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April 20, 2017

Holly Mason, District Administrator Licensing & Certification Division California Department of Public Health 2170 Northpoint Parkway Santa Rosa, CA 95407

VIA E-MAIL: holly.mason@cdph.ca.gov

RE: Complaint regarding Eureka Rehabilitation & Wellness Center (Facility ID: 010000078)

Dear Ms. Mason:

I am writing to request that your agency investigate the recent death of a resident of Eureka Rehabilitation & Wellness Center, a 99-bed skilled nursing facility located in Eureka, Calif. Earlier this week, your office confirmed it is not presently investigating this death.

Details regarding the case are publicly known due to press reports and a lawsuit filed by the resident's family. Consequently, I have included below the name of the resident along with various details noted in his family's lawsuit, which is known as Theresa Kruger v. Eureka Rehabilitation & Wellness Center, LP et al (Case No. DR170144, Humboldt County Superior Court, March 10, 2017). I have attached a copy of the lawsuit and a news article.

The lawsuit alleges that the resident, Randy Lee Kruger, resided at Eureka Rehabilitation & Wellness Center for approximately 15 months (July 2015 to November 2017), where he developed a Stage 4 pressure ulcer on his coccyx that protruded to the bone. In November of 2016, Mr. Kruger was transported by ambulance from Eureka Rehabilitation & Wellness Center to a nearby acute-care hospital with a Stage 4 pressure sore and complaints of chest pain, fever, and pain to his tailbone area, according to the lawsuit. Mr. Kruger was admitted to the hospital for treatment and died approximately seven days later from osteomyelitis (an infection of the bone) and pneumonia. The following is a brief chronology:

Resident: Randy Lee Kruger

July 21, 2015: Mr. Kruger is admitted to Eureka Rehabilitation & Wellness Center

November 2, 2016: Mr. Kruger is transported by ambulance from Eureka Rehab & Wellness Center to St. Joseph Eureka Hospital, where he is admitted for treatment.

November 9, 2016: Mr. Kruger dies at St. Joseph Eureka Hospital.

On behalf of the National Union of Healthcare Workers (NUHW), I request that your office investigate Eureka Rehabilitation & Wellness Center and its treatment of Mr. Kruger to determine whether it committed any violations of statutes, regulations, and other laws that contributed to his injuries and death.

Sincerely,

Fred Seavey, Research Director

Attachments

Eureka Times-Standard

Wrongful death suits filed against Eureka nursing homes



Eureka law firm is alleging that lack of staffing at the Eureka Rehabilitation and Wellness Center and another local nursing home owned by Brius Healthcare Services caused the deaths of two patients in 2016. The Times-Standard file

By Will Houston, Eureka Times-Standard

POSTED: 03/29/17, 9:57 PM PDT

Editor's note: This article contains graphic descriptions that some readers may find disturbing.

A Eureka law firm has filed two wrongful death complaints against two Eureka nursing homes alleging that neglect and a lack of nursing staff led to the deaths of two patients in 2016.

Janssen Malloy LLP attorney W. Timothy Needham is representing the families of the two deceased patients Ralph Sorensen and Randy Kruger. He said both men died after developing severe pressure ulcers that became infected while they were patients at the Eureka and Seaview rehabilitation and wellness centers.

"Although our investigation is not yet complete, it appears to us from our investigation to date that these facilities are being consciously understaffed," Needham said.

Needham said pressure ulcers are entirely avoidable and can form when patients are not moved regularly by nursing stuff. Wheelchair- or bed-bound patients can have circulation cut at pressure points if they are not moved, causing underlying tissue to become damaged and form an ulcer.

The two nursing homes as well as their owning company Brius Healthcare Services, their administrative company Rockport Healthcare Services and Brius CEO Shlomo Rechnitz have been named as defendants in the complaints. Attempts to contact Rockport and Brius as well as their representing attorney James Yee were not returned Wednesday.

The lawsuits come after Eureka Rehabilitation and Wellness Center was fined \$160,000 by the state last month for patient care and staffing violations in 2016, which are currently being appealed by the nursing home.

The latest lawsuit filed March 10 alleges that the Eureka Rehabilitation and Wellness Center failed to check on Kruger's skin.

According to the complaint, Kruger was admitted to the nursing home in July 2015 after being treated for a neurological condition at hospitals in Eureka and San Francisco two months earlier.

Needham states in his complaint that the nursing home became aware that Kruger had developed ulcers on his tailbone in August 2016. By November, the ulcer had dramatically worsened.

"You have to realize what (the facilities) have literally done is they've allowed this person to rot to the point that they've got a hole in their back so large you can put your fist in it all the way to their backbone," Needham said Wednesday.

Complaining of chest pain, fever and pain to his tailbone, Kruger was taken to St. Joseph Hospital in Eureka where he died of bone infection and pneumonia on Nov. 9, 2016. He was 64.

About eight months earlier, the 76-year-old Sorensen died at the same hospital from an infected ulcer on his tailbone, according to the complaint.

Sorensen was admitted to Seaview Rehabilitation and Wellness Center in Humboldt Hill in November 2015 after being treated for an aortic valve replacement, according to the complaint. He did not have an ulcer when he was admitted, the complaint states, but was known to be at risk for ulcer formation in his resident care plan.

In December 2015, a nursing assistant noticed a pressure ulcer on Sorensen's right buttock, "but neither Mr. Sorensen's family nor his physician was told about the ulcer," the complaint states.

Another nurse noticed the ulcer three days later but did not document the wound or inform Sorensen's family or physician, the complaint alleges. Sorensen then began running a fever of up to 102 degrees and was found to have an abscess on his hip bone, which was later determined to be the ulcer at St. Joseph Hospital.

The complaint alleges that Seaview did not have the required nursing staff under state law to ensure Sorensen received the care identified in his care plan.

"During his stay at Seaview, Ralph Sorensen never once received a shower or a bath," the complaint alleges. "Nor was his weight monitored regularly, his nutrition intake was not recorded, and regular assessments of Ralph Sorensen's skin were not made as required of his care plan."

Needham said the California Department of Public Health issued two state enforcement actions against Seaview in August 2016 for failing to report Sorensen's health status changes and failing to provide treatment for or prevent a pressure sore from forming. The facility was fined \$40,000 for these violations, but the nursing home has appealed the fines, according to the department website.

According to the Medicare nursing home comparison website, Seaview nursing staff provide an average of 18 minutes of time per resident each day compared to the state average of one hour and 57 minutes. Eureka Rehabilitation and Wellness Center has one hour and 29 minutes of nursing care time per patient per day.

This does not include certified nursing assistant time that patients receive, which is two hours or more at the two facilities, according to the Medicare website.

Brius is based in Los Angeles and has acquired more than 80 nursing homes throughout the state since 2006. The company acquired five nursing homes in Humboldt County — Eureka, Seaview, Fortuna, Granada and Pacific rehabilitation and wellness centers — from Skilled Healthcare Group in 2011.

Needham said these staffing issues are not isolated incidents, but are pervasive to Brius Healthcare Services' nursing homes.

Last year, the Department of Public Health denied Brius Healthcare's applications to acquire five nursing homes because of the company's history of health care violations. Former California Attorney General Kamala Harris issued an emergency motion to block Brius from acquiring 19 nursing homes in 2014, referring to the company as a "serial violator" of state health care laws.

Brius Healthcare sought to close three of its Humboldt County nursing homes last year due to nursing staff recruitment issues. The closure would have resulted in more than 100 patients having to be transferred out of the county, prompting an outcry from local officials and the community. Brius announced last year that it would only be closing Pacific Rehabilitation and Wellness Center in Eureka, which occurred in January.

Will Houston can be reached at 707-441-0504.

Amelia F. Burroughs (CSB #221490) Megan A. Yarnall (CSB #275319) JANSSEN MALLÒY LLP 730 Fifth Street P.O. Drawer 1288 Eureka, CA 95501 Telephone: (707) 445-2071 Michael D. Thamer (CSB #101440) LAW OFFICE OF MICHAEL D. THAMER Old Callahan School House 12444 South Highway 3 P.O. Box 1568 Callahan, CA 96014-1568 Telephone: (530) 467-5307 Attorneys for Theresa Kruger, as individual and as successor-in-interest to Randy Lee Kruger, deceased SUPERIOR COURT OF CALIFORNIA COUNTY OF HUMBOLDT THERESA KRUGER, as individual and as successor-in-interest to RANDY KRUGER, deceased. Plaintiff, VS. EUREKA REHABILITATION & WELLNESS CENTER, LP, EUREKA WELLNESS GP.

FILED

MAR 10 2017

SUPERIOR COURT OF CALIFORNIA COUNTY OF HUMBOLDT

Case No.:

DR 170144

COMPLAINT FOR DEPENDENT ADULT ABUSE – NEGLECT (WELFARE AND **INSTITUTIONS CODE SECTION 15610.57)** AND WRONGFUL DEATH

LLC, ROCKPORT ADMINISTRATIVE SERVICES, LLC DBA ROCKPORT HEALTHCARE SERVICES, BRIUS MANAGEMENT CO., INC., BRIUS, LLC. EUREKA-LET, LP, EUREKA-LET GP, LLC, SHLOMO RECHNITZ, and DOES 1 through 100, inclusive,

Defendants

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COMPLAINT FOR DEPENDENT ADULT ABUSE - NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

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GENERAL ALLEGATIONS

- 1. Plaintiff Theresa Kruger is a resident of Humboldt County, California. In making the claims herein, plaintiff brings this action on behalf of herself and the decedent, Randy Lee Kruger, who died on November 9, 2016. Pursuant to Code of Civil Procedure §377.60, et seq., plaintiff acts as the personal representative of her now deceased husband. Plaintiff has complied with Code of Civil Procedure sections 364 and 377.32. In addition, plaintiff is informed and believes that she has standing under Welfare and Institutions Code section 15657.3(d) to commence and maintain this action as decedent's lawful heir and has standing as an individual to bring this said cause of action for the wrongful death of her husband.
- 2. Plaintiff is informed and believes, and based thereon alleges, that at all times mentioned herein defendant EUREKA REHABILITATION & WELLNESS CENTER, LP (hereinafter referred to as "Eureka"), was and is a limited partnership formed and existing under the laws of the State of California. Eureka is skilled nursing facility, licensed to operate 99 beds by the California Department of Public Health ("CDPH").
- 3. Plaintiff is informed and believes, and based thereon alleges, that at all times mentioned herein defendant EUREKA WELLNESS GP, LLC was and is a limited partnership formed and existing under the laws of the State of California, formed for the purpose of protecting the revenue generated at Eureka.
- 4. Plaintiff is further informed and believes, and based thereon alleges, that at all times mentioned herein defendant ROCKPORT ADMINISTRATIVE SERVICES, LLC DBA ROCKPORT HEALTHCARE SERVICES (hereinafter referred to as "Rockport") was and is a limited liability company formed and existing under the laws of the State of California. Though Rockport is not a licensed administrative company for Eureka, it functions as such and it was involved in making many of the decisions herein on behalf of Eureka that resulted in Mr. Kruger's death,
- 5. Plaintiff is also informed and believes, and based thereon alleges, that at all times mentioned herein defendant BRIUS MANAGEMENT CO., INC. was and is a California COMPLAINT FOR DEPENDENT ADULT ABUSE - NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

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corporation formed for the purpose of protecting the revenue generated at Eureka.

- 6. Plaintiff is additionally informed and believes, and based thereon alleges, that at all times mentioned herein defendant BRIUS, LLC, was and is a California limited liability company formed for the purpose of protecting the revenue generated at Eureka.
- 7. Plaintiff is also informed and believes, and based thereon alleges, that at all times mentioned herein defendant EUREKA-LET, LP was and is a limited partnership formed and existing under the laws of the State of California formed for the purpose of protecting the revenue generated at Eureka.
- 8. Plaintiffs is additionally informed and believes, and based thereon alleges, that at all times mentioned herein defendant EUREKA-LET GP, LLC was and is a limited liability company formed and existing under the laws of the State of California formed for the purpose of protecting the revenue generated at Eureka.
- 9. Plaintiff is informed and believes, and based thereon alleges, that at all times mentioned herein defendant SHLOMO RECHNITZ is a citizen of the State of California, with a place of residence in Los Angeles, California. Mr. Rechnitz is identified as the sole owner having a five-percent or more equity interest in Eureka, and he is the sole governing board officer and member identified for the facility in CDPH licensing documents.
- 10. The true names and capacities, whether individual, corporate, associate, or otherwise of the defendant designated herein as DOES 1 through 100 are presently unknown to plaintiff, who, therefore, sues said defendants by such fictitious names. Plaintiff is informed and believes, and based thereon, alleges, that each of the defendants designated herein as a "Doe" is legally responsible for the events and happenings hereinafter referred to, and proximately caused or contributed to the injuries and damages as hereinafter described. Plaintiff will seek leave of the court to amend this complaint, to show the true names and capacities of such parties, when the same has been ascertained.
- 11. Plaintiff is informed and believes, and based thereon alleges, that at all times herein mentioned, each of the defendants was the agent, partner, joint venturer, aider and abettor, alter ego, and/or employee of each of the remaining defendants, and was acting within COMPLAINT FOR DEPENDENT ADULT ABUSE - NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

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27 28 the course and scope of such agency, partnership, joint venture, and/or employment or in the capacity of an aider and abettor or alter ego.

- 12. Plaintiff is informed and believes, and based thereon alleges that defendants are required to provide skilled nursing care, room and board, twenty-four-hour supervision, and personal care and assistance to the residents. Care and supervision required of said defendants included custodial care and services, physician services, skilled nursing services, dietary services, pharmaceutical services, and activities services as more specifically described in 22 California Code of Regulations section 72301, et seg.
- 13. It is well known and has been expressly noted by the California legislature in its adoption of Welfare and Institutions Code section 15600(a)-(d), that the dependent adult population is particularly subject to various forms of abuse and neglect. Physical infirmity or mental impairment, such as those experienced by Mr. Kruger, often place one in a dependent and vulnerable position. At the same time, such infirmity and dependence leave those such as Mr. Kruger as incapable of asking for help or protection.
- 14. Recognizing the problems described in the preceding paragraph, the California legislature promulgated the Elder Abuse and Dependent Adult Civil Protection Act ("EADACPA"). This act is codified in Welfare and Institutions Code section 15600 et seg. Pursuant to additions, the California legislature found and declared that infirm, elderly, and dependent adults are a disadvantaged population, and that few civil cases are brought in connection with their abuse due to the problems of proof and delays, plus the lack of incentive to prosecute such suits.
- 15. EADACPA defines a "dependent adult" as any person who resides in California and is between 18 and 64 years old that has certain mental or physical disabilities that keep him or her from being able to perform normal activities or protect himself or herself. (Welfare & Institutions Code section 15610.23)
- 16. As further defined under EADACPA, "abuse" of a dependent adult includes: (a) physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or (b) the deprivation by a care COMPLAINT FOR DEPENDENT ADULT ABUSE - NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

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custodian of goods or services necessary to avoid physical harm or mental suffering. (Welfare & Institutions Code section 15610.07.)

- 17. Welfare and Institutions Code section 15610.57 defines "neglect" to include: "The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (Welfare & Institutions Code section 15610.57(a)(1).) Under the code, neglect includes but is not limited to: (a) failure to provide medical care for physical or mental health needs; and (b) failure to protect from health and safety hazards. (Welfare & Institutions Code section 15610.57(b).)
- 18. In or about May of 2015, Mr. Kruger became infected with Baylisascaris procynis roundworms which caused a sudden and rapid neurologic decline. Following extensive treatment at St. Joseph's Hospital in Eureka California and at the University of California, San Francisco, Mr. Kruger was admitted to Eureka for continued rehabilitation. At the time of his admission, he could ambulate with assistance, though his balance was impaired and he had reduced strength. Mr. Kruger required assistance with daily living tasks such as eating, ambulation, and toileting. At the time of his admission, he was not able to self-administer his own medications.
- Title 42 of the Code of Federal Regulations section 483.25(b) provides that a 19. nursing home facility must ensure that: (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.
- A "pressure ulcer" is a lesion caused by unrelieved pressure that results in 20. damage to the underlying tissues. A pressure ulcer is "avoidable" if a resident developed a pressure ulcer and the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factor; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and COMPLAINT FOR DEPENDENT ADULT ABUSE - NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

evaluate the impact of the interventions; or revise the intervention as appropriate.

- 21. A pressure ulcer can occur whenever pressure has impaired circulation to the tissue. Critical steps in pressure ulcer prevention and healing include: identifying the individual resident at risk for developing pressure ulcers, identifying and evaluating the risk factors and changes in the resident's condition, identifying and evaluating factors that could be removed, implementing individualized interventions in an attempt to stabilize, reduce, or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate.
- 22. Because pressure ulcers can develop within two to six hours of the onset of pressure the at risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers.
 - 23. Among the risk factors for pressure ulcers are:
 - Impaired/decreased mobility and decreased functional ability;
 - Cognitive impairment;
 - Exposure of skin to urinary and fecal incontinence; and
 - Nutrition and hydration deficits.

Whenever these factors are present it is absolutely critical that nursing staff regularly conduct thorough skin assessments on each resident who is at risk for developing pressure ulcers.

- 24. Mr. Kruger was admitted to Eureka for skilled nursing services and rehabilitation on or about July 21, 2015. He was 63 years of age and a "dependent adult" within the legal definition.
 - 25. Mr. Kruger resided in Eureka for approximately fifteen months.
- 26. On August 24, 2016, the records note that defendants first observed a pressure ulcer on Mr. Kruger's coccyx. By November 2, 2016, that pressure ulcer had progressed to the point where it was a full thickness, stage four pressure ulcer protruding to the bone.
- 27. On November 2, 2016, Mr. Kruger complained of chest pain, fever, and pain to his tail bone area. Mr. Kruger was transported by ambulance from Eureka to St. Joseph's COMPLAINT FOR DEPENDENT ADULT ABUSE NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

Hospital where he was admitted.

28. On November 9, 2016, Mr. Kruger died of pneumonia and osteomyelitis. FIRST CAUSE OF ACTION FOR DEPENDENT ADULT ABUSE

- 29. Plaintiff refers to and incorporates herein by reference all preceding paragraphs above as though fully set forth herein.
- 30. During Mr. Kruger's residency at Eureka, he was a "dependent adult" within the meaning of California's Welfare & Institutions Code section 15610.23 and was in the care and custody of defendants.
- 31. Defendants are "care custodians" within the meaning of California's Welfare & Institutions Code section 15610.17.
- 32. At all times herein mentioned, the residents at Eureka, including Mr. Kruger, were relatively helpless, infirm, disabled, frail, vulnerable, and dependent individuals, in constant need of adequate and reasonable care and services.
- 33. As such, defendants, and each of them, had a duty, under applicable federal and state laws (which were designed for the protection and benefit of residents such as Mr. Kruger) to provide for and to protect plaintiff's health and safety, including his mental well-being. Defendants, and each of them, also had a common law duty to provide for the health and welfare of Mr. Kruger.
- 34. Defendants neglected Mr. Kruger within the meaning of Welfare and Institutions Code section 15610.57 in that defendants failed to exercise the degree of care that a reasonable person having the care and custody of Mr. Kruger would exercise. Defendants' conduct as herein alleged also constitutes the reckless and wanton neglect of Mr. Kruger's health and safety. In particular, and without limiting the generality of the foregoing, defendants failed to consistently check Mr. Kruger's skin condition and failed to appropriately care for Mr. Kruger's skin to avoid development of a stage four pressure ulcer.
- 35. As a result, Mr. Kruger developed a stage four pressure ulcer on his coccyx that required hospitalization, lead to bone infections, and Mr. Kruger's death.
- 36. As a result of said defendants' continuing pattern of dependent adult abuse, as COMPLAINT FOR DEPENDENT ADULT ABUSE NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

trial;

and

alleged above, Mr. Kruger suffered the following damages for which plaintiff seeks compensation:

- a. mental and emotional distress, all to Mr. Kruger's damage in a sum that will be proven at trial;
 - b. Extra expenses for transportation and medical care, according to proof at
 - c. General and special damages in an amount that will be proven at trial;
- d. Payment of funds for services which were not rendered, according to proof at trial.
- 37. At all times herein mentioned, defendants knew of the need to comply with the laws applicable to the ownership, operation, management, and/or supervision of Eureka, and further knew that non-compliance with such laws would put the health and welfare of the residents, including plaintiff, unreasonably at risk. Defendants also knew that the continual failure or refusal to discharge their duties to Mr. Kruger would likely result in injury.
- 38. The conduct of defendants, as alleged above, constitutes "abandonment" and "neglect," as those terms are defined in Welfare & Institutions Code section 15610.57, in that defendants failed to exercise the degree of care that a reasonable person having the custody of plaintiff would exercise. The continuing pattern of abuse, as alleged above, was a direct result of defendants' conscious plan to operate Eureka at inadequate staffing and patient care levels to wrongfully maximize their business profits, including patient dumping to avoid incurring costs associated with transfer to another appropriate facility under the law. Under Welfare & Institutions Code Section 15657(a)-(b), defendants are liable to plaintiff for damages related to her personal injuries, medical expenses, plus attorneys' fees and costs.
- 39. As a result of the above-described oppressive, malicious and fraudulent conduct of defendants, plaintiff alleges that she is entitled to an award of punitive and exemplary damages pursuant to Civil Code §3294.

40.

above as though fully set forth herein.

41. During Mr. Kruger's residency at Eureka, he was (a) a dependent adult and (b) in the care and custody of defendants.

PURSUANT TO HEALTH AND SAFETY CODE §1430(b)

SECOND CAUSE OF ACTION FOR VIOLATION OF PATIENT'S RIGHTS

Plaintiff refers to and incorporates herein by reference all preceding paragraphs

- 42. As such, defendants, and each of them, had a duty, under applicable federal and state laws (which were designed for the protection and benefit of residents such as Mr. Kruger) to provide for and to protect Mr. Kruger's health and safety, including not neglecting him. Defendants, and each of them, also had a common law duty to provide for the health and welfare of Mr. Kruger. Without limiting the generality of the foregoing, defendants had, among other duties, the duty with respect to Mr. Kruger's health and welfare to:
 - a. Protect Mr. Kruger from sustaining injuries to his person;
- b. Monitor and accurately record Mr. Kruger's condition, and notify the attending physician and family members of any meaningful change in his condition;
 - c. Note and properly react to emergent conditions;
- d. Establish and implement a care plan for Mr. Kruger, based upon, and including, an ongoing process of identifying his health and care needs and making sure that such needs were timely met;
- e. Accurately monitor and provide for Mr. Kruger's health, comfort and safety;
 - f. Maintain accurate records of Mr. Kruger's condition and activities;
 - g. Adopt, observe, and implement written infection control policies;
- h. Maintain in number and qualification sufficient staff to meet residents' needs; and
- i. Treat Mr. Kruger with dignity and respect, and without abuse and neglect.
- 43. Additionally, Title 22 C.C.R. §72311(a)(3) required Eureka to promptly notify COMPLAINT FOR DEPENDENT ADULT ABUSE NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

III

Mr. Kruger's healthcare practitioner of "[a]ny sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient;" and § 72329.1 requires specific levels and types of nursing staff to meet resident needs. Eureka violated all of these regulations.

- 44. In addition to federal rights, Mr. Kruger enjoyed numerous state rights, including: (a) the facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility and (b) each patient shall show evidence of good personal hygiene and be given care to prevent bedsores. Eureka violated Mr. Kruger's state rights.
- 45. During Mr. Kruger's residency at Eureka, defendants, and each of them, failed to use the degree of care that a reasonable person in the same situation would have used in protecting Mr. Kruger from health and safety hazards, including the development of pressure ulcers. Defendants, and each of them, declined to provide Mr. Kruger with appropriate assessment with respect to his risk of injury or death. Defendants, and each of them, deliberately did not staff Eureka in such a way as to permit Eureka's employees to properly care Mr. Kruger, and Defendants' actions were a conscious choice of a course of action with respect to Mr. Kruger's risk assessment and the determination of his needs, with knowledge of the serious danger in which Mr. Kruger was placed as a result such actions.
- 46. As a direct result of each defendant's neglect, Mr. Kruger was injured in his person and health, and sustained serious physical injuries and damages, and ultimately death.
- 47. Defendants' conduct constitutes "neglect" as that term is defined in Welfare and Institutions Code §§15610.63 and 15610.57 in that defendants failed to use the degree of care that a reasonable person having the custody of Mr. Kruger would exercise. Under Welfare and Institutions Code §15651(a)-(b), defendants are liable to plaintiffs for damages related to Mr. Kruger's damages related to personal injuries and medical expenses.
- 48. As a result of defendants' neglect as alleged, plaintiff, on behalf of herself and as Mr. Kruger's personal representative, seeks all economic damages to which she is entitled according to proof at trial.

THIRD CAUSE OF ACTION FOR WRONGFUL DEATH

- 49. Plaintiff refers to and incorporate herein by reference all preceding paragraphs above as though fully set forth herein.
- 50. As a consequence of the injuries suffered by Mr. Kruger at Eureka, he died on November 9, 2016.
- 51. As a result of the acts of defendants Eureka and DOES 1 through 100, inclusive, and each of them, as alleged above, Mr. Kruger died, and plaintiff lost the love, companionship, comfort, affection, and society of her husband, for which plaintiff seeks general damages.
- 52. As a further result of the acts of the defendants, and each of them, as alleged above, the decedent's family incurred funeral and burial expenses for the burial of Mr. Kruger, for which the plaintiff seeks special damages.

FOURTH CAUSE OF ACTION FOR NEGLIGENCE

- 53. Plaintiff refers to and incorporates herein by reference all preceding paragraphs above as though fully set forth herein.
- 54. At all times herein mentioned, defendants failed to exercise the degree of skill and care commonly required of skilled nursing facilities for dependent adults pursuant to state laws detailed above.
- 55. As a legal result of defendants' negligence and carelessness, Mr. Kruger was severely injured and thereafter died.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs pray for judgment as follows:

- 1. For damages pursuant to Health and Safety Code §1430(b);
- 2. For general damages in a sum to be proven at the time of trial;
- 3. For special damages in a sum to be proven at the time of trial;
- For pre-death pain and suffering pursuant to Welfare and Institutions
 Code §15657;
- 5. For punitive damages;
- 6. For pre-judgment and post-judgment interest, according to law; COMPLAINT FOR DEPENDENT ADULT ABUSE NEGLECT (WELFARE AND INSTITUTIONS CODE SECTION 15610.57) AND WRONGFUL DEATH

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| 7. For attorneys' | fees; |
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- 8. For costs of suit herein; and
- 9. For such other and further relief as the Court may deem just and proper.

Dated March <u>10</u>, 2017

JANSSEN MALLOY LLP

Amelia F. Burroughs

Attorneys for Theresa Kruger, as individual and as successor-in-interest to Randy Kruger