STATE OF MICHIGAN

IN THE SUPREME COURT

COSETTE ROWLAND, Personal Representative of the Estate of VIRGINIA KERMATH, deceased,

Plaintiff-Appellant,

v

INDEPENDENCE VILLAGE OF OXFORD, LLC d/b/a Independence Village of Waterstone; UNIFIED MANAGEMENT SERVICES, LLC d/b/a Senior Village Management; and SENIOR VILLAGE MANAGEMENT, LLC d/b/a Independence Village Management,

Defendants-Appellees,

Supreme Court No._____

Court of Appeals No. 345650

Lower Court No. 16-156377-NO

PLAINTIFF'S-APPELLANT'S APPLICATION FOR LEAVE TO APPEAL

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ORDER BEING APPEALED FROM AND RELIEF SOUGHT

Plaintiff-Appellant, Cosette Rowland, personal representative of the estate of Virginia Kermath, deceased seeks peremptory reversal of the Michigan Court of Appeals decision dated January 14, 2020. A copy of that opinion is Exhibit 1 to this application. That opinion affirmed a circuit court decision granting summary disposition to Defendants'-Appellants' on Plaintiff's-Appellant's claims of negligence.

Plaintiff-Appellant requests that this Court peremptorily reverse the Court of Appeals' January 14, 2020 decision and remand this matter to the Oakland County Circuit Court for further proceedings. Alternatively, Plaintiff-Appellant requests that this Court grant leave to appeal to consider the legal questions presented in this case.

STATEMENT REGARDING QUESTIONS PRESENTED

I. SHOULD THIS COURT PEREMPTORILY REVERSE THE COURT OF APPEALS' JANUARY 14, 2020 DECISION AFFIRMING THE TRIAL COURT'S AWARD OF SUMMARY DISPOSITION TO DEFENDANTS, WHERE THE MICHIGAN COURT OF APPEALS FAILED TO RECOGNIZE A SPECIAL RELATIONSHIP THAT GAVE RISE TO A DUTY BETWEEN SENIOR CARE FACILITIES AND THE VULNERABLE RESIDENTS THEY HOUSE?

Plaintiff-Appellant says "Yes".

Defendants-Appellees says "No".

II. SHOULD THIS COURT PEREMPTORILY REVERSE THE COURT OF APPEALS' JANUARY 14, 2020 DECISION AFFIRMING THE TRIAL COURT'S AWARD OF SUMMARY DISPOSITION TO DEFENDANTS, WHERE THE MICHIGAN COURT OF APPEALS FAILED TO RECOGNIZE THAT IT WAS FORESEEABLE THAT VULNERABLE ELDERLY RESIDENTS OF A SENIOR CARE FACILIY WOULD BE HARMED WHEN THAT SENIOR CARE FACILITY FAILED TO TAKE SIMPLE PROTECTIVE PRECAUTIONS?

Plaintiff-Appellant says "Yes".

Defendants-Appellees says "No".

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

> *There is . . . a fundamental distinction about the residents in assisted living facilities that is not true of those in traditional landlord/tenant relationships. Unlike people who choose to live in single family homes,* ***the residents of this assisted living facility have their home there because they must. They have been forced by the afflictions of age, by deteriorating cognitive and mental acuity as well as physical decline, to give up their conventional home.*** *. .* ***In short they have turned to assisted living facilities*** *not in the same way that the general public chooses ordinary homes . . . but instead* ***for protection from the ordinary risks of everyday life associated with the steady decline in their own abilities to look after themselves****. What plaintiff appears to claim is that this facility failed to exercise due care in the single thing—the sole unction—that made him seek out such a facility.*
>
> *-United States District Court Judge*
> *Julian Abele Cook, Jr.*

The instant case arises out of the special relationship between unlicensed senior care facilities and the vulnerable adults who reside there specifically to gain protection from the ordinary risks of everyday life associated with the steady decline in their own abilities to look after themselves. The Defendants in this case operate an unlicensed senior care facility and charge a premium to its residents, who in turn receive room and board and supervised personal care. The Court of Appeals held that these unlicensed senior care facilities do not owe a legal duty to their residents. However, Defendants deliberately market and cater to a specific group of 'at risk' individuals. This type of business carries a significantly higher degree of moral blame when it fails to provide the most basic of protections to the persons whom it serves. Allowing the ruling by the Court of Appeals to stand would be detrimental to protecting and promoting the public health. If unlicensed senior care homes are deemed to have no legal duty to protect their residents, then these homes will have no incentive to provide any safety measures to protect their vulnerable residents from the known dangers of everyday life which have led them to seek out such a facility.

DEFENDANTS OPERATE AN UNLICENSED SENIOR CARE FACILITY WHICH HOUSES VULNERABLE ADULTS

Defendants' facility is an *unlicensed* senior care facility which houses vulnerable adults, or adults who are "unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or because of advanced age." MCL 400.11(f).

The facility is divided into two sections which it refers to as "independent living" and "enhanced living." Both sections of the facility provide residents with "room and board" and "supervised personal care." Room and board is defined as "*the provision of housing and meals to meet the needs of the resident*." R 325.1901(20). Supervised personal care is defined as "*guidance of or assistance with activities of daily living provided to the resident by a home or an agent or employee of a home*." R 325.1901(22). Activities of daily living (ADL) are routine activities people do every day without assistance.[1]

There is no doubt that Ms. Kermath was being provided with room and board, as well as supervised personal care, while living at Independence Village. Obviously, all of the residents living at Independence Village were provided with housing. In addition, Defendants provided meal service to all of the residents no matter whether they were living in "independent" or "enhanced" living. In fact, Defendants' leasing consultant, Susan Taylor explained that residents in independent living were offered breakfast and dinner while those in enhanced living were also offered lunch. Residents could eat in whichever dining room they preferred irrespective of whether they were in enhanced or independent living. (Exhibit 3, Deposition of Susan Taylor, p. 38)

In addition, guidance of or assistance with ADLs were also provided to all of the residents, whether in "independent living" or "enhanced living." In fact, even the residents of "independent

[1] There are six basic ADLs: eating, bathing, getting dressed, toileting, transferring, and continence.

living" were provided with the following guidance or assistance:

- medication reminders
- bathing reminders to full bathing assistance
- meal and activity reminders
- wake up and turn down service
- room checks ranging from every 5 minutes to every 2 hours
- grooming / hygiene assistance
- toileting assistance and incontinence care
- escorting via wheelchair

(Exhibit 18, Service Agreement with Senior Home Care Services) There is no doubt that these tasks amount to "supervised personal care."

The Michigan Department of Consumer and Industry Services, Bureau of Health Systems, Division of Health Facility Standards and Licensing requires facilities that offer room and board and supervised personal care to be *licensed* as a home for the aged. MCL 333.21311; MCL 333.20106(3). Licensed homes for the aged have a statutory duty to provide room and board, protection, supervision, assistance, and supervised personal care for its residents. R 325.1921. The statutory provisions that apply to homes for the aged are part of the Public Health Code, which was enacted to "**protect and promote the public health**." Act 368 of 1978.

Prior to 2018, however, there was a loophole in the home for the aged statute, which allowed a facility such as Independence Village to avoid licensure. In fact, in order to avoid licensure, a facility could provide room and board to residents, and simply establish a separate, related entity to provide supervised personal care services to its residents. This is precisely how Independence Village avoided licensure as a home for the aged.[2] In fact, it established a "sister

[2] Despite the change in the law in 2018, Independence Village was "grandfathered" in to the pre-existing loophole and may continue to operate unlicensed because it was eligible for and was granted an exemption to the new law by the state of Michigan, because it has had a supervised personal care arrangement in effect for at least 2 consecutive years prior to the passage of the new law.

company" called Senior Home Care Solutions to provide supervised personal care to its residents.[3]

Senior Home Care Solutions was located within Defendants' building, right next to their leasing office. Moreover, it was owned by the same company that owned Independence Village. (Exhibit 2, Deposition of Dan Marchione, pp. 6, 7, 10 12) During her deposition testimony, Grace Derzen, Defendants' executive director, admitted that the regional manager preferred and encouraged the employees of Independence Village to refer their residents to Senior Home Care Solutions. (Exhibit 4, Deposition of Grace Derzen, pp. 19, 20, 21) In other words, Independence Living avoided licensure requirements by steering residents to their sister company for supervised personal care services that were provided within its buiding. (Exhibit 2, Deposition of Dan Marchione, pp. 6, 12)

To be sure, Defendants deliberately marketed and catered their senior care facility to elderly individuals like Ms. Kermath, who needed additional support, care and treatment. As the Michigan Court of Appeals noted in its opinion, the median age of a resident at Defendants' facility varies between 70 and 90 years old. There was no question that every resident was a member of a vulnerable group in need of support and assistance. Susan Taylor, Defendants' leasing consultant and salesperson stated that when prospective residents came to meet with her, they were usually accompanied by family. (Exhibit 3, Deposition of Susan Taylor, pp. 4, 8, 14) Taylor stated that 50% of the time the families came to check out Defendants' facility without the resident who would be living there, 30% of the time family came with the resident, and only 20% of their residents came alone to meet with her. *Id.* at p. 15.

Cosette Rowland, Ms. Kermath's daughter, was present with Ms. Kermath on June 12, 2010, when she signed the lease agreement with Defendants. Ms. Kermath was not competent to

[3] Additionally, for residents who were unsatisfied with the services of Senior Home Care Solutions, Independence Village referred those residents to a private care giver named Octavia Jones.

read and understand the documents that she was signing, a fact Cosette Rowland testified that she made clear to the leasing office. (Exhibit 5, Deposition of Cosette Rowland, pp. 39, 49-50)

Now, Independence Village is asking this court to carve out another loophole for unlicensed senior care facilities: Despite its special relationship with its residents, and the fact that the vulnerable residents who live there are most certainly provided with room and board and supervised personal care, Independence Village is asking this court to absolve it of any legal duty to the vulnerable residents whom it houses.

DEFENDANTS MARKET TO VULNERABLE ADULTS LIKE MS. KERMATH

During her deposition, Cosette Rowland, Ms. Kermath's daughter, stated that when the time came to move Ms. Kermath into a facility, the family chose Defendants' facility because they believed it was a safe, clean and beautiful environment, which offered assistance to their residents. (Exhibit 5, Deposition of Cosette Rowland, pp. 45, 108) In fact, Defendants' marketing materials and brochures advertised that their facility offered around the clock staffing. (Exhibit 6, Marketing Materials) Defendants deliberately markets their facility and services to elderly individuals who are in need of additional care and support, using materials providing that: "Independence Village is a champion for **seniors** and their loved ones." (Exhibit 6, Marketing Materials) Defendants advertise that they provide **all residents** with **24-Hour staffing** with **professional on-site management**. (Exhibit 7, Screenshot of Website) In their own informational pamphlet, one resident is quoted, "the best thing about Independence Village is the camaraderie. **Every person is looking out for the other**." The pamphlet also indicates that a "24-hour response system" is included with Independent Living services. (Exhibit 6)

In addition, Grace Derzen, the executive director of Defendants' facility, stated in her deposition testimony that staff was in the building 24 hours a day to give residents whatever

assistance they needed. Derzen stated that staff even walked the building and offered services to people who needed help. (Exhibit 4, Deposition of Grace Derzen, p. 20)

Likewise, in her deposition, Trisha Lenarcic, Defendants' lead receptionist stated that Defendants' employees were instructed to keep an eye on residents trying to leave the building to make sure they did not walk out unattended. (Exhibit 8, Deposition of Trisha Lenarcic, pp. 19-20) The staff was told to watch out for individuals with cognitive impairments to make sure they would not walk out. Lenarcic admitted that if she had seen someone with a cognitive impairment walk out of the building, she would have stopped him or her. (Exhibit 8, Deposition of Trisha Lenarcic, p. 17)

In her deposition, Lenarcic also stated that all of the residents at Defendants' facility were monitored. Lenarcic stated that they did daily check-ins with residents to make sure they were all accounted for. She testified that residents were required to call or come by the front desk daily to let staff know they were okay and that they would look in on residents who did not check in. (Exhibit 8, Deposition of Trisha Lenarcic, pp. 4-5)

Taylor also acknowledged that it was not unusual for seniors who are advancing in age to have changing medical conditions requiring more assistance and protection. (Exhibit 3, Deposition of Susan Taylor, pp. 59-60) Even the lease agreement which allowed for early termination was designed with the changes commonly experienced by the elderly in mind. The lease permitted a resident to terminate the agreement early if they could no longer live independently or if they couldn't afford their lease anymore. (Exhibit 4, Deposition of Grace Derzen, pp. 39-41; Exhibit 2, Deposition of Dan Marchione, p. 15) Ms. Kermath moved into Defendants' facility because of the safe and supportive environment it offered her as a vulnerable, elderly woman who had been diagnosed with dementia.

ELOPEMENT IS A KNOWN DANGER AMONG VULNERABLE ADULTS AND WAS CERTAINLY KNOWN TO INDEPENDENCE VILLAGE

There is no doubt that elopement among the elderly, cognitively impaired population, is a known danger in the senior living industry. Insurance companies often issue bulletins to the senior living communities that they insure to advise them on how to prevent elopement. (Exhibit 9) Defendants' community specialist, Dan Marchione, admitted that he is "familiar with that behavior" when asked about the danger of elopement in the senior living industry. (Exhibit 2, Deposition of Dan Marchione, p. 17) Marchione admitted he would note and communicate any odd or concerning behavior in a prospective resident to the wellness director of Senior Home Care Solutions or Defendants' executive director because he wanted to make sure that the placement was safe for that person and their other residents. (*Id.* at pp. 26-27) Marchione admitted that he participated in an in-service to educate himself on dementia and other diseases that affect senior citizens to keep himself relevant and to make himself more marketable. *Id*. at p. 31, 32.

In contrast, Ms. Rowland had no ties to the senior living industry and was unfamiliar with the risk of elopement in such a community, nor did anyone explain that risk to her. Ms. Kermath and her family sought an apartment at the Defendants' senior care facility because Ms. Kermath needed additional support, care and treatment. (Exhibit 5, Deposition of Cosette Rowland, p. 44) Ms. Kermath and her family sought an apartment at this particular facility because Defendants assured them that their facility was "safe" and "secure". (Exhibit 5, Deposition of Cosette Rowland, p. 89) Defendants specifically represented to Ms. Kermath and her family that the round the clock staffing would include a front desk that was staffed 24 hours a day for security. (Exhibit 5, Deposition of Cosette Rowland, pp. 108-109) During her deposition, Cosette Rowland stated that she believed the facility was "independent with help." *Id*. at p. 32) Because Ms. Kermath had

been diagnosed with dementia, Cosette Rowland looked for a supportive environment like the one advertised by Defendants to ensure her mother's safety and well-being. *Id*. at p. 39) Given all of the services and supervision Defendants offered, Defendants were more than a residential building for senior citizens.

In finding that there was no genuine issue of material fact in this case, the Court of Appeals held that "Both Rowland and Christian testified that Virginia could come and go from Independence Village as she pleased." This testimony, however, was taken out of context and clearly was not viewed in the light most favorable to plaintiff. When read in context with Rowland and Christian's complete testimony, it is clear that Ms. Kermath's family were referring to the fact that Ms. Kermath was free to come and go from Independence Village *when accompanied by family members*. Neither Rowland nor Christian believed that their mother would be allowed to leave Independence village *alone*. As further evidence that this testimony was taken out of context, defendants' staff also testified that Defendants' employees were instructed to keep an eye on residents trying to leave to make sure they did not walk out unattended. (Exhibit 8, Deposition of Trisha Lenarcic, pp. 19-20) Defendants' lead receptionist, Trisha Lenarcic, testified that she was told to watch out for individuals with cognitive impairments to make sure they did not walk out of the building, and that she would have stopped someone with cognitive impairments from leaving if they tried. (*Id.*, p. 17) If anyone actually believed that Ms. Kermath was free to come and go as she pleased – alone – there would be no need for anyone at Independence Village to stop residents from leaving the building.

DEFENDANTS WERE WELL AWARE THAT MS. KERMATH WAS A VULNERABLE ADULT WHO NEEDED ROOM AND BOARD AND SUPERVISED PERSONAL CARE

On or about August 1, 2010, Ms. Kermath moved into Defendants' facility. (Exhibit 10,

Lease Agreement) Under the terms of the lease agreement, Ms. Kermath was to pay $2,100 a month for her apartment. *Id*. At the time of her move, Ms. Kermath was an elderly woman who had a known history of dementia. She required assistance with daily activities and had been taking medications for dementia. (Exhibit 5, Deposition of Cosette Rowland, pp. 7, 20, 47)

During the initial term of the lease, Defendants provided personal caregiving services, such as medication administration (including her dementia medications), to Ms. Kermath in exchange for a monthly fee through Senior Home Care Solutions. They assisted her by making sure she took her dementia medication and reminded her to come to meals. This was in addition to monthly rent. *Id*. at pp. 8-9, 74) When the Senior Home Care Solutions began making mistakes with Ms. Kermath's medication administration, Ms. Kermath's children, Cosette Rowland and Chris Kermath went to Defendants and complained about the medication errors, looking for help.

Defendants knew that Ms. Kermath was an elderly individual who had dementia, required assistance with activities of daily living, and required assistance with medication administration. However, Defendants failed to do any assessments of Ms. Kermath to ensure that it was safe for her to continue reside in their home. Instead, Defendants' manager informed Cosette Rowland that they had a contract with Senior Home Care Solutions and they were not supposed to take business away from them. Nevertheless, they recommended another caregiver for Ms. Kermath – someone who was already helping other residents in their facility – Octavia Jones. (Exhibit 5, Deposition of Cosette Rowland, pp. 28-29) After the initial term of the lease expired, Ms. Kermath renewed her lease and her family hired Ms. Jones to meet their mother's needs, in place of Senior Home Care Solutions. (*Id*. at p. 10).

Ms. Kermath's condition declined during the time she was living at Defendants' facility. When Ms. Kermath first moved to the facility, she was able to take her meals in the independent

dining room. As her mental status deteriorated, her behavior (taking out her dentures and wiping her nose a lot) at mealtimes disturbed other residents who reported her behavior to management. Ms. Kermath was then asked to eat in the assisted living dining room. Later on, she was required to eat alone in her room. (Exhibit 5, Deposition of Cosette Rowland, p. 94; Exhibit 11, Deposition of Octavia Jones, pp. 41, 61)

In addition, Octavia Jones was contacted by Defendants' staff because Ms. Kermath was found roaming around the Defendants' building. (Exhibit 11, Deposition of Octavia Jones, p. 62) Ms. Jones was informed that she needed to come and get Ms. Kermath because she was in a location of the building where she was not supposed to be. Notably, Defendants' staff member did not just instruct Ms. Kermath go back to her side of the building on her own. Instead, Defendants' staff member summoned Ms. Kermath's care giver to come and get her. The staff needed to call Ms. Jones because Ms. Kermath was not independent or able to navigate the building on her own.

DEFENDANTS' NEGLIGENCE ALLOWED MS. KERMATH TO ELOPE FROM THE BUILDING AND SUFFER SERIOUS INJURY

Shortly thereafter, on or about December 15, 2013, in the early morning hours, Ms. Kermath exited the facility - unnoticed - through the side door, which she accessed through double fire doors that were perpetually propped open. The door she exited from could not be opened from the outside. When Ms. Kermath exited the facility, no alarm sounded. There was no operative surveillance camera or communication system so Ms. Kermath could notify staff that she was locked out. (Exhibit 5, Deposition of Cosette Rowland, pp. 66, 116)

As a result, when Ms. Kermath exited the facility, she was stranded outside of the door in freezing temperatures with no ability to reenter or summon help. Due to mobility difficulties, she

was unable to walk to the front of the building. (Exhibit 12, pp. 73-74) She was not found until at least 30 minutes later, when her independent caregiver arrived at the facility around 7:45 a.m.[4] She was barefoot in snow and ice and wearing only a nightgown. (Exhibit 5, Deposition of Cosette Rowland, pp. 120-121)

Ms. Kermath was hypothermic at the time she was found. When EMS arrived, Ms. Kermath was unable to verbally communicate. She was cold to the touch, had unequal pupils and was hypertensive. Her blood glucose reading was 200 and her body temperature was 90.5. Ms. Kermath was unable to open her mouth for an oral temperature reading. She appeared to have a right sided facial droop. Ms. Kermath had several cuts on her toes and feet. (Exhibit 12)

Upon admission to Crittenton Hospital Medical Center, Ms. Kermath was found to have systemic inflammatory response syndrome (SIRS), hypothermia, frostbite and altered mental status. She was started on antibiotics. She required lengthy treatment and rehabilitation because of the damage caused by the hypothermia and frostbite. Unfortunately, however, Ms. Kermath's frostbite and blistered feet compromised her ability to participate in the physical therapy she needed to help her get better. On December 16, 2013, Ms. Kermath was diagnosed with acute altered mental status secondary to hypothermia. She also had leukocytosis, a reaction from stress.

The bottom of Ms. Kermath's great toes were black and necrotic, and she had fluid filled bullae and dark skin on the bottom of her feet. She also had edema in both of her feet. Ms. Kermath now required assistance with eating. Ms. Kermath's necrosis continued through December 29, 2013. AS of January 8, 2014, Ms. Kermath had lost a significant amount of weight and continued to suffer edema to her lower extremities.

[4] At the time that Ms. Kermath exited the facility, it was snowing outside and there was six inches of snow on the ground. It was approximately 19 degrees Fahrenheit and the wind speed was approximately 4 mph. (Exhibit 13, Weather History Data) According to the National Weather Service's Wind Chill Temperature index, under those conditions, it would take more than 30 minutes for frostbite to set in. (Exhibit 14, Wind Chill Chart)

Weeks later, on January 22, 2014, Ms. Kermath had not made significant progress. The majority of both her feet were both still necrotic. Despite the extensive and continuing treatment, Ms. Kermath passed away on January 28, 2014. Frostbite and hypothermia caused and/or contributed to her death.

After Ms. Kermath eloped, Cosette Rowland went to the facility to pick up her mother's belongings. While there, a group of residents commented to her, "we tell them this at every residential meeting that something like this was going to happen. We told them they need a buzzer on that door. They need some kind of safety on that door. We've told them over and over again, but do they listen? No. All they care about is money." (Exhibit 5, Deposition of Cosette Rowland, p. 67)

DEFENDANTS FINALLY TOOK SUBSEQUENT REMEDIAL MEASURES TO PROTECT THEIR RESIDENTS

Despite the known danger to their residents, it was not until after Ms. Kermath's elopement that Defendants installed video surveillance on the exit doors. (Exhibit 3, Deposition of Susan Taylor, p. 42) According to Derzen, after Ms. Kermath's injury, Defendants also hired a nurse to do regular assessments of residents to ensure they are appropriately placed at the facility. (Exhibit 4, Deposition of Grace Derzen, p. 30) These improvements, however, came too late for Ms. Kermath.

It is important to note that allowing the ruling by the Court of Appeals be allowed to stand would be detrimental to protecting and promoting the public health. In fact, if unlicensed senior care homes are deemed to have no legal duty to protect their residents, then these homes will have no incentive to provide any safety measures to protect their vulnerable residents from the known dangers of everyday life associated with the steady decline in their own abilities to look after themselves.

PROCEDURAL HISTORY

Plaintiff filed a complaint against Defendants on December 13, 2016, alleging that Defendants owed Ms. Kermath a duty to exercise due care and caution and breached that duty of care by "negligently and recklessly failing to monitor and/or protect doorways and exits at all times so as to prevent an elderly, confused resident from being locked out of the building." Plaintiff alleged that Defendants breached their duty of care by failing to provide functional alarms on all of the doors to alert staff that a resident exited the facility and failing to provide residents with a reliable means of notifying staff that they are locked out of the facility.

On February 7, 2018, Defendants filed a Motion for Summary Disposition under MCR 2.116(C)(8) and (10) contending that there was no genuine issue of material fact and that Defendants were entitled to a judgment as a matter of law. Plaintiff filed a response to Defendants' Motion for Summary Disposition on March 28, 2018. Defendants replied to Plaintiff's response on April 11, 2018.

The trial court issued an order granting Defendants' motion on June 26, 2018. (Exhibit 15)

Plaintiff filed a Motion for Reconsideration on July 17, 2018, arguing that the trial court improperly made findings of fact that were not supported by the evidence when it decided Defendants' Motion for Summary Disposition. Plaintiff also argued that the trial court improperly drew inferences in favor of the moving party. On September 5, 2018, the trial court issued an order denying Plaintiff's motion for reconsideration under MCR 2.119 (F)(2). (Exhibit 16)

Plaintiff filed a brief on appeal with the Michigan Court of Appeals on March 6, 2019. Defendants filed their responsive brief on appeal on May 7, 2019. The Michigan Court of Appeals

issued an opinion affirming the trial court's decision to grant Defendants summary disposition on January 14, 2020. In its opinion, the Michigan Court of Appeals erroneously found that her elopement was not foreseeable because there was no evidence that shows that Defendants were specifically aware of Ms. Kermath's dementia or declining mental health and that Defendants had no notice that Ms. Kermath might wander outside the building. The Michigan Court of Appeals also erroneously found that there was no special relationship between Defendants and Ms. Kermath because Ms. Kermath never entrusted herself to Defendants' control and protection, and relinquished any control to protect herself. Following this opinion, given the facts in this case and the risk to senior citizens like Ms. Kermath who reside in senior care facilities claiming to be independent living, Plaintiff files this application for leave to appeal.

ARGUMENT

I. THIS COURT SHOULD PEREMPTORILY REVERSE THE COURT OF APPEALS' JANUARY 14, 2020 DECISION AFFIRMING THE TRIAL COURT'S AWARD OF SUMMARY DISPOSITION TO DEFENDANTS, WHERE THE MICHIGAN COURT OF APPEALS FAILED TO RECOGNIZE A SPECIAL RELATIONSHIP THAT GAVE RISE TO A DUTY BETWEEN SENIOR CARE FACILITIES AND THE VULNERABLE RESIDENTS THEY HOUSE

A. Pursuant to *Valcaniant,* a duty to act affirmatively is owed where there is a special relationship

In Michigan, a Plaintiff must prove the following elements to establish a prima facie case of negligence: "(1) the defendant owed the plaintiff a legal duty, (2) the defendant breached the legal duty, (3) the plaintiff suffered damages, and (4) the defendant's breach was a proximate cause of the plaintiff's damages." *Loweke v Ann Arbor Ceiling & Partition, Co., L.L.C.,* 489 Mich 157, 162, 809 NW2d 553 (2011).

Duty is defined as "a legally recognized obligation to conform to a particular standard of conduct toward another." *Riddle v. McLouth Steel Products Corp.*, 440 Mich 85, 96, 485 NW2d

676 (1992). "Duty" has further been defined as a question of whether the defendant is under any obligation for the benefit of the particular plaintiff, and concerns the problem of the whether the relationship between the actor and the injured individual is such that it imposes upon one a legal obligation for the benefit of the other. *Brown v Brown*, 478 Mich 545, 552; 739 NW2d 313 (2007) quoting *Moning v Alfono*, 400 Mich 425, 438-439; 254 NW2d 843 (1977). "Duty is not sacrosanct in itself, but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection." *Brown* at 553 (citations omitted).

In discussing the issue of duty, the Supreme Court in *Loweke* stated:

> As this Court has historically recognized, a separate and distinct duty to support a cause of action in tort can arise by statute, or by a number of preexisting tort principles, including duties imposed because of a special relationship between the parties and the generally recognized common-law duty to use due care in undertakings.

Id. at 169-170 (internal citations omitted).

In further addressing its previous decision of *Fultz v. Union-Commerce Assoc.*, 470 Mich 460, 683 NW2d 587 (2004), the *Loweke* Supreme Court stated that a contract does not do away with an existing common law duty:

> Thus, under *Fultz*, while the mere existence of a contractual promise does not ordinarily provide a basis for a duty of care to a third party in tort, "the existence of a contract [also] does not extinguish duties of care otherwise existing. . . ." ***Fultz* did not extinguish the "simple idea that is embedded deep within the American common law of torts . . . : if one 'having assumed to act, does so negligently,' then liability exists as to a third party for 'failure of the defendant to exercise care and skill in the performance itself.'"**

Id. at 170-171 (internal citations omitted, emphasis added)

In common-law negligence cases, a duty is "'an obligation, to which the law will give recognition and effect, to conform to a particular standard of conduct toward another.'" *Antcliff v State Employees Credit Union*, 414 Mich 624, 630-31; 327 NW2d 814 (1982), quoting Prosser,

Torts (4th ed), § 53, p. 324; see Prosser & Keaton, Torts (5th ed), § 53, p. 356. More specifically, a duty "concerns whether a defendant is under any legal obligation to act for the benefit of the plaintiff." *Valcaniant v Detroit Edison Co*, 470 Mich 82, 86 n 4; 679 NW2d 689 (2004) (emphasis in original), citing *Buczkowski v McKay,*441 Mich 96, 100, 490 NW2d 330 (1992).

Here Ms. Kermath was vulnerable and dependent on Defendants who had control over her welfare. Senior care facilities like Defendants gain an economic advantage by housing and providing services to elderly people like Ms. Kermath. Senior care facilities have a special relationship with the adults they house and care for. Defendants therefore had a duty to alarm or monitor the side exit door of their facility.

In an Order issued by the United States District Court for the Eastern District of Michigan, the court addressed the special relationship between senior living facilities and their residents. The court explained why "[b]usinesses that deliberately market and cater to a specific group of 'at risk' individuals carry a significant higher degree of moral blame when they fail to provide the most basic of protections to the persons whom they serve." *Washnock v. Brookdale Senior Living, Inc*., 2:12-cv-11607-JAC-MAR, p. 10 (E.D. Mich February 6, 2014) (Exhibit 17) The *Washnock* court cited to *Selvin v. DMC Regency Residence, Ltd.*, 807 So 2d 676, 681 (Fla Dist Ct App 2001) to explain why a duty of care is owed by facilities such as Defendants':

> There is . . . a fundamental distinction about the residents in assisted living facilities that is not true of those in traditional landlord/tenant relationships. Unlike people who choose to live in single family homes, **the residents of this assisted living facility have their home there because they must. They have been forced by the afflictions of age, by deteriorating cognitive and mental acuity as well as physical decline, to give up their conventional home.** . . **In short they have turned to assisted living facilities** not in the same way that the general public chooses ordinary homes . . . but instead **for protection from the ordinary risks of everyday life associated with the steady decline in their own abilities to look after themselves**. What plaintiff appears to claim is that this facility failed to exercise due care in the single thing—the sole unction—that made him seek out such a facility.

Washnock (citing *Selvin*, 807 So. 2d at 681 (emphasis added)).

Other jurisdictions in this country have also held that a special relationship exists between senior care facilities and the vulnerable elderly population. In *Breslin v Mountain View Nursing Home, Inc*, 171 A3d 818 (2017), the Court concluded there was a special relationship which started when the plaintiff began residing in defendant's facility. In *Breslin* the complaint alleged that the plaintiff was elderly, frail and relied on Defendants to provide for his medical care, daily and personal needs and that that Defendants exercised complete and exclusive control over Plaintiff's care. The Court found that these facts created the type of relationship that supported the imposition of a duty.

Similarly, a California appellate court noted that '"[A] typical setting for the recognition of a special relationship is where "the plaintiff is particularly vulnerable and dependent upon the Defendant who, correspondingly, has some control over the plaintiff's welfare." ' " *Regents of University of California v Superior Court*, 4 Cal 5th 607, 621, 230 Cal Rptr 3d 415, 413 P3d 656 (2018). That Court also stated that "[s]pecial relationships also have defined boundaries. They create a duty of care owed to a limited community, not the public at large." *Id*. The limited community in this case should be comprised of the vulnerable elderly who reside in senior care facilities in Michigan.

The Michigan Court of Appeals erred when it found that no special relationship giving rise to a duty existed between Defendants, a senior care facility, and Ms. Kermath, a cognitively impaired, vulnerable elderly resident of the facility. The Michigan Court of Appeals erroneously found that Ms. Kermath never relinquished control over her own safety to Defendants. These findings are unsupported by the facts in this case. Like many of Michigan's senior care facilities calling themselves "Independent Living", Defendants had significant influence and control over

the welfare and safety of their residents, who relinquished control to Defendants. Although they called themselves "independent living" they were in fact a senior care facility providing more than just a residence to the vulnerable population residing there.

B. Defendants had a special relationship with the vulnerable adults who lived in their home

In its written opinion the Michigan Court of Appeals properly noted that the median age of a resident at Defendants' facility is between 70 and 90 years old. Defendants' leasing consultant, Susan Taylor admitted their residents were people who were looking for a place to live that provided more assistance than they could get if they were living on their own. (Exhibit 3, Deposition of Susan Taylor, p. 27) She also acknowledged that it was not unusual for seniors who are advancing in age to have changing medical conditions requiring more assistance and protection. (*Id*. at pp. 59-60)

Both the "independent living" and "enhanced living" units designated for residents in need of more support were housed in the same building. (Exhibit 3, Deposition of Susan Taylor, p. 15) The only difference between the two types of living arrangements was that the independent living apartments had a stove and balcony or patio while the enhanced living apartments did not have a stove and only had a patio if the resident was on an enclosed courtyard. *Id*. at pp. 16, 17. Although Defendants marketed themselves as an independent living facility, it functioned as a senior care facility because it provided meals, cleaning, home care services and supervision to the residents it housed. Defendants home was a senior care facility for vulnerable adults and therefore had a special relationship with residents like Ms. Kermath.

1. Defendants provided meals and cleaning services

Defendants provided food service to all of the residents no matter which living arrangement they were in. (Exhibit 2, Deposition of Dan Marchione, p. 6) Taylor further explained that residents in Defendants' independent living were offered breakfast and dinner while those in enhanced living were also offered lunch. Residents could even eat in whichever dining room they preferred irrespective of whether they were in enhanced or independent living. (Exhibit 3, Deposition of Susan Taylor, p. 38) Taylor stated that anyone in independent living could add on additional cleaning and food service. (*Id*. at p. 19)

In addition to meal service all residents at the Defendants' facility received biweekly cleaning services. Residents in enhanced living also got a light daily cleaning. Similarly, in enhanced living the residents' clothes were washed while in independent living only linens were washed. (*Id*. p. 17) Any resident in independent or enhanced living was free to add on additional laundry service. Taylor stated that anyone in independent living could add on additional cleaning service. (*Id*. at p. 18)

2. <u>Defendants provided home care services</u>

Because of the specific issues and vulnerabilities of the elderly residents who came to live in Defendant' home, Defendants offered home care services through Senior Home Care Solutions, an on-site home care company that was located within their building and owned by the same company that owned Defendants' home. (Exhibit 4, Deposition of Grace Derzen, pp. 9, 20-21; Exhibit 8, Deposition of Trish Lenarcic, pp. 15-16; Exhibit 2, Deposition of Dan Marchione, p. 6) According to community specialist Dan Marchione, residents found out about these services because Senior Home Care Services leased space in their building and everyone could "see them in our building when they are physically in the building." (*Id*. at p. 12) Residents would also be introduced to various service providers in the building on demand. (*Id*) Taylor explained that that

Senior Home Care Solutions had two offices in their building, one for a wellness coordinator and one for a their wellness director. (*Id*.) This company also offered bathroom assistance, dressing assistance and escorts to activities and meals. A resident in both enhanced living and independent living could obtain these services. (*Id*. at p. 20) If a resident wanted someone to given them medication, Senior Home Care Solutions would provide it. (*Id*. at p. 19)

Taylor stated that she introduced all of the residents that were interested in services or that she thought might need services to someone from Senior Home Care Solutions. (*Id*. at p. 20) In fact, Ms. Kermath's daughter, Cosette Rowland had originally hired Senior Home Care services to assist Ms. Kermath until they made so many medication errors that Rowland requested that Defendants provide her with a referral for outside help. (Exhibit 5, Deposition of Cosette Rowland, pp. 28-29)

3. <u>Defendants provided supervision, monitoring and protection</u>

Although Defendants claimed to provide complete independence to their residents, they asserted control over their safety. Defendants were entrusted with the safety, care and protection of their residents. Every apartment at Defendants' facility had at least two emergency pull cords, one in the bathroom and one in every bedroom. If a resident pulled the cord, Defendants' and Home Care Services' staff would be paged. Even if a resident did not have any services provided by their home care, someone from home care services would be notified and might come. (Exhibit 3, Deposition of Susan Taylor, pp. 50)

Moreover, there is no doubt that Defendants were concerned with safety and protection of residents and was more than just a housing facility for people seeking to live independently. Dan Marchione, community specialist, admitted he would note and communicate any odd or concerning behavior in a prospective resident to the wellness director of Senior Home Care

Solutions or the executive director of Defendants' facility because he wanted to make sure that the placement was safe for that person and their other residents. (Exhibit 2, Deposition of Dan Marchione, pp. 26-27) Marchione even admitted that he participated in an in-service to educate himself on dementia and other diseases that affect senior citizens to keep himself relevant and to make himself more marketable. *Id*. at p. 31, 32. Defendants were undoubtedly a senior care facility because otherwise their community specialist would have no reason to concern himself with diseases that affected senior citizens.

Defendants also monitored the residents who lived in the facility. Trisha Lenarcic, Defendants' lead receptionist, clearly stated that the residents at Defendants' facility were monitored. Lenarcic stated that Defendants conducted daily check-ins with residents to make sure they were all accounted for. Lenarcic also testified that residents were required to call or come by the front desk daily to let staff know they were okay. (Exhibit 8, Deposition of Trisha Lenarcic, pp. 4-5) Lenarcic also testified that Defendants' employees were instructed to keep an eye on residents trying to leave to make sure they did not walk out unattended. (*Id.*, pp. 19-20) Lenarcic stated that she was told to watch out for individuals with cognitive impairments to make sure they did not walk out of the building and that she would have stopped someone with cognitive impairments from leaving if they tried. (*Id.*, p. 17)

There is no question that Ms. Kermath was not free to roam inside of the facility, and was certainly not free to come and go as she pleased. Ms. Kermath's caregiver, Octavia Jones, stated that when Ms. Kermath was found roaming *inside* the Defendants' building, one of Defendants' employees contacted her to come and get Ms. Kermath. (Exhibit 11, Deposition of Octavia Jones, p. 62) The fact that Ms. Jones was called to come and get Ms. Kermath when she was roaming *inside* the building directly contradicts Defendants' claim that Ms. Kermath was allowed to roam

freely within the building. This testimony clearly showed that Ms. Kermath, a woman with known cognitive impairments, was not allowed to come and go as she pleased.

In finding that there was no genuine issue of material fact in this case, the Court of Appeals held that "Both Rowland and Christian testified that Virginia could come and go from Independence Village as she pleased." This testimony, however, was taken out of context and clearly was not viewed in the light most favorable to plaintiff. When read in context with Rowland and Christian's complete testimony, it is clear that Ms. Kermath's family was referring to the fact that Ms. Kermath was free to come and go from Independence Village *when accompanied by family members*. Neither Rowland nor Christian believed that their mother would be allowed to leave Independence village *alone*. The testimony above from Defendants' staff about how they would watch for individuals with cognitive impairments to make sure they did not walk out of the building, and stop any who tried, and the fact that Defendants' staff did indeed stop Ms. Kermath from wandering *inside* the facility, is further evidence that no one believed Ms. Kermath could come and go as she pleased *on her own*.

Moreover, Cosette Rowland, Ms. Kermath's daughter stated that Defendants' employees specifically represented to Ms. Kermath and her family that their facility was "safe" and "secure" and that **24-hour staffing** would include a front desk that was staffed 24 hours a day. (Exhibit 5, Deposition of Cosette Rowland, p. 89) The Defendants' brochures indicated that the facility offered **round the clock staffing**. (Exhibit 6, Marketing Materials) The existence of the 24-hour staffing was also independently supported by the deposition testimony of the executive director Grace Derzen who confirmed that staff was in the building 24 hours a day to give residents whatever assistance they needed. Derzen testified that staff walked the building and offered services for people who needed help. (Exhibit 4, Deposition of Graze Derzen, p. 20)

Although Defendants would like this Court to believe the residents did not oversee the safety of their residents and it did not have a special relationship with their residents in their independent housing, after Ms. Kermath died, in 2014, Defendants hired a nurse navigator to assess every resident before a resident moved in. This nurse navigator was hired to ensure that no incoming resident would be a threat to himself or another resident.[5] (Exhibit 3, Deposition of Susan Taylor, pp. 40, 41) Defendants also began assessing residents at regular intervals, every six months. According to Taylor, Defendants began a "red flag" procedure after Ms. Kermath's death when there were concerns about whether a resident was still a good fit for their community. (Exhibit 3, Deposition of Susan Taylor, p. 77) Taylor further admitted that memory issues like Ms. Kermath's that cause confusion might be reason to red flag a resident. (*Id*. at p. 82) Notably, after Ms. Kermath died, the facility also installed a security camera on the side door where Ms. Kermath exited. (Exhibit 8, Deposition of Trish Lenarcic, p. 20; Exhibit 3, Deposition of Susan Taylor, p. 42)

Defendants experienced another fatal elopement after a resident wandered away from one of their facilities in Petoskey and died.

> Q. Do you know the details of what happened to the resident in Petoskey who wandered from the facility?
>
> A. Yes.
>
> Q. What happened?
>
> A. I just heard that she had wandered off and that they found her passed away. So that's really the story that I heard. *And then it was after that that the company started putting that process in place.* They hired somebody, Nancy Sarrow. She was like the regional nurse. They hired her, and I think she might have been the

[5] Derzen admitted there were no assessments on residents living in the building to determine whether they were at risk of elopement or of their memory status when she began working there in 2012. (Exhibit 4, Deposition of Grace Derzen, pp. 30)

> one, too, that worked with John Fitzpatrick with the *red flag calls* and also the *nursing program* at the properties. Nancy Sarrow was her name.

(Exhibit 4, Deposition of Grace Derzen, p. 32)

4. Defendants marketed themselves as a senior care facility

Defendants targeted vulnerable seniors in need of care, protection and assistance. Defendants deliberately marketed and catered to elderly individuals in need of additional care and support: "Independence Village is a champion for **seniors** and their loved ones." (Exhibit 6, Marketing Materials) The marketing pamphlet also indicates that a "24-hour response system" is included with Independent Living services. (Exhibit 6) Taylor confirmed that they were marketing the facility specifically to seniors. (Exhibit 3, Deposition of Susan Taylor, p. 31) Grace Derzen, the executive director of Defendants' facility admitted that they were not a "normal" apartment building. (Exhibit 4, Deposition of Grace Derzen's, p. 39)

Susan Taylor, Defendants' leasing consultant and salesperson stated that when prospective residents came to meet with her, they were usually accompanied by family. (Exhibit 3, Deposition of Susan Taylor, pp. 4, 8, 14) Taylor stated that in 50% of their residents the families came without the resident, in 30% the family came with the resident and only 20% of their residents came alone to meet with her. *Id.* at p. 15.

Defendants' lease agreement differed significantly from that of a typical lease agreement. Defendants' lease anticipated the fact that senior citizens' conditions were likely to change over the term of their lease and they may no longer be appropriate to live in the apartment. The lease permitted a resident to break it early if they could no longer live independently. According to Derzen, this type of provision was common to senior leases. *Id*. at pp. 39-41. In fact, Derzen stated: "I have seen that in all my senior leases." *Id*. at p. 41. The lease also had a provision to

terminate early if a resident became eligible for subsidized senior housing. In other words, if they ran out of money and couldn't pay their lease, they would be allowed to terminate their lease. (Exhibit 2, Deposition of Dan Marchione, pp. 14, 15)

C. Failing to recognize a special relationship giving rise to a duty between senior care facilities and the residents they house is detrimental to public health and safety.

1. The Court of Appeals' ruling allows unlicensed senior care homes to avoid any legal duty of care to the vulnerable residents they house.

In failing to recognize a special relationship that gave rise to a duty between an unlicensed senior care facility and its vulnerable residents, the ruling of the Michigan Court of Appeals **enables unlicensed senior care facilities like Defendants' facility – which is already taking advantage of a legal loophole allowing them to avoid licensing requirements – *to also avoid any legal duty of care to the vulnerable residents it houses.***

In justifying its ruling, the Court of Appeals distinguished Independence Village from a licensed nursing home. However, when it comes to senior living, there is a broad spectrum of continuing care communities, and a comparison to a nursing home is irrelevant. In fact, the continuing care community disclosure act, MCL 554.903(j), defines a continuing care community as:

> a retirement community in which a person undertakes to provide or arrange for continuing care and which is 1 or more of the following:
> (i) An adult foster care facility.
> (ii) **A home for the aged.**
> (iii) An independent living unit.
> (iv) A nursing home.
> (v) A home health care services agency.
> (vi) Hospice.
> (vii) A place that undertakes to provide care to a member for more than 1 year.

In this case, the more relevant comparison would have been to compare Independence Village to a *licensed home for the aged*, rather than a nursing home. Such a comparison reveals

that there is no legitimate reason for allowing a facility which takes advantage of a legal loophole, but is essentially operating as a home for the aged and/or is granted an exemption from licensure as a home for the aged, to avoid a legal duty to its vulnerable residents.

Pursuant to MCL 333.20106(3), a "Home for the aged" is defined as follows:

> a supervised personal care facility at a single address, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility that provides ***room, board, and supervised personal*** care to 21 or more unrelated, nontransient, individuals 55 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 55 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home. Home for the aged does not include an area excluded from this definition by section 17(3) of the continuing care community disclosure act, 2014 PA 448, MCL 554.917.

Homes for the Aged are governed by Act 368 of 1978. MCL 333.21301 *et seq*. This statute requires that all homes for the aged be licensed. MCL 333.21311. In other words, an operation needs to be licensed under Act 368 as a home for the aged (HFA) if it provides ***room and board and supervised personal care*** to 21 or more unrelated people who are 55 years of age or older. A review of the meaning of these terms as defined by statute reveals that Independence Village was indeed operating no differently from a home for the aged in providing room and board and supervised personal care to Ms. Kermath.

"*Room and board*" is defined by Michigan's licensing rules for homes for the aged, and means "the provision of housing and meals to meet the needs of the resident." R 325.1901(20). There is no doubt Independence Village was providing both room and board to Ms. Kermath.

Michigan's licensing rules for homes for the aged further define "*supervised personal care"* as "guidance of or assistance with activities of daily living provided to the resident by a home or an agent or employee of a home."[6] R 325.1901(22).

[6] The Michigan statute applicable to Homes for the Aged was amended in 2018 (after the date of incident in this matter). As part of those amendments, MCL 333.21302, which includes a definition of supervised personal care, was

There is also no doubt that Independence Village was providing supervised personal care to Ms. Kermath. However, the legal loophole that allowed Independence Village to operate as an unlicensed home for the aged is the fact that the supervised personal care which was being provided to Ms. Kermath was being provided by its on-site sister home care company, Senior Home Care Solutions, and then later, a third party individual whom it directly recommended (Octavia Jones). Through Senior Home Care Solutions, and later Octavia Jones, Ms. Kermath was offered supervised personal care within Defendants' facility. In other words, through a legal loophole, Defendants were able to call themselves an "independent living" facility, when in reality, the facility was being operated as an unlicensed home for the aged and profiting from vulnerable adults in a way that would otherwise require a license.

Defendants' employee Marchione explained that CSIG Holding Co owned Defendants' facility. (Exhibit 2 Deposition of Dan Marchione, p. 7) Senior Home Care Solutions was under the umbrella Corso Care and Corso Care was part of CSIG Holding. He stated, "they're owned by us." *Id*. at p. 10. Derzen further explained Defendants' facility and the home care company it housed were under the same "umbrella".

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added to the statute. MCL 333.21302(2) defines "supervised personal care" as:

> the direct guidance or hands-on assistance with activities of daily living offered by a facility to residents of the facility that include 2 or more of the following services provided by the facility to any resident for 30 or more consecutive days as documented in the resident's service plan:
>
> (a) Direct and regular involvement by staff in assisting a resident with the administration of the resident's prescription medications, including direct supervision of the resident taking medication in accordance with the instructions of the resident's licensed health care professional.
>
> (b) Hands-on assistance by staff in carrying out 2 or more of the following activities of daily living: eating, toileting, bathing, grooming, dressing, transferring, and mobility.
>
> (c) Direct staff involvement in a resident's personal and social activities or the use of devices to enhance resident safety by controlling resident egress from the facility.

Q. When you say that they are under the same umbrella, are they owned, is Senior Care Services owned by the same people that own Independence Village? Is that what you mean?

A. It was kind of my understanding

Q. Did someone encourage you to refer people to the Senior Care Solutions as opposed to any other home care companies?

A. Yes.

Q. Who was that?

A. That was our, probably, my regional manager.

Q. So when people would come in, they would be recommended to use Senior Care Home Solutions?

A. Correct.

Q. Who would make the recommendation? Would that come from the leasing department?

A. It would.

Q. Did the leasing department, do you know, would they make that recommendation to every possible resident?

A. Yes.

(Exhibit 4, Deposition of Grace Derzen, pp. 20-21)

Grace Derzen admitted that Defendants preferred their residents to use their on-site home care company. She stated: "I have an obligation to the home care company in my building. So we really would prefer to have our residents have home care by a preferred provider. (Exhibit 4, Deposition of Grace Derzen, p. 19) Notably, Plaintiff requested the contract between Defendants and Senior Home care Services but this contract was not provided before Summary disposition was granted.

If this court were to recognize a special relationship between senior care facilities and the vulnerable residents they house, it would be imposing a duty on those facilities to do the right thing

and impose a legal duty on those facilities which do in fact provide meals, supervision and personal care to vulnerable residents.

It is important to point out that the legal loophole which defendant took advantage of in 2014 has now been closed. In other words, the legislature chose to prohibit a facility from avoiding licensure by providing room and board to a resident, while a related entity provides supervised personal care. In fact, in 2018, MCL 333.21311a became effective. Pursuant to MCL 333.21311a(1), which applies to then existing facilities, it is prohibited for the person that offers board to be related to the person that provides room or supervised personal care, or both. 333.21311a(1)(a). However, an exemption was allowed for then existing facilities in situations where the person that provides supervised personal care, whether or not related to the person that provides room or board, or both, *has had a supervised personal care arrangement in effect for at least 2 consecutive years before the date of the attestation required under subsection (3) and residents at the facility have the option to select any supervised personal care provider of their choice*. MCL 333.21311(1)(b). Notably, in 2018, Independence Village applied for and was granted an exception to be licensed as a home for the aged by the state of Michigan for 290 units. This is further proof of the relationship between Independence Village and Senior Care Services. This is also further proof that Independence Village is in fact providing room and board and supervised personal care to the vulnerable residents which live in its facility.

2. <u>Michigan law favors protecting vulnerable adults</u>

Notably, Ms. Kermath fits the description of a vulnerable adult pursuant to Michigan's criminal statute. MCL 400.11(f) defines "vulnerable" as a condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or because of advanced age. Allowing a senior care facility like Defendants to provide

room and board and supervised personal care to vulnerable adults like Ms. Kermath, but then not imposing a legal duty in the way they provide those services, is inconsistent with Michigan's laws aimed at protecting vulnerable seniors.

Defendants had a special relationship with Ms. Kermath and had an affirmative legal duty to act by protecting her safety in their facility.

II. THIS COURT SHOULD PEREMPTORILY REVERSE THE COURT OF APPEALS' JANUARY 14, 2020 DECISION AFFIRMING THE TRIAL COURT'S AWARD OF SUMMARY DISPOSITION TO DEFENDANT, WHERE THE MICHIGAN COURT OF APPEALS FAILED TO RECOGNIZE THAT IT WAS FORESEEABLE THAT VULNERABLE ELDERLY RESIDENTS OF A SENIOR CARE FACILIY WOULD BE HARMED WHEN THAT SENIOR CARE FACILITY FAILED TO TAKE PROTECTIVE PRECAUTIONS?

A. It Was Foreseeable That Ms. Kermath, A Vulnerable, Elderly Woman With Dementia, Would Elope And Get Hurt At Defendants' Facility When She Wandered Out an Unmonitored, Unalarmed side door.

The Michigan Court of Appeals erroneously found that "even if this Court were to decide that Defendants had a special relationship with their residents, there still would be no duty of care because it was not foreseeable that Virginia would wander outside at night in December, wearing just her nightgown and without her keys." The Court's analysis erroneously defined foreseeability, improperly stated how specific foreseeability has to be and improperly decided the question of foreseeability, which is a factual issue.

1. The test of foreseeability considers whether there is *risk* of harm

This Court set out the law on the subject of foreseeability in *Moning v Alfono*, 400 Mich 425, 439; 254 NW2d 759 (1977), where the Court held that the appropriate determination of foreseeability as it bears on the negligence concept of duty depends on "whether it is foreseeable that the [defendant's] conduct *may create a risk of harm* to the victim…"

What is important, therefore, is whether it is foreseeable that a defendant's conduct *may* create a risk of harm to the plaintiff. Here, it was foreseeable the Defendants' failure to alarm or place video surveillance on the side door of a senior care facility that houses vulnerable elderly may well create a risk of harm.

The risk of harm was so foreseeable that one need not be in the senior care business to recognize the risk. It was a risk foreseeable to lay people, including some of the residents of Defendants' facility. Shortly after Ms. Kermath wandered out of the building, Cosette Rowland went to the facility to pick up her mother's belongings. While she was there, a group of residents commented to her, "we tell them this at every residential meeting that something like this was going to happen. We told them they need a buzzer on that door. They need some kind of safety on that door. We've told them over and over again, but do they listen? No. All they care about is money." (Exhibit 5, Deposition of Cosette Rowland, p. 67)

2. <u>The mechanism of injury need not be foreseeable in specific detail</u>

In *Schultz v Consumers Power Co*. 443 Mich 445, 452; 506 NW2d 175 (1993), this Court explained that the test of foreseeability "is not whether the company should have anticipated the particular act from which the injury resulted, but whether it should have foreseen the *probability that injury might* result from any reasonable activity done on the premises. Thus, this Court held in *Schultz*, that "[a] plaintiff need not establish that the mechanism of injury was foreseeable or anticipated in **specific detail**. It is only necessary that the evidence establishes that *some injury to the plaintiff was foreseeable* or to be anticipated." *Id*. at 452-453 n. 7.; see also *Comstock v General Motors Corp*, 358 Mich 163, 180; 99 NW2d 627 (1999) ("The law does not require precision in foreseeing the exact hazard or consequence which happens. It is sufficient if what occurred was one of the kind of consequences which might reasonably be foreseen."; *Lockridge v Oakwood*

Hosp, 285 Mich App 678, 683; 777 NW2d 511 (2009); *Hiner v Mojica*, 271 Mich App 604, 614 n. 3; 722 NW2d 914 (2006); *Allen v Owens-Corning Fiberglas Co*, 225 Mich App 397, 408; 571 NW2d 530 (1997).

Here the Michigan Court of Appeals analysis was again erroneous when it stated "it was not foreseeable that Virginia would wander outside at night in December, wearing just her nightgown and without her keys." The Michigan Court of Appeals considered **the specific risk** of injury instead of ***a*** risk of injury, and took into account details that were not relevant to the inquiry, like the month Ms. Kermath eloped and whether her injury was life-threatening. Alternatively stated, the Michigan Court of Appeals improperly made a finding with too much specificity. The issue the Michigan Court of Appeals should have considered was whether a reasonable person could anticipate that a given event – elopement - might occur under certain conditions at senior care facilities, where many of the residents were in various states of cognitive decline.

a. Cognitive Decline in a Senior Care Facility is foreseeable

Defendants' senior care facility housed elderly residents, many of whom were vulnerable due to cognitive impairments. Cognitively impaired individuals become confused and are prone to wander. It would therefore be anticipated that a cognitively impaired adult may wander from Defendants' facility through an unmonitored and unalarmed side door and suffered harm.

The residents in Defendants' facility had higher rates of cognitive impairments and increased risk of undetected decline than the general population, a fact of which Defendants were well aware. In fact, Grace Derzen admitted that dementia could "very well could be part of the aging process." (Exhibit 4, Deposition of Graze Derzen, p. 34)

The high rates of cognitive decline in the senior population were such a concern that

Defendants offered Senior Home Care Solutions to every single resident who moved into their facility. (*Id.* at pp. 20-21) Defendants knew that their targeted residents needed support and assistance. Moreover, in this case, the Defendants had actual knowledge that Ms. Kermath was experiencing cognitive decline. The Michigan Court of Appeals disregarded the record when it incorrectly found: "there is no evidence that shows that Defendants were specifically aware of Virginia's dementia or declining mental health."

Months prior to Ms. Kermath's elopement from Defendants' facility on December 15, 2013, Defendants' management also fielded complaints by other residents bothered by Ms. Kermath's behavior in the common dining area. When Ms. Kermath kept taking her dentures in and out at the dining table during mealtimes and wiping her nose incessantly, it bothered her tablemates. (Exhibit 5, Deposition of Cosette Rowland, p. 94; Exhibit 11, Deposition of Octavia Jones, pp. 41, 61)

Ms. Kermath's socially inappropriate behavior was an obvious indication of cognitive decline. As a result, management forced Ms. Kermath to stop eating in the communal dining room and forced Ms. Kermath to eat alone in her room because the other residents did not want to share a meal with someone who had the level of cognitive impairments of Ms. Kermath. (Exhibit 11, Deposition of Octavia Jones, pp. 41, 61)

The Defendants also referred Ms. Kermath to Senior Home Care Solutions because they knew she was an elderly woman who required additional services. In addition, Defendants had a copy of the contract with Ms. Kermath in their possession. This contract showed that Senior Home Care Solutions was administering dementia medication to Ms. Kermath so Defendants knew or should have known she had dementia. (Exhibit 5, Deposition of Cosette Rowland, pp. 8-9, 74)

When Ms. Kermath signed her lease agreement with Defendants, her daughter, Cosette

Rowland had to be there because Ms. Kermath was not competent to read and understand the documents she was signing and Rowland informed Defendants of this. (Exhibit 5, Deposition of Cosette Rowland, pp. 49-50) In addition, when Senior Home Care Solutions began making mistakes with Ms. Kermath's medication administration, Cosette Rowland and Chris Kermath went to Defendants and complained about the medication errors, looking for help. At that time, the Defendants staff recommended another caregiver for Ms. Kermath - someone who was already helping other residents in their facility: Octavia Jones. (Exhibit 5, Deposition of Cosette Rowland, pp. 28-29)

Defendants' staff knew Ms. Kermath had cognitive issues because they contacted Ms. Jones when she was found roaming the building. (Exhibit 11, Deposition of Octavia Jones, p. 62) They would not have needed to contact Jones if Ms. Kermath was not cognitively impaired, but they did so because they knew it was unsafe for her to wander alone. This series of events proves without a doubt that Defendants had affirmative knowledge of Ms. Kermath's knowledge of her impairments and need for assistance within their facility. Thus, Defendants' claim and the Court of Appeals finding that harm was not foreseeable because no one knew Ms. Kermath had cognitive impairments, is erroneous.

Defendants were aware that the residents within their facility required more care than a tenant in a typical apartment building; in fact, Defendants not only charged a **premium** for rent, but also referred every resident of their facility to their sister company, Senior Home Care Solutions, for additional services. (Exhibit 4, Deposition of Graze Derzen, pp. 20-21) It is unthinkable to allow Defendants to claim ignorance as a result of their own negligence in failing to assess their residents.

b. Elopement is a known danger in senior care facilities

Likewise, even though "[a] plaintiff need not establish that the mechanism of injury was foreseeable or anticipated in **specific detail,**" *Schultz Supra* at 452-453 n. 7, the Michigan Court of Appeals nonetheless incorrectly found: "Defendants had no notice that Virginia might wander outside the building." Although specificity is not required, the Court made a finding about the location where she wandered.

This finding is without support from the record. Plaintiff presented uncontradicted evidence that elopement among the elderly and cognitively impaired population is a known danger *and that it was known to Defendants*. Defendants' own community specialist, Dan Marchione, admitted that he is "familiar with that behavior" when asked about the danger of elopement in the senior living industry. (Exhibit 2, Deposition of Dan Marchione, p. 17) Similarly, Grace Derzen admitted that the individual who wandered from their Petoskey facility and died also had memory issues.

> Q. Do you know if the person who walked away from the facility in Petosky had memory issues?
>
> A. That was my understanding.
>
> Q. You had heard of people eloping, I'm assuming, before that incident that happened in Petosky?
>
> A. Sure.
>
> Q. You know what elopement means?
>
> A. Yes.
>
> Q. You have heard of it happening at other senior living facilities, correct?
>
> A. And on the news, yep.

(Exhibit 4, Deposition of Grace Derzen, p. 33)

Given that most of the residents who moved into Defendants' facility were elderly,

vulnerable, in need of assistance and moved there for the supportive environment and monitoring Defendants offered, it was not merely reasonably foreseeable but it was *inevitable* that one of the residents in Defendants' facility might be harmed if his or her condition was to deteriorate and he or she was allowed to wander in or out of the building unnoticed. This inevitability was noted by the other residents to Rowland when she was moving Ms. Kermath's belongings out of the facility. The residents commented to Rowland that they had been telling Defendants at every residential meeting that they should have alarms or a safety on the side exit doors because they knew something like what happened to Ms. Kermath was likely to happen. (Exhibit 5, Deposition of Cosette Rowland, p. 67)

There is no question that Ms. Kermath's elopement was foreseeable because she had previously been found roaming the building by Defendants' staff. (Exhibit 11, Deposition of Octavia Jones, p. 62) It was certainly foreseeable that Ms. Kermath, a woman with a history of wandering, might wander again.

3. The question of foreseeability is a question of fact for the jury

As the Michigan Court of Appeals noted in its opinion, "foreseeability is a question of fact." Michigan courts have ruled that these disputed factual issues going to the existence of a duty must be submitted to a jury. *Farwell v Keaton*, 396 Mich 281, 286-287; 240 NW2d 217 (1976); *Bonin v Gralewicz*, 378 Mich 521, 526-527; 146 NW2d 647 (1966). Thus, the Supreme Court held in *Robinson v City of Detroit*, 462 Mich 439, 452; 613 NW2d 307 (2000), that "when a genuine issue of material fact exists concerning whether….the [defendant] owed a duty, the question is appropriately resolved by the trier of fact."

Among the duty related questions that have to be resolved by the trier of fact in the appropriate case is reasonable foreseeability. The Supreme Court's decision in *Bonin*

demonstrates that reasonable foreseeability may be the subject of competing evidence such that the existence of a duty must be submitted to the trier of fact. In *Bonin*, the Court explicitly held that, "the jury should have been allowed to decide that fact issue of forseeability of harm…" *Bonin*, 378 Mich 526.

The ruling in *Bonin* was reaffirmed by the Supreme Court in *MacDonald v PKT, Inc*, 464 Mich 322; 628 NW2d 33 (2001). In *MacDonald*, the defendant moved for summary disposition on the issue of duty. A panel of this Court held that the defendant was not entitled to summary disposition because there was a genuine issue of material fact on the question of whether Ms. Kermath's injury was reasonably foreseeable. *MacDonald v PKT*, Inc, 233 Mich App 395, 400; 593 NW2d 176 (1999). While the Supreme Court in *MacDonald* reversed the panel's ruling with respect to duty, it embraced this Court's reasoning that a jury submissible issue on the question of reasonable foreseeability would preclude the entry of summary disposition.

In this case, the Michigan Court of Appeals contradicts itself. After correctly stating that foreseeability is a question of fact, then concludes that "it was not foreseeable that Virginia would wander outside at night in December, wearing just her nightgown and without her keys." In making this finding the Court decided a question of fact that should have been submitted to the jury.

It was foreseeable that Ms. Kermath, a vulnerable, elderly woman with dementia, was in danger of elopement and injury. The Court's analysis is deeply flawed because it erroneously defined what foreseeability is, improperly stated how specific foreseeability has to be and improperly decided the question of foreseeability.

There is no question the Defendants knew Ms. Kermath had dementia and was at risk of cognitive decline. The probability of injury was clear. The Court improperly decided a question

of fact regarding foreseeability.

RELIEF REQUESTED

Plaintiff-Appellant, Cosette Rowland, Personal Representative of the Estate of Virginia Kermath respectfully requests that this Court peremptorily reverse the Court of Appeals' January 14, 2020 decision and remand this case to the Oakland County Circuit Court for further proceedings. In the alternative, Plaintiff-Appellant requests that the Court grant leave to appeal and give full consideration to the issues raised in this application.

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