davidow cited the reason for hospitalization as "Jefry endangers himself outside of protective setting."

180. According to Davidow, other than bouts of diarrhea and asthma that he previously outgrew, Jefry was otherwise healthy.

181. Jefry had no prior history of seizures.

182. Davidow admitted Jefry to the "neurobehavioral program" on Unit 8 which was not licensed by DBHDS.

183. Unit 8 had at best a 7:1 staff to patient ratio, with usually only one registered nurse per shift.

184. Davidow prescribed various medications, including the previously unsuccessful 37.5 mg dose of Sertraline, as well as Inderol, a beta-blocker.

185. Both medications are of questionable effectiveness in ASD treatment and not FDA approved for the treatment of ASD.

186. Sertraline can increase SIB behavior in ASD patients.

187. Dr. Davidow never explored either FDA-approved ASD medication.

188. Davidow knew that Jefry needed constant adult assistance in all activities of daily living.

189. Davidow then crafted Jefry's generalized "plan" for admission:

PLAN:

Jefry will be involved in the neurobehavioral treatment program. The overarching behavioral program will be utilized. We will see if we can improve his ability to communicate effectively, his social functioning, and his self-care skill ability. I will continue Zoloft for transitional purposes, but introduce Inderal to help with emotional flooding and frustration tolerance. We could also consider Xanax or Seroquel, but these would be more potent medications (Xanax would be used primarily for the purpose of disinhibiting speech). His nutritional status would be monitored on a regular cut-up diet. Family support will be provided.

190. Davidow ordered four evaluations, including a psychological evaluation, but did not order evaluation for placement in a 1:1 patient to staff setting.

191. Jefry was first admitted to Cumberland Hospital on November 26, 2018.

192. Part of Davidow's admission intake was completion of a "High Risk Notification Alert" which is completed and signed by the attending physician for distribution to staff on Jefry's unit.

193. Davidow did not check the box next to "Self-Harm" and made no note of self-harm indicators.

194. Davidow made no order as to Jefry's need to wear a helmet other than to advise nursing to assist in applying a helmet "if patient agitated to prevent head banging."

195. Jefry was not required to wear any sort of helmet while sleeping.

196. Jefry did not reside in a padded room.

197. Davidow made no order that Jefry be closely monitored at either 1:1 or 2:1 staff to patient ratios as he was in school.

198. Davidow made no provision for a trained ASD behavioral specialist like Jefry had at school.

199. Neither UHS, Inc., UHS-D, nor Cumberland Hospital employed any specially trained ASD behavioral specialists or child psychiatrists or child psychologists at Cumberland Hospital.

200. Davidow ordered patient observation rounds of Q15, i.e., every 15 minutes, which is the minimum monitoring level available at Cumberland Hospital (the other levels being Q5 and 1:1).

201. Jefry did not have an admission consultation with a "pediatric neurologist, pediatric psychiatrist, or neuropsychologist" as promised by Dr. Davidow and Cumberland Hospital. *Supra* ¶ 74.

JEFRY'S FIRST STINT AT CUMBERLAND – NOVEMBER 2018 TO MARCH 2019

202. Jefry underwent a "psychology consult" conducted by Michael E. Hayes, Ph.D., a clinical psychologist, on December 31, 2018.

203. Dr. Hayes had no specialization in child psychology or ASD.

204. In his report, Dr. Hayes wrote, "Jefry had over 300 episodes of self-harm during the most recent reporting period. Most of these were mild in intensity but some head banging has resulted in bruising."

205. Dr. Hayes offered no substantive treatment recommendations in his report.

206. Dr. Hayes noted that "Jefry does not possess the requisite cognitive abilities, self-regulation, or level of self-awareness necessary to be able to benefit from participation in individual or group therapies" at Cumberland Hospital.

207. This was Jefry's only contact with a clinical psychologist at Cumberland Hospital.

208. Jefry's daily medical progress notes, mostly authored by Davidow, almost always reflect SIB and head banging, sometimes dozens and up to 20 times per day.

209. One such note dated January 12, 2019 states that Jefry "does not bang his head for long enough to put his helmet on."

210. Another note on January 22, 2019 states that he "engages in SIB repeatedly, but has not required the use of his helmet."

211. Davidow noted on February 1, 2019 that "[w]e do use his helmet as a contingency, but he can take it off and so it is not a restraint."

212. Davidow knew that his facility was not licensed to legally employ safety restraint.

213. On March 15, 2019, Davidow noted "facial bruises from self-abuse earlier this week when he took his helmet off and smashed the right cheek bone under the floor."

214. Cumberland Hospital maintained a standard Q15 Patient Observation Round sheet to be used daily and filled in by unit staff. The top of the sheet includes a box captioned "Precaution Type." One of the available precautions to be checked is "Self-Injury." There is also a box for "None."

215. In the 115 days Jefry was at Cumberland Hospital a sheet was completed every day.

216. Not once was the precaution box checked for "Self-Injury." In fact, on the few occasions any box was checked, it was marked "None."

217. Jefry was repeatedly placed in "time-out" and "seclusion" while a patient of Cumberland Hospital.

218. Jefry suffered a seizure on or about March 6-20, 2019 while at Cumberland Hospital.

219. The only reflection of this in Cumberland Hospital records is the March 6, 2019 patient care sheet showing that he was on "precaution/observation status" for seizure.

220. Davidow and Cumberland Hospital did not offer Jefry any medical care for a seizure.

221. On March 21, 2019, Davidow authored a "Certification of Need for Admission to Therapeutic Group Home."

222. In it, Davidow acknowledged that neither he nor Cumberland Hospital could adequately provide for Jefry's safety. He wrote:

> Jefery [sic] has participated in various outpatient community supports including Psychiatric Medication Management and hospitalization program at Cumberland Hospital. Jefery [sic] continues to engage in self-harm behaviors and has an average of 66 instance [sic] of self-harm in his last reporting period at Cumberland.
>
> Jefery [sic] continues to engage in self-harm behaviors that require intervention by staff and place him at risk of physical harm. Jefery [sic] also struggles with physical aggression, anxiety, frustration tolerance, focus and attention as well as emotional reactivity. ***Jefery's [sic] continued difficulties with self-harm and behavior can best be managed in a therapeutic group home at this time to maintain his safety*** and continue working to decrease self-harm and improve frustration tolerance and anxiety symptoms. (Emphasis added).

223. Davidow simultaneously minimized Jefry's condition in his discharge plan.

224. In the discharge summary signed by Davidow on March 27, 2019, he wrote that "Jefry made good progress during his stay" and "demonstrated a decrease in self-injury."

225. Davidow further noted that "Jefry wears his helmet 50% to 60% of the time to prevent self-injury and must be monitored when the helmet is off."

226. Davidow concluded with "Jefry is medically stable and continued care can be achieved at a therapeutic group home. Grafton Health will secure outpatient appointments."

JEFRY'S STINT AT GRAFTON: MARCH 2019 – AUGUST 2019

227. Jefry was admitted to Grafton Integrated Health Network – Berryville ("Grafton") on March 22, 2019.

228. Unlike Cumberland Hospital, Grafton was and is a licensed mental health child residential treatment facility for children as young as age 6.

229. His initial plan of care noted that Jefry was "referred to Grafton due to the severity and intensity of his self-injurious behaviors and physical aggression."

230. On April 18, 2019, Dr. Don Lee, a psychiatrist with specialization in child and adolescent psychiatry, conducted Jefry's diagnostic evaluation.

231. In it, Dr. Lee noted "SEIZURE ON 3/20/17 [sic] AT CUMBERLAND HOSPITAL" as well as "HX [history] OF SEIZURE."

232. Dr. Lee ordered Applied Behavior Analysis, an evidence-based behavioral intervention treatment for children with ASD and continued his current medication regimen.

233. Dr. Lee and others also ordered continuous use of Jefry's helmet.

234. Jefry sometimes left Grafton to spend time at home with his parents on a "therapeutic pass."

235. Jefry did not engage in SIB when he was home with his family.

236. However, after worsening SIB incidents at Grafton, on June 14, 2019, Dr. Lee ordered Abilify, an FDA-approved ASD medication.

237. Grafton held an internal review meeting on June 24, 2019 and approved an order for continuous wear of a new hard helmet Jefry could not easily remove.

238. Jefry had continued instances of removing his helmet and engaging in SIB.

239. On three occasions, Grafton staff took Jefry to the emergency room for injuries related to SIB.

240. On the last occasion in July 2019, Jefry incurred a subconjunctival hemorrhage (i.e., broken blood vessels in his eye).

241. However, Jefry did not sustain any skull or orbital fractures.

242. On August 6, 2019, Grafton staff determined that they were not equipped to maintain Jefry's safety despite different helmet and medication interventions.

243. Dr. Lee wrote on August 8, 2019: "At this time, and based on medical necessity, Jefry's treatment team is recommending he be served in a hospital setting where he may access a program that offers more restrictive interventions, in order to stabilize him. All while providing for his safety and well-being."

244. Jefry's transition plan noted the following:

> Jefry's triggers are anytime that there is a change to his environment or staffing. He typically will choose one staff member and if that staff leaves or engages with another staff or peers he can begin to engage in SIB or aggressive behaviors. He also has a hard time transitioning from a preferred staff to an un-preferred staff member. Jefry will also engage in aggressive behaviors when he is not able to hold onto staff the way he wants to at that point in time. He sometimes will be fine with holding one hand but other times he wants to hold both hands. If he is not able to get his way that is when SIB and aggressions will occur.
>
> When a crisis arises the main goal is to keep Jefry safe. Jefry will aim to hit his head on any hard object he can find. He will drop to the floor, bang it on walls, corners of furniture, and has resulted [sic] to using his own helmet to hit his head.

245. Dr. Lee believed Cumberland Hospital was licensed and qualified to provide restrictive interventions for Jefry's safety.

246. Marisol relied upon Cumberland Hospital's representations from Jefry's previous admission that Jefry's safety would be ensured with one-to-one monitoring.

JEFRY'S SECOND ADMISSION TO CUMBERLAND HOSPITAL

247. Jefry returned to Cumberland Hospital on August 14, 2019 with a black helmet with clear face shield to protect him from known SIB.

248. Marisol again accompanied Jefry throughout the admission process, but no interpreter was provided.

249. Again, she was asked to sign a number of release forms and policy acknowledgments that were all in English and not available in or otherwise translated to Spanish, including the restraint and seclusion policies and notices.

250. Again, she was assured that Jefry would receive continuous one-to-one care. This was of particular importance given the concerns about SIB at Grafton.

251. Dr. Davidow examined Jefry and noted a right periorbital bruise and hematoma that was healing.

252. Davidow assigned Jefry again to Unit 8, which had a 7:1 staff to patient ratio.

253. Davidow again ordered Q15 checks, the minimum offered at Cumberland Hospital.

254. Davidow stopped the use of Abilify immediately and reinstated Inderal at 100 mg twice per day.

255. Unlike before, Davidow completed the "High Risk Notification Alert" and checked the box next to "Self-Harm."

256. Davidow ordered: "Helmet, while awake until eye healed" and then to "apply helmet if patient agitated (or requests it)."

257. In a progress note dated August 16, Davidow added that "we are trying to keep his helmet on during the day at all times although he will subsequently be allowed to take it [off] when he calms down."

258. Between August 15-16, Jefry incurred an injury which, according to Ashley Osorio, MSW, an employee of Cumberland Hospital, "resulted in his ***other eye*** being swollen." (Emphasis added).

259. This injury was not documented by staff caring for Jefry between admission and the morning of August 16.

260. Carmen Cather, BT cared for Jefry from 3:00 p.m. to 11:00 p.m. on August 15.

261. Cather, BT did not care for Jefry during his first stint at Cumberland Hospital.

262. Cather, BT was very rigid and strict with Jefry.

263. During her shift, Cather, BT charted 10 episodes of non-compliance, 25 episodes of SIB, and 22 episodes of grabbing.

264. Between August 16-17, Jefry incurred another significant injury.

265. On August 16, Cather, BT was Jefry's caretaker for the 3:00 p.m. to 11:00 p.m. shift.

266. Cather, BT again charted disproportionate misbehavior by this autistic child, including 10 instances of "noncompliance," 8 SIB, and 12 instances of "grabbing."

267. Cather, BT also placed Jefry in seclusion/time out.

268. Cumberland Hospital, operating without a DBHDS license, is prohibited by law from using seclusion/time out.

269. Cather, BT and Cumberland Hospital failed to properly document and report the use of seclusion/time out.

270. Again, on August 17, Cather, BT was Jefry's caretaker between 3:00 p.m.- 4:00 p.m. and 8:15 p.m.- 9:15 p.m.

271. Cather, BT charted disruptive behavior in her limited time with Jefry.

272. Between 8:30 p.m. – 9:00 p.m., Cather charts Jefry as being "off unit." No explanation is given as to where he was or why.

273. Cather described Jefry between 8:15 p.m. and 9:15 p.m. as being "out of control."

274. Shamika Jones, BT also cared for Jefry during the 7:00 a.m. – 3:00 p.m. shift.

275. Jones, BT also had no prior experience with Jefry.

276. Jones charted numerous disruptive behaviors and a claim that Jefry "does not let staff do their job."

277. On August 18, 2019, the morning shift nurse Teena Dean, R.N. noted Jefry had "two black eyes and edema."

278. She further noted that when she removed his helmet, "it revealed pitting edema on sides of head."

279. She added that Jefry "began to cry and c/o [complain of] pain on head."

280. No medical progress note exists for August 18.

281. Jefry was noted in an August 19 progress note to have "significant swelling of this face and eyes" and was only "intermittently wearing his helmet with face shield."

282. It turned out that Jefry sustained a "significant bilateral periorbital edema" and was in significant pain. Both of his eyes were "swollen to slits."

283. Jefry received no emergency treatment at the time the injury was incurred or thereafter.

284. Chrystal Doyle, FNP-BC wrote a progress note on August 20 noting a request to "the medical team for additional imaging to rule out fracture or bleeding after physical assessment and to establish a baseline for previous/current injury in case patient has a change in status that suggests new or worsening injury."

285. Davidow signed the note on August 23, but no new imaging was ever done.

286. Cather, B.T. again managed Jefry on the August 21 3:00 p.m. – 11:00 p.m. shift.

287. As was her custom, she documented abundant disproportionate infractions, including 10 instances of "noncompliance."

288. In fact, Jefry's head was so swollen that it was rubbing against his helmet, causing pain and bleeding.

289. Teena Dean, R.N. noted at 7:45 p.m. that Jefry's helmet was rubbing against his two forehead cuts and that Jefry was banging his head and pulling off the helmet.

290. Jefry was noted to be very tired throughout evening of August 22. He would lay down but could not go to sleep and ate little dinner. Jefry cried, asking for his mother.

291. Belenda Washington, B.T., charted a note on August 25 that Jefry refused dinner and was out sick with "Peds staff" and refused to go to bed.

292. There is no other note or documentation of Jefry's visit with "Peds staff."

293. Ronnie Flores, BT was responsible for Jefry during the 7:00 a.m. – 3:00 p.m. shift on August 27.

294. Flores, BT noted an instance of elopement, i.e., he lost track of Jefry during his shift. There is no further explanation of what happened.

295. On August 27 at 7:50 p.m., Valerie Mutchler-Fornili, M.D. noted that Jefry has "serious soft tissue injuries" and also observed "new abrasions on his hands."

296. Jessica Gray, R.N. noted at 10:00 p.m. on August 27 that when "staff stepped away for a moment" Jefry awakened and banged his head on the floor, reopening his head wound and was bleeding heavily.

297. On August 28-29, Jefry exhibited very little activity and ate little.

298. In fact, even Cather, BT noted almost no activity from Jefry during her August 29 shift.

299. Cumberland Hospital staff continued to fail to check the box for 'Self-Injury" on the daily Q15 Patient Observation Round sheets.

JEFRY'S ADMISSION TO PEDIATRIC INTENSIVE CARE UNIT AT VCU

300. On August 30, Dr. Davidow noted ordering Jefry a new helmet that would "hopefully fit better" while they "are still trying to heal up the laceration on Jefry's right face."

301. Throughout the day, Jefry was again lethargic with little charted activity.

302. No Q15 observation logs are available for August 30.

303. Centra Wilson, B.T. was Jefry's 3:00 p.m. – 11:00 p.m. shift caregiver.

304. Carmen Cather, BT was also on the unit the night of August 30 into the morning of August 31, though she charted no observations.

305. Teena Dean, R.N. created a progress note reflective of Jefry sustaining an ***unwitnessed*** head injury from head banging.

306. According to Dean, R.N., at 10:00 p.m. Jefry was asleep in his room and wearing his helmet when she heard a noise that sounded like head banging. Jefry then came out of his room crying and walked to the nursing station.

307. Dean, R.N. goes on to recite that four minutes later at 10:04 p.m., Jefry vomited and began posture like activity with arms straightening and hands turning in. She also noted elevated blood pressure and a dilated right pupil. She was unable to examine his left pupil because it was swollen shut.

308. Dean, R.N. did not immediately call for physician.

309. Inge Eser-Scott, R.N., the nurse supervisor, responded to the floor at 10:30 p.m. but also did not call for a physician.

310. Dean, R.N. noted that Jefry was beginning to respond to verbal questions at 10:45 p.m.

311. Eser-Scott, R.N. finally placed a 9-1-1 call at 10:54 p.m., almost an hour after Jefry collapsed and vomited.

312. Eser-Scott, R.N. reported to dispatch that Jefry had "seizure-like activity" but that "[w]e don't think it's a seizure."

313. Eser-Scott, R.N. went on to say "Whatever we seen [sic] like was seizure-like, but it was more decorticated. He vomited once and then had this decorticated stage of -- which could be seizure, could not be a seizure."

314. Decorticate posturing is a sign of potential severe damage to the brain.

315. Eser-Scott, R.N. also told dispatch that Jefry is "now moving" but "was not responding about 10 minutes ago."

316. Eser-Scott, R.N. added: "He -- he came here with both eyes blue and yellow. But what I have seen -- I wasn't here for two days. So, what I've seen now and what I can tell you is that the left eye is completely shut swollen. He's not responding. He might be responding to some movements. He does not respond to sternal rub, and the right eye -- I can assess the right eye and it's responding very sluggish."

317. New Kent Fire Rescue ("NKFR") responded Cumberland Hospital.

318. NKFR EMS officials noted Jefry had a hard helmet next to him that did not have damage to it.

319. NKFR also documented Jefry had a soft spot on the left side of his head with an indentation mark and both of his eyes were swollen shut.

320. LifeEvac was activated at 11:27 p.m. and transported Jefry to VCU Medical Center ("VCU").

321. LifeEvac staff charted that "there is no evidence of seizure activity or vomiting."

322. Carmen Cather, BT accompanied Jefry to VCU.

323. Later, when EMS went back to Cumberland Hospital for signatures, they asked additional questions and charted that Jefry had been wearing a soft helmet that was damaged.

324. Dr. Jeff Stern, the trauma chief at VCU, noted an "Admission History & Physical" at 1:00 a.m. on August 31.

325. Dr. Stern wrote that Jefry reportedly sustained "a ground level fall."

326. Dr. Stern further noted that "[i]t was reported that he typically wears a helmet due to repeatedly banging his head against his wall, but experienced a ground level fall earlier today without his helmet on. Unclear at this time if the fall was witnessed."

327. Dr. Stern received that report from Dr. Davidow.

328. Drs. Brittany Ann Ockenfels, and Mark A. Marinello charted history and physical addenda later in the morning of August 31.

329. Drs. Ockenfels and Marinello wrote: "Reports of events conflicted; initial report given to [emergency department] was that patient fell and hit his head and was seen to have seizure-like activity with jerking movements. However, behavioral health worker [Cather, BT] who arrived with patient reported that he wasn't wearing his helmet and started head-banging injuring his L periorbital area, then had a seizure-like episode sometime later."

330. Dr. Robin Foster was Jefry's attending physician at the VCU emergency department.

331. Dr. Foster is Board certified in pediatric emergency medicine and child abuse pediatrics and is Director of VCU's Child Protection Team.

332. Dr. Foster examined Jefry and reported "severe, left, frontal, temporal, swelling, ecchymosis."

333. Dr. Foster also diagramed Jefry's injuries as pictured below:

334. Dr. Foster further noted that "CT scan here has moderate size left subdural hematoma that is acute in nature with hyperintense blood products on imaging."

335. Dr. Foster also noted "discrepant history from staff at Cumberland" as to how Jefry's injuries occurred.

336. Specifically, Dr. Foster noted that the transferring attending, Dr. Davidow, "reported that the child had fallen and then had a seizure."

337. She then noted that the "[m]edics [were] concerned that the patient had significant bruising and swelling on the left side of his head."

338. Dr. Foster also reported that the "care tech [Cather, BT] at the bedside here with patient says that the patient was sleeping alone in his room and then they (the two staff in the nursing station) heard him head banging with his helmet on. The tech walked the patient out to the nursing station and let him lay down on chairs with blankets. The nurse was asked to check on him and he vomited and then stiffened up and looked like he was having a seizure."

339. Dr. Foster noted that Cather, BT "reported that there are 14 patients on the unit and two staff present."

340. Dr. Foster noted "[c]oncern for nonaccidental trauma versus self inflicted" and that a "[social worker is] contacting CPS and law enforcement secondary to concerns about pattern of injury."

341. Jefry was admitted to the pediatric intensive care unit.

342. The initial CT scan showed an 8mm acute left subdural hemorrhage with 5mm midline shift and effacement of left supracellar cistern, left scalp hematoma extending to periorbital region, and a small right scalp hematoma.

343. Subdural hematoma is the most common CNS injury detected on imaging in abusive head trauma.

344. Imaging on September 3 showed that the acute left subdural hematoma decreased in size to 4mm.

345. Jefry was given precautionary Keppra for possible seizure but otherwise was deemed normal neurologically.

346. Jefry was given a continuous one on one observer during his time at VCU.

347. Cather, BT wrote an extensive progress note on August 31 taking issue with the fact that she was questioned by VCU staff and social workers.

348. In the note, Cather, BT questioned why Dr. Foster and VCU staff staff would take photos of Jefry to document his injuries.

349. Cather, BT quoted a VCU nurse as saying, "Since the injuries are reported self induced, and the severity of the injuries and brain bleed, CPS was called and there will be an investigation."

350. Davidow also made a medical progress note on August 30.

351. In it, he recounted a different version of events than what he relayed to VCU, writing that Jefry "came out of his room crying and appeared to have been banging his head

again, even though his helmet was in place. He had a swollen left eye and then he had a seizure with tonic posturing which lasted approximately 10 minutes."

352. A Cumberland Hospital incident report noted that "At that time the patient exhibited tonic seizure activity, sluggish pupil response, and cortical posturing."

THE CPS INVESTIGATION

353. Suzanne Grable led the CPS investigation in conjunction with VCU social workers.

354. Marisol initially told Ms. Grable she did not want Jefry returning to Cumberland.

355. Ms. Grable reported on September 4 that even though Jefry was medically cleared for discharge, she did not feel Cumberland Hospital was a safe disposition.

356. Ms. Grable and VCU social workers worked to craft a discharge plan for a return to Cumberland Hospital. Their priority was arranging one to one supervision for Jefry.

357. On September 6, Dr. Davidow and other officials from Cumberland Hospital told Ms. Grable that Jefry would be moved to Unit 2, the acute care unit, which has a 2:1 nursing to patient ratio.

358. Unit 2 was not licensed by DBHDS to provide child residential or inpatient psychiatric services.

359. Davidow and Cumberland Hospital also represented that they would have Jefry in 1:1 supervision whenever possible.

360. Davidow and Cumberland Hospital knew at the time they made this representation that Jefry would not receive 1:1 supervision.

361. Davidow and Cumberland Hospital also represented that the behavioral techs and other staff who cared for Jefry when he was injured "will NOT be caring for [him] on the new unit."

362. Ms. Grable approved this discharge plan based on Cumberland Hospital's representations.

363. Ms. Grable was led to believe that Cumberland was licensed and qualified to ensure Jefry's safety through one-to-one monitoring, staff training, and safety restraint.

364. Marisol agreed with this plan after being informed of Cumberland Hospital's representations.

365. Ms. Grable noted that her investigation was continuing and that she planned to interview all staff, as well as Davidow.

366. VCU staff sent Jefry's discharge summary to "Sherry and Donna at Cumberland" via facsimile.

367. Jefry was discharged in stable condition and had follow-up appointments with pediatric neurosurgery and pediatric surgery set for September 24 and September 25.

368. Jefry's discharge summary contained the following order: "If any change in neurological status such as: dizziness, nausea/vomiting, somnolence, altered mental status, or changes in vision, please return to the ED immediately."

369. The discharge summary also contained the following: "CPT consulted, open CPS case with New Kent. Discharged back to Cumberland with 24/7 1:1 until CPS finishes investigation."

JEFRY'S RETURN TO CUMBERLAND HOSPITAL

370. Davidow signed an admission assessment on September 6 admitting Jefry to Unit 2.

371. Davidow did not circle the option for a 1:1 supervision evaluation.

372. In fact, Davidow specifically ordered "every 15 minute checks" with "helmet on day and night."

373. As soon as September 9, a nurse employed by Cumberland Hospital noted: "Staff remains by patient side to prevent head banging. When he falls asleep, staff leaves, and returns when he bangs his head."

374. Angela Quarles, BT was Jefry's caretaker on September 10 and September 12 from 7:00 a.m. – 3:00 p.m.

375. On each shift, Quarles, BT put Jefry in seclusion/time out, once for "physical aggression" (grabbing her shirt) and another for SIB.

376. Also on September 12, Quarles, BT charted Jefry as asking to go to bed after lunch.

377. Lori Seeling, BT cared for Jefry on the 3:00 p.m. to 11:00 p.m. shift and charted the following: "When the nurse had him sit alone with no staff close by . . . he appeared to go to sleep. Staff checked on him approximately 10 minutes later [6:52 p.m.] and noticed he was rigid. Staff laid him on the floor and were unable to arouse him and he remained rigid. . . . Patient remained rigid and unresponsive for 5 minutes."

378. Teresa Critz, R.N. was the nurse on duty and caring for Jefry at the time. She noted that Jefry was snorting, "rapid breathing and decorticate posturing." She added that he was unresponsive at 6:52 p.m. and began vomiting at 6:55 p.m.

379. Decorticate posturing is a neurological event and sign of potential brain damage.

380. Neither Seeling, BT nor Critz, R.N. charted notifying the attending physician, Dr. Davidow.

381. Despite the fact that Jefry suffered these same symptoms on August 30, neither Seeling, BT, Critz, RN, nor any other Cumberland Hospital staff to any measures to get Jefry a higher level of care or return him to VCU.

382. Davidow noted on September 13 that "Jefry had ***another*** tonic-clonic seizure during the night. Therefore I have started loading with Depakote." (Emphasis added).

383. Depakote is used to treat certain seizures as well as mania and bipolar disorder.

384. Seizures are a neurological disorder.

385. Despite the fact that Jefry suffered these same symptoms on August 30, Davidow did not take any measures to get Jefry a higher level of care or return him to VCU.

386. Paulette Nock, R.N., the nursing supervisor, administered the Depakote on September 13 but did not attend the patient and did not notify Davidow of clinical indications of hematoma rebleed that were present.

387. Nock, R.N. did not take any measures to get Jefry a higher level of care or return him to VCU.

388. Jefry's neurological condition continued to deteriorate in the following days as the existing subdural hematoma rebled and expanded.

389. Jefry was noted as very tired and sleepy on September 13, more tired than usual and very tired on September 14, continually resting his head on staff as if it hurt him, tearful complaining of stomach pain and refused dinner on September 15 and went to sleep after lunch on September 16.

390. Jefry was not returned to VCU. No VCU provider was notified of these events.

391. Chrystal Doyle, FNP-BC wrote a medical progress note on September 16 stating that Jefry "continues on fall risk and seizure precautions ***with no seizures documented since his return***" despite the fact that Jefry suffered an apparent seizure on September 12. (emphasis added).

392. Jefry's final day at Cumberland Hospital was September 17.

393. Torronda F. Haley, BT cared for Jefry on the 3:00 p.m. – 11:00 p.m. shift.

394. Haley BT noted the following events:

> When [Jefry] was sitting with staff, he attempted to take off his pants while in the day area. [Jefry] was prompted to go to the bathroom with

> staff where he was observed dropping to the floor and hitting his head (SIB x 1). [Jefry] then grabbed staff's collar of shirt. Staff was assisted by another staff . . . . He then dropped to the floor with staff lowering him. Nurse was immediately notified. [Jefry] taken to hospital.

395. Amanda Hayes Wilkins, R.N. arrived at 4:50 p.m. and found Jefry to be hypertensive with dilated pupils that were not responsive to light.

396. Wilkins, R.N. notified Dr. Davidow of her findings but did not request him on site at until 5:07 p.m.

397. Wilkins R.N. wrongly charted Jefry's oxygen saturation as 96-98%, when it was in fact only 80% and he was cyanotic.

398. Dr. Davidow arrived and instructed Inge Eser-Scott, R.N., the nurse supervisor, to call for a rescue squad.

399. Eser-Scott, R.N. did not make the call for EMS not made until 5:23 p.m., 33 minutes after a seizure in child with subdural hematoma.

400. Eser-Scott, R.N. reported Jefry's issue to 9-1-1 as "breathing difficulty" with hypertension and cyanotic appearance.

401. The only medical history Eser-Scott, R.N. provided was a previous eye hematoma incurred on July 31.

402. A Cumberland Hospital incident report states that Jefry "at the time of the incident was on q15 minute observation monitoring. . . . Between September 6, 2019 and September 17, 2019, the patient self-injurious behavior averaged three times daily."

403. Upon arrival at VCU, a CT scan showed significant worsening in the subdural hematoma, now with more pronounced acute components.

404. The hematoma measured approximately 9.3 mm from inner table (previously 4 mm).

405. The left to right midline shift worsened to 1.4 cm (previously 4.8 mm).

406. Noted also was significant worsening in mass effect upon left lateral ventricle with compensatory dilation of right lateral ventricle; Significant worsening in diffuse brain edema, obliteration of the suprasellar and quadrigeminal plate cisterns, favoring uncal/transtentorial herniation, crowding of the structures at the foramen magnum, highly concerning for impending tonsillar herniation.

407. The neurological examination was consistent with brain death with the opinion that no neurosurgical intervention would improve Jefry's status.

408. Jefry was pronounced dead at 11:27 p.m. on September 17, 2019.

409. His cause of death was noted to be "head trauma w/ subdural hemorrhage." It was further noted that Jefry "ultimately expired from increased pressure due to subdural hemorrhage and hernation into the brainstem resulting in cardiac arrest."

410. **Dr. Davidow** owed a duty to the decedent Jefry Rodriguez as being under his care and treatment, to exercise that degree of skill and diligence, practiced by a reasonably prudent physician in the application of their skill in Virginia in 2018 and 2019.

411. Notwithstanding said duty, **Dr. Davidow** breached that duty in that he:

a. Failed to treat and care for the decedent adequately and completely under the circumstances existing;

b. Failed to respond to the complaints, signs and symptoms of the decedent;

c. Failed to consider the medical risks to which the decedent was particularly susceptible;

d. Failed to respond to medical warning signals;

e. Failed to carry out the proper medical procedures;

f. Failed to order the administration of appropriate and proper treatment;

g. Failed to perform a proper differential diagnosis;

h. Specifically, but not limited to the following, Davidow:

i. Failed to exercise care and attention for Jefry's safety at all times given his known conditions;

ii. Failed to recognize that he and Cumberland Hospital were not qualified to provide Jefry the care he required and that Jefry should not be admitted;

iii. Admitted Jefry to Cumberland Hospital twice knowing that he, his staff, and all staff at Cumberland Hospital were not licensed by DBDHS;

iv. Admitted Jefry to Cumberland Hospital twice knowing that he, his staff, and all staff at Cumberland Hospital were not appropriately trained;

v. Admitted Jefry to Cumberland Hospital twice knowing that Cumberland Hospital was not adequately staffed to provide the continuous care and supervision Jefry required;

vi. Failed to order continuous one-to-one monitoring of Jefry;

vii. Failed to order that Jefry wear a hard, properly fitting helmet that Jefry could not remove during all waking hours;

viii. Failed to order padding for Jefry's room;

ix. Failed to prescribe appropriate medications, including FDA-approved ASD medications;

x. Abruptly discontinuing Jefry's FDA-approved ASD medication upon his return from Grafton in blatant disregard of the medical risks involved;

xi. Failed to alter Jefry's medications when it was clear that they were causing Jefry's condition to worsen, including increased SIB and hypotension;

xii. Fraudulently and knowingly or innocently and negligently misrepresented to CPS, VCU, and Plaintiff Marisol Rodriguez that Jefry would receive at least one-to-one monitoring upon his return to Cumberland Hospital in September 2019, intending to mislead CPS, VCU and Plaintiff in order to induce Jefry's return to Cumberland Hospital;

xiii. Failed to order one-to-one monitoring and higher than Q15 checks of Jefry upon his return from VCU;

xiv. Failed to recognize that Jefry's subdural hematoma was worsening in the days after his return from VCU;

xv. Failed to order additional imaging when it was clear Jefry's subdural hematoma was worsening in the days after his return from VCU;

xvi. Failed to consult with appropriate specialists as to how to best care for Jefry's worsening condition;

xvii. Failed to get Jefry higher care and return him to VCU as directed when Jefry had a seizure and otherwise was experiencing neurological changes before and on September 12, 2019;

xviii. Willfully, wantonly, and recklessly disregarding Jefry's discharge summary orders from VCU requiring one-to-one monitoring knowing that doing so would probably result in further injury to Jefry given his history with his patient and the surrounding circumstances;

xix. Willfully, wantonly, and recklessly failing to order a helmet as a restraint for protective purposes knowing that his not doing so was part

of a conscious effort to avoid DBHDS regulations while providing unlicensed services; and

xx. Was otherwise negligent.

412. **Davidow, P.C.** is vicariously liable for Davidow's acts and omissions committed during his care of Jefry in 2018 and 2019.

413. **Cumberland Hospital** is vicariously liable for Davidow's acts and omissions committed during his care of Jefry in 2018 and 2019.

414. **UHS, Inc.** is vicariously liable for Davidow's acts and omissions committed during his care of Jefry in 2018 and 2019.

415. **UHS-D** is vicariously liable for Davidow's acts and omissions committed during his care of Jefry in 2018 and 2019.

416. Had Davidow complied with the applicable standard of care, the decedent would have survived.

417. As a direct and proximate result of the Defendants' negligent acts and omissions, Jefry Rodriguez died on September 17, 2019.

418. **Cumberland Hospital**, independently, and through Davidow and its nonparty officers, employees, and agents, named and unnamed, all acting in the course of their employment/agency, owed a duty to the decedent Jefry Rodriguez as being under its care and treatment, to duty to exercise reasonable care and attention for Jefry's safety as his known mental and physical condition required. **Cumberland Hospital**, independently, and through Davidow and its nonparty officers, employees, and agents, named and unnamed, all acting in the course of their employment/agency, also owed a duty to the decedent Jefry Rodriguez to exercise the degree of skill and diligence practiced by a reasonably prudent physician, registered nurse, psychologist,

psychotherapist, and by a reasonably prudent behavioral technician in the application of their skill in Virginia in 2018 and 2019.

419. Notwithstanding said duty, **Cumberland Hospital** breached that duty in that it:

a. Failed to treat and care for the decedent adequately and completely under the circumstances existing;

b. Failed to respond to the complaints, signs and symptoms of the decedent;

c. Failed to consider the medical risks to which the decedent was particularly susceptible;

d. Failed to respond to medical warning signals;

e. Failed to carry out the proper medical procedures;

f. Failed to order the administration of appropriate and proper treatment;

g. Failed to perform a proper differential diagnosis;

h. Specifically, but not limited to the following, **Cumberland Hospital**, acting through its staff, agents, officers, and employees, all of whom were also agents, servants, and/or employees of UHS, Inc. and/or UHS-D:

i. Failed to exercise care and attention for Jefry's safety at all times given his known conditions and knowing he could not care for himself;

ii. Failed to adequately monitor and supervise Jefry knowing he could not care for himself;

iii. Failed to adequately staff its facility so that it could provide the type of care and supervision required for a patient like Jefry;

iv. Failed to obtain appropriate and necessary licenses from DBHDS;

v. Failed to adhere to the standards promulgated by credentialing agencies;

vi. Failed to employ physicians, staff, and behavioral specialists trained in caring for patients with severe ASD;

vii. Knowingly and negligently provided unlicensed services while knowing Jefry was a member of the class of persons whose protection was intended when such provisions were enacted, and that he would suffer the harm against which the aforementioned regulations were intended to prevent;

viii. Knowingly provided unlicensed services with the intent to avoid regulation and enforcement by state agencies;

ix. Knowingly failed to properly license its facility despite the high number of patients, including Jefry, who were admitted with a primary diagnosis of mental illness or developmental disability but were receiving medical services in a general hospital;

x. Allowed its employees, agents, and staff to use restraint, seclusion, and time out without adhering to regulatory standards; and

xi. Fraudulently and knowingly or innocently and negligently misrepresented to CPS, VCU, and Plaintiff Marisol Rodriguez that Jefry would receive at least one-to-one monitoring at both admissions and upon his return to Cumberland Hospital in September 2019, intending to mislead Plaintiff, CPS, VCU and Shenandoah County school officials in order to induce Jefry's admission and return to Cumberland Hospital;

xii. Failed to provide one-to-one monitoring and higher than Q15 checks of Jefry at both admissions and upon his return from VCU;

xiii. Failed to recognize that Jefry's subdural hematoma was worsening in the days after his return from VCU;

xiv. Failed to provide or seek additional imaging when it was clear Jefry's subdural hematoma was worsening in the days after his return from VCU;

xv. Failed to consult with appropriate specialists as to how to best care for Jefry's worsening condition;

xvi. Failed to get Jefry higher care and return him to VCU as directed when Jefry had a seizure and otherwise was experiencing neurological changes before and on September 12, 2019;

xvii. Willfully, wantonly, and recklessly disregarding Jefry's discharge summary orders from VCU requiring one-to-one monitoring knowing that doing so would probably result in further injury to Jefry given its history with the patient and the surrounding circumstances;

xviii. Willfully, wantonly, and recklessly failing to order a helmet as a restraint for protective purposes knowing that not doing so was part of a conscious effort to avoid DBHDS regulations while providing unlicensed services; and

xix. Was otherwise negligent.

420. **UHS, Inc.** is vicariously liable for Cumberland Hospital's acts and omissions committed during its care of Jefry in 2018 and 2019.

421. **UHS-D** is vicariously liable for Cumberland Hospital's acts and omissions committed during its care of Jefry in 2018 and 2019.

422. Had the Defendants complied with the applicable standard of care, the decedent would have survived.

423. As a direct and proximate result of the Defendants' negligent acts and omissions, Jefry Rodriguez died on September 17, 2019.

424. **UHS, Inc., UHS-D, and Cumberland Hospital** are also directly and vicariously liable, jointly and severally, for non-medical negligence in failing in their duty to protect Jefry that arose from their special relationship. As outlined *supra*:

a. UHS, Inc., directly or indirectly through UHS-D or otherwise, owned Cumberland Hospital.

b. UHS, Inc. and/or UHS-D was listed as the operator of Cumberland Hospital on all licensing documentation.

c. Agents of UHS, Inc., UHS-D, and Cumberland Hospital, including CEO Brooks, Davidow, and other staff at Cumberland, all of whom were employed by UHS, Inc., knew at both admissions that Jefry was a danger to himself, that he needed continuous one-to-one monitoring, that he had severe ASD with SIB, and that he was a high risk of self-injury.

d. UHS, Inc., UHS-D, and Cumberland Hospital knew at both admissions it was billing and profiting for one-to-one care of Jefry it was not providing.

e. An agent or agents of UHS, Inc., UHS-D, and Cumberland Hospital clearly expressed to Marisol Rodriguez and to Shenandoah school representatives at both admissions that Jefry would receive one-to-one monitoring at Cumberland Hospital.

f. An agent or agents of UHS, Inc., UHS-D, and Cumberland Hospital clearly expressed to Marisol Rodriguez and to CPS that Jefry would receive one-to-one monitoring at Cumberland Hospital upon his discharge from VCU.

g. Marisol, the Plaintiff herein, justifiably relied upon those clear expressions when she agreed to admit and return Jefry to Cumberland Hospital.

425. Given its express undertakings and representations, **UHS, Inc., UHS-D, and Cumberland Hospital** had a legal duty to protect Jefry from self-harm.

426. **UHS, Inc., UHS-D, and Cumberland Hospital** breached this duty when it:

a. Failed to provide Jefry with continuous one-to-one monitoring for his safety and protection despite clear directives and notices from Shenandoah school officials, Jefry's IEP, Marisol Rodriguez, VCU medical providers, and CPS officials;

b. Failed to ensure Jefry wore a protective helmet during all waking hours;

c. Failed to ensure proper preventative safety measures were taken during waking and non-waking hours, such as special bedding and padding.

d. Failed to exercise care and attention for Jefry's safety at all times given his known conditions and knowing he could not care for himself;

e. Failed to adequately monitor and supervise Jefry knowing he could not care for himself;

f. Failed to adequately staff its facility so that it could provide the type of care and supervision required for a patient like Jefry;

g. Failed to obtain appropriate and necessary licenses from DBHDS in violation of Virginia statute;

h. Failed to adhere to the standards promulgated by credentialing agencies;

i. Failed to employ physicians, staff, and behavioral specialists trained in caring for patients with severe ASD;

j. Knowingly and negligently provided unlicensed services while knowing Jefry was a member of the class of persons whose protection was intended by the regulatory authorities when such provisions were adopted, and that he would suffer the harm against which the aforementioned regulations were intended to prevent;

k. Knowingly provided unlicensed services with the intent to avoid regulation and enforcement by state agencies;

l. Knowingly failed to properly license its facility despite the high number of patients, including Jefry, who were admitted with a primary diagnosis of mental illness or developmental disability but were receiving medical services in a general hospital;

m. Allowed its employees, agents, and staff to use restraint, seclusion, and time out without adhering to regulatory standards; and

n. Fraudulently and knowingly or innocently and negligently misrepresented to CPS, VCU, and Plaintiff Marisol Rodriguez that Jefry would receive at least one-to-one monitoring upon his return to Cumberland Hospital in September 2019, intending to mislead CPS, VCU and Plaintiff in order to induce Jefry's return to Cumberland Hospital;

o. Failed to provide one-to-one monitoring and higher than Q15 checks of Jefry upon his return from VCU;

p. Failed to recognize that Jefry's subdural hematoma was worsening in the days after his return from VCU;

q. Failed to provide or seek additional imaging when it was clear Jefry's subdural hematoma was worsening in the days after his return from VCU;

r. Failed to consult with appropriate specialists as to how to best care for Jefry's worsening condition;

s. Failed to get Jefry higher care and return him to VCU as directed when Jefry had a seizure and otherwise was experiencing neurological changes before and on September 12, 2019;

t. Willfully, wantonly, and recklessly disregarding Jefry's discharge summary orders from VCU requiring one-to-one monitoring knowing that doing so would probably result in further injury to Jefry given its history with the patient and the surrounding circumstances;

u. Willfully, wantonly, and recklessly failing to order a helmet as a restraint for protective purposes knowing that not doing so was part of a conscious effort to avoid DBHDS regulations while providing unlicensed services; and

v. Was otherwise negligent.

427. **UHS, Inc.** is vicariously liable for its employees' and agents' acts and omissions committed during its care of Jefry in 2018 and 2019.

428. **UHS-D** is vicariously liable for its employees' and agents' acts and omissions committed during its care of Jefry in 2018 and 2019.

429. **Cumberland Hospital** is vicariously liable for the acts and omissions of its employees and agents.

430. Had the Defendants complied with the applicable standard of care, the decedent would have survived.

431. As a direct and proximate result of the Defendants' negligent acts and omissions, Jefry Rodriguez died on September 17, 2019.

432. **UHS, Inc., UHS-D, and Cumberland Hospital** are also directly and vicariously liable for non-medical negligence *per se* by establishing, conducting, and operating a facility providing unlicensed behavioral health services and admitting, treating, and housing Jefry.

433. The duty supporting this claim arises from the special relationship between Jefry and the Plaintiff and UHS, Inc., UHS-D, and Cumberland Hospital, as well as the

Defendants' general duty, and that of its agents, to provide services necessary for Jefry's health, safety, and welfare in holding itself out as a licensed provider of services undertaking long-term care for Jefry.

a. UHS, Inc. employed CEO Brooks, the agent responsible for licensing, who was subject to its direct control and supervision.

b. CEO Brooks and other members of the management team were not providing "health care" in carrying out their corporate duties, including licensing and regulatory compliance, in the course of their employment with Cumberland Hospital, UHS, Inc. and UHS-D.

c. UHS, Inc. corporate officers were intimately involved in licensing processes.

d. UHS, Inc. oversaw all operations, staffing, training, and policies regarding the provision of services at Cumberland Hospital.

e. UHS, Inc. held out that Cumberland Hospital was a licensed and credentialed children's residential treatment facility and inpatient psychiatric facility.

f. Cumberland Hospital held itself out as a licensed and credentialed children's residential treatment facility and inpatient psychiatric facility.

g. UHS, Inc. employed Davidow, who was responsible for admissions and subject to its direct control and supervision.

h. CEO Brooks and Davidow at all relevant times were acting within their scope of their agency and employment.

i. UHS, Inc., UHS-D, and Cumberland Hospital, directly and through its agents, knew or should have known that Jefry, and similar patients, were admitted to its facility for treatment of mental illnesses and the provision of services Cumberland Hospital was not licensed to provide.

j. UHS, Inc., UHS-D, and Cumberland Hospital knew it did not have the staff to provide Jefry with one-to-one monitoring.

k. UHS, Inc., UHS-D, and Cumberland Hospital knew that its lack of licensure limited the care it could legally provide Jefry in terms of safety restraint, seclusion, and time out as evidenced primarily by Davidow's conduct.

l. Davidow, an employee and agent of UHS, Inc., UHS-D, and Cumberland Hospital, went to great lengths to document that Jefry's helmet wearing was not a "restraint" when, in fact, a safety restraint, as defined by law, is exactly what Jefry needed.

m. Cumberland Hospital staff, all employees and agents of UHS, Inc., UHS-D, and Cumberland Hospital, improperly utilized and concealed their provision of seclusion and time out when they knew or should have known that Cumberland Hospital was not licensed to legally apply seclusion and time out.

n. UHS, Inc., UHS-D, and Cumberland Hospital knew that its lack of proper licensure allowed it to avoid regulation, monitoring, reporting requirements, and compliance with DBHDS regulations regarding training, staffing, supervision, and the use of restraint, seclusion, and time out.

o. An agent or agents of UHS, Inc., UHS-D, and Cumberland Hospital required Marisol, as Jefry's parent and legal guardian to sign forms regarding the use of restraint, seclusion and time out, knowing that it was not licensed to legally utilize those treatment methods.

434. **UHS, Inc., UHS-D, and Cumberland Hospital** breached that duty specifically to Jefry by repeatedly violating Va. Code §§ 37.2-405(A) and (C) and 37.2-422.

a. Those Code sections are contained in Chapter 4 of Title 37.2 entitled "Protection of Consumers."

b. Jefry and Marisol both were members of the class of persons whose protection was intended by the General Assembly when such provisions were adopted. *See* Code § 37.2-405(C).

c. The harm to Jefry and Marisol, specifically Jefry's death occurring under the watch of an unlicensed facility, is precisely the type of harm against which the aforementioned laws were intended to prevent.

435. As a direct and proximate result of the Defendants' violation of these statutes, Jefry Rodriguez died on September 17, 2019.

436. Had the Defendants complied with the statutes, the decedent would have survived.

437. **UHS, Inc.** is vicariously liable for its employees' and agents' acts and omissions committed during its care of Jefry in 2018 and 2019.

438. **UHS-D** is vicariously liable for its employees' and agents' acts and omissions committed during its care of Jefry in 2018 and 2019.

439. **Cumberland Hospital** is vicariously liable for the acts and omissions of its employees and agents.

440. **UHS, Inc., UHS-D, and Cumberland Hospital** are also directly and vicariously liable for non-medical negligence in the provision to Jefry of professional services related to Jefry's care that occurred outside the course of medical treatment and services beyond those rendered in a general hospital setting, specifically that of its non-medical employees.

a. Jefry Rodriguez died because Cumberland Hospital's staff failed to ensure his safety.

b. Behavioral technicians and other non-medical staff are not "health care providers" as defined by Virginia law.

c. CEO Brooks, Davidow, and other members of the management team were not providing "health care" in carrying out their management duties, including staffing, training, staff supervision, and licensing/regulatory compliance, in the course of their employment with Cumberland Hospital, UHS, Inc. and UHS-D.

d. UHS, Inc., UHS-D, and Cumberland Hospital did not and do not require behavioral technicians (BT's) to have any training in the diagnosis or treatment of medical conditions.

e. In fact, based upon public job listings posted by UHS, Inc., BT's must only have "two years related experience" with children, a current Virginia driver's license with a good driving record, and the ability to remain on their feet and sustain physical activity throughout a scheduled shift.

f. The duties of BT's include completing monitoring logs, safety checks, assistance with daily living activities, and provision of restraint, seclusion, or time out.

g. When a BT or similar staffer fails or is negligent in his or her duties, it is "abuse" or "neglect" instead of "medical malpractice." *See* 12VAC35-115-30 ("Neglect" is " failure by a person, program, or facility . . . responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness [or] intellectual disability ....").

441. At all times relevant to this action, UHS, Inc., UHS-D, Cumberland Hospital, through their employees and staff, including BT's, owed a duty to Jefry to provide services necessary for his health, safety, and welfare, including, but not limited to, continuous one-to-one monitoring, ensuring his helmet was securely affixed to his

head at waking hours, refraining from the use of seclusion/time out as a punishment or for their own convenience, protecting against elopement, and actually checking on him every fifteen minutes at minimum in accordance with Davidow's orders.

442. UHS, Inc., UHS-D, Cumberland Hospital, and their employees and staff, including BT's, breached that duty by:

a. Willfully, wantonly, and recklessly or negligently disregarding Jefry's discharge summary orders from VCU requiring one-to-one monitoring knowing that doing so would probably result in further injury to Jefry given its history with the patient and the surrounding circumstances;

b. Willfully, wantonly, and recklessly or negligently failing to order or provide a helmet as a continuous restraint for protective purposes knowing that not doing so was part of a conscious effort to avoid DBHDS regulations while providing unlicensed services;

c. Failing to ensure continuous one-to-one monitoring given Jefry's known mental illness, intellectual disability, and risk to himself, or even the minimal Q15 monitoring as ordered;

d. Failing to ensure his helmet was secured to his head at all waking hours given Jefry's known mental illness, intellectual disability, and risk to himself;

e. Placing Jefry in seclusion/time out as a punishment or convenience instead of consistent with actual behavioral treatment given Jefry's known mental illness, intellectual disability, and risk to himself; and

f. Such other particulars as may be ascertained through discovery.

443. Had UHS, Inc., UHS-D, Cumberland Hospital, and their employees and staff, including BT's, not breached their duty, Jefry would have survived.

444. As a direct and proximate result of the Defendants' negligent acts and omissions, Jefry Rodriguez died on September 17, 2019.

445. UHS, Inc., UHS-D, and Cumberland Hospital are all vicariously liable for the negligence of Cumberland Hospital's non-medical staff, including that of the BT's responsible for Jefry's care.

446. **Cumberland Hospital** is also directly liable for actual and constructive fraud because of its employees' and agents' actions in admitting and attempting to treat Jefry without appropriate and necessary licenses from DBHDS, and due to its inadequate staffing numbers, staff training and qualifications, and lack of specialized treatment for patients with severe mental illnesses like ASD.

a. At all times relevant to this action, Cumberland Hospital knowingly, fraudulently, negligently, and with the intent to deceive Jefry and the Plaintiff, held Cumberland Hospital out as a necessarily and appropriately licensed and credentialed facility providing child residential treatment services and inpatient psychiatric services for children.

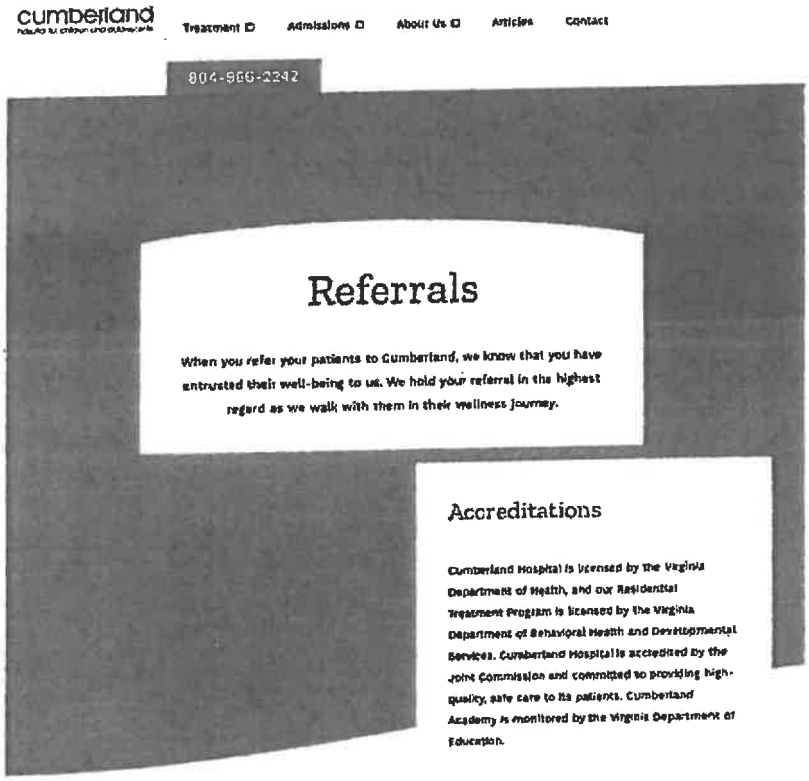
b. It did so through the words and conduct of its agents, including Davidow and CEO Brooks, through its website, marketing and promotional material, referral network, licensure applications and renewals, and during the admissions process.

c. These words and conduct were offered as fact but were false. They produced a false or misleading impression of fact in the mind of the Plaintiff and those working with and for her to find Jefry an appropriate behavioral health facility that could safely and effectively manage his severe ASD.

d. Cumberland Hospital and its agents and employees knew at the time of Jefry's admission that the Plaintiff, as Jefry's guardian, would have to authorize his admission to the facility.

e. Cumberland Hospital and its agents and employees knew that referring agencies, such as county schools and doctors, would rely upon Cumberland Hospital's portrayal of its facility as one licensed and credentialed by DBHDS in deciding whether to refer a patient like Jefry.

f. In the "Referrals" section of its website in 2018, Cumberland Hospital represented:



g. But for these misrepresentations, the Plaintiff would not have authorized Jefry's admission to Cumberland Hospital and would have sought treatment elsewhere.

h. In reliance on and as a direct and proximate result of these misrepresentations, the Plaintiff authorized Jefry's admission to Cumberland Hospital on two occasions.

i. In addition, officers, employees, and agents of Cumberland Hospital were fully aware of the CPS plan that secured Jefry's return to the facility in September 2019 and VCU's discharge summary orders.

j. However, knowing Cumberland Hospital was not adequately staffed to undertake one-to-one monitoring, these same officers, employees, and agents informed the Plaintiff, directly and through CPS and VCU, that Jefry would be given one-to-one supervision upon his return.

k. Initially the Plaintiff did not want Jefry to return to the facility but was induced to agree after Cumberland Hospital misrepresented the care Jefry would receive.

l. But for these misrepresentations, the Plaintiff would not have authorized Jefry's return to Cumberland Hospital and would have sought treatment elsewhere.

m. In reliance on and as a direct and proximate result of these misrepresentations, the Plaintiff authorized Jefry's return to Cumberland Hospital.

n. As a direct and proximate result of these misrepresentations, Jefry Rodriguez died.

o. UHS, Inc. and UHS-D are vicariously liable for Cumberland Hospital's fraud.

447. **UHS, Inc. and UHS-D** are liable to the Plaintiff for actual and constructive fraud.

a. UHS, Inc., UHS-D, and Cumberland Hospital are in effect the same entity. This is shown by the fact that, despite UHS, Inc.'s self-serving public representations, they actually portray themselves as a single entity named "UHS," and each entity's assets and employees are used by the other entities as if the other entities also own them. This is evident by the facts outlined *supra* regarding funding, licensing, recruitment

and control of officers and employees, and deliberate seeking of business ventures involving UHS, Inc. facilities in Virginia, including Cumberland Hospital.

b. UHS, Inc. used its dominion and control over its subsidiaries, including UHS-D and Cumberland Hospital, to perpetuate a fraud, namely the knowing and intentional provision of unlicensed services for profit. It also uses its subsidiaries to gain a competitive advantage in the behavioral health marketplace in Virginia and elsewhere by authorizing and ratifying the practice of providing unlicensed services and underqualified and understaffed facilities like Cumberland Hospital.

c. UHS, Inc. hired CEO Brooks and Davidow. Brooks and Davidow were executive officers at Cumberland Hospital as well as agents of UHS, Inc. and UHS-D.

d. UHS, Inc. and UHS-D ratified Brooks' and Davidow's failure to license and the provision of unlicensed services. They paid the licensing fees each year and listed UHS, Inc. (or "UHS") as owner of Cumberland Hospital on all licenses.

e. At all times relevant to this action, UHS, Inc. and UHS-D knowingly, fraudulently, negligently, and with the intent to deceive Jefry and the Plaintiff, held Cumberland Hospital out as a necessarily and appropriately licensed and credentialed facility providing child residential treatment services and inpatient psychiatric services for children. It did so through the words and conduct of its agents, including Davidow and CEO Brooks, through its website, marketing and promotional material, referral network, licensure applications and renewals, and during the admissions process.

f. These words and conduct were offered as fact but were false. They produced a false or misleading impression of fact in the mind of the Plaintiff and those working with and for her to find Jefry an appropriate behavioral health facility that could safely and effectively manage his severe ASD.

g. UHS, Inc. and UHS-D and its officers, agents, and employees knew at the time of Jefry's admission that the Plaintiff, as Jefry's guardian, would have to authorize his admission to the facility.

h. UHS, Inc. and UHS-D and its officers, agents and employees knew that referring agencies, such as county schools and doctors, would rely upon their portrayal of its facility as one licensed and credentialed by DBHDS in deciding whether to refer a patient like Jefry.

i. But for these misrepresentations, the Plaintiff would not have authorized Jefry's admission to Cumberland Hospital and would have sought treatment elsewhere.

j. In reliance on and as a direct and proximate result of these misrepresentations, the Plaintiff authorized Jefry's admission to Cumberland Hospital on two occasions and his return there from VCU.

k. In addition, officers, employees, and agents of UHS, Inc. and UHS-D were fully aware of the CPS plan that secured Jefry's return to the facility in September 2019 and VCU's discharge summary orders.

l. However, knowing Cumberland Hospital was not adequately staffed to undertake one-to-one monitoring, these same officers, employees, and agents informed the Plaintiff, directly and through CPS and VCU, that Jefry would be given one-to-one supervision upon his return.

m. Initially the Plaintiff did not want Jefry to return to the facility but was induced to agree after Cumberland Hospital misrepresented the care Jefry would receive.

n. But for these misrepresentations, the Plaintiff would not have authorized Jefry's return to Cumberland Hospital and would have sought treatment elsewhere.

o. In reliance on and as a direct and proximate result of these misrepresentations, the Plaintiff authorized Jefry's return to Cumberland Hospital.

p. As a direct and proximate result of these misrepresentations, Jefry Rodriguez died.

448. **Cumberland Hospital, UHS, Inc. and UHS-D** are liable to the Plaintiff under the Virginia Consumer Protection Act ("VCPA").

a. The transaction through which Cumberland Hospital, UHS, Inc. and UHS-D agreed that Cumberland Hospital would safeguard, care for, protect, and otherwise supervise Jefry and Cumberland Hospital, UHS, Inc. and UHS-D would receive consideration for those services constituted a "consumer transaction" within the meaning of the VCPA. *See* Va. Code § 59.1-196, *et seq.* ("The … offering for sale, lease or license, of … services to be used primarily for personal, family or household purposes.").

b. Defendants were "suppliers", and the Plaintiff was a "consumer" under the VCPA.

c. Defendants Cumberland Hospital, UHS, Inc. and UHS-D violated §§ 59.1-200(A) (2), (3), (5), (6), (10), and (14) of the VCPA, all of which are incorporated herein by reference.

d. UHS, Inc., UHS-D, and Cumberland Hospital and/or their agents, servants, or employees, including Davidow and CEO Brooks, individually and collectively, knowingly and negligently made false statements and misrepresentations with the intent to deceive the public, including Jefry and his mother, that described and portrayed Cumberland Hospital as a long term residential "behavioral health provider" offering "specialized care" when, in fact, the facility was not licensed, credentialed, staffed, equipped, prepared, or willing to provide appropriate residential behavioral health services to any child, especially one with severe ASD.

e. UHS, Inc., UHS-D, and Cumberland Hospital and/or their agents, servants, or employees, including Davidow and CEO Brooks, individually and collectively, made various material misrepresentations in public forums, on their websites, in their referral network, and to state agencies that Cumberland Hospital was safe and could undertake proper care for a child with severe ASD and SIB.

f. The acts and words of UHS, Inc., UHS-D, and Cumberland Hospital and/or their agents, servants, or employees, including Davidow and CEO Brooks, individually and collectively, were willful, wanton, reckless, and intentional, as they knew the staff was insufficient in number, quality, and competence to protect Jefry from SIB when they knew he was incapable of protecting himself.

g. UHS, Inc., UHS-D, and Cumberland Hospital and/or their agents, servants, or employees, including Davidow and CEO Brooks, individually and collectively, knew that the Plaintiff, and those similarly situated, would rely and did rely on their material misrepresentations concerning the safety and quality of services at Cumberland Hospital in making the choice to relinquish and trust Jefry's care to the Defendants.

h. As a direct and proximate cause of the foregoing violations, Jefry Rodriguez died on September 17, 2019.

i. Because the Defendants' violations of the VCPA were all willful and wanton, the Plaintiff is entitled to treble damages pursuant to Code § 59.1-204(A).

449. Davidow, Davidow, P.C., Cumberland Hospital, UHS, Inc., and UHS-D are jointly and severally liable for all damages directly and proximately caused to the Plaintiff.

450. Davidow, P.C., Cumberland Hospital, UHS, Inc., and UHS-D are vicariously liable for the negligent and intentional acts and omissions of their employees and agents.

451. As a direct and proximate result of the Defendants' negligent, intentional, fraudulent, and tortious acts and omissions and breach(es) of the standard of care, Jefry Rodriguez died.

452. As a direct and proximate result of the Defendants' negligent, intentional, fraudulent, and tortious acts and omissions and breach(es) of the standard of care, the Plaintiff and the statutory beneficiaries suffered and are entitled to the following damages:

a. Sorrow, mental anguish and solace including the society, companionship, comfort, guidance and kindly offices and advice of the decedent;

b. Reasonably expected loss of services, protection, care and assistance provided by the decedent;

c. Medical expenses of the decedent incident to the injuries which caused his death;

d. Punitive damages for the Defendants' willful and wanton acts and omissions;

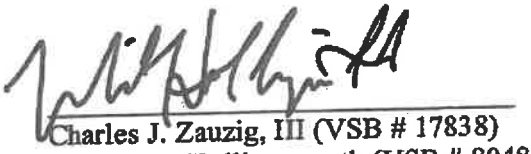
e. Funeral expenses; and

f. Prejudgment interest.

WHEREFORE, the Plaintiff prays for judgment against the Defendants, jointly and severally, in the amount of TWENTY-FIVE MILLION DOLLARS ($25,000,000), plus prejudgment and post-judgment interest, and punitive damages, plus prejudgment and post-judgment interest, and treble damages pursuant to Code § 59.1-204(A), and attorney's fees pursuant to Code § 59.1-204(B), and all taxable costs expended in connection with this action, and any other relief this Court may deem appropriate.

MARISOL RODRIGUEZ, as Administrator of the Estate of **JEFRY RODRIGUEZ**, deceased

By Counsel:



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