GARCIA, ARTIGLIERE, MEDBY & FAULKNER
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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF HUMBOLDT

MARIE WHITE,

Plaintiff,

vs.

BRIUS MANAGEMENT CO., INC.; EUREKA REHABILITATION & WELLNESS CENTER, LP; ROCKPORT HEALTHCARE SERVICES, BOARDWALK FINANCIAL SERVICES, LLC, and DOES 1 through 250, inclusive,

Defendants.

CASE NO.

COMPLAINT FOR DAMAGES

1) Elder Abuse (Pursuant to the Elder Abuse and Dependent Adult Civil Protection Act – *Welfare and Institutions Code* §§15600, *et seq*.)
2) Negligent Hiring and Supervision (CACI 426)
3) Violations of Cal. Health & Saf. Code § 1430(b)
4) Violations of the Consumer Legal Remedies Act
5) Violations of Business & Professions Code §§17200 and 17500
6) Fraud (*Randi W. v. Muroc* (1997) 14 Cal.4th 1066; *McCall v. Pacifcare of Cal. Inc.* (2001) 25 Cal.4th. 412)

Trial Date: None Set

Plaintiff alleges on information and belief as follows:

THE PARTIES

1. Plaintiff MARIE WHITE (hereinafter sometimes referred to as "PLAINTIFF") was at all times relevant hereto a resident and citizen of the State of California, County of Humboldt and brings this action by and through her Attorney in Fact David Brodsky.

2. Defendants EUREKA REHABILITATION & WELLNESS CENTER, LP and DOES 1 through 50 (hereinafter referred to as the "FACILITY") were at relevant times hereto in the business

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of providing long-term custodial care as the licensee of a 24-hour skilled nursing facility doing business under the fictitious name Eureka Rehabilitation & Wellness Center, located at 2353 23rd Street, Eureka, California 95501, with its principal place of business located at 5900 Wilshire Blvd., Suite 1600, Los Angeles, California 90036, and were subject to the requirements of federal and state law regarding the operation of skilled nursing facilities operating in the State of California.

3. Defendants BRIUS MANAGEMENT CO., INC.; BOARDWALK FINANCIAL SERVICES, LLC , ROCKPORT HEALTHCARE SERVICES and DOES 51 through 100 (hereinafter the "MANAGEMENT DEFENDANTS") were at all relevant times the FACILITY'S owners, operators, parent company, and/or management company of the FACILITY and actively participated and controlled the business of the FACILITY and thus provided long-term professional and custodial care as a 24-hour skilled nursing facility (hereinafter the FACILITY and the MANAGEMENT DEFENDANTS are collectively sometimes jointly referred to as "DEFENDANTS").

4. MARIE WHITE is informed and believes and therefore alleges that at all times relevant to this complaint, DOES 101-250 were licensed and unlicensed individuals and/or entities, and employees of the DEFENDANTS rendering care and services to MARIE WHITE and whose conduct caused the injuries and damages alleged herein. It is alleged that at all times relevant hereto, the DEFENDANTS were aware of the unfitness of DOES 101-250 to perform their necessary job duties and yet employed these persons and/or entities in disregard of the health and safety of MARIE WHITE.

5. MARIE WHITE is ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 250, and for that reason has sued such Defendants by fictitious names. MARIE WHITE will seek leave of the Court to amend this Complaint to identify said Defendants when their identities are ascertained.

6. The liability of the DEFENDANTS for the abuse of MARIE WHITE as alleged herein arises from their own direct misconduct as alleged herein as well as all other legal bases and according to proof at the time of trial.

7. The DEFENDANTS, by and through the corporate officers, directors and/or managing agents, including Shlomo Rechnitz, Tammy Pirhekyati, Kathy Raizman, Helen Scott, Jessica

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Hernandez; Melvin Daignault, Budgie Amparo, Sharrod Brooks,; Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and others presently unknown to MARIE WHITE and according to proof at time of trial, ratified the conduct of their co-defendants and the FACILITY, in that they were aware of the understaffing of the FACILITY, in both number and training, the relationship between understaffing and sub-standard provision of care to patients of the FACILITY, including MARIE WHITE, the rash, and truth, of lawsuits against the DEFENDANTS' Skilled Nursing Facilities including the FACILITY, and the FACILITY'S customary practice of being issued deficiencies by the State of California's Department of Public Health as alleged herein.

8. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS, which led to the injuries to MARIE WHITE as alleged herein, was the direct result and product of the financial and control policies and practices forced upon the FACILITY by the financial limitations imposed upon the FACILITY by the MANAGEMENT DEFENDANTS by and through the corporate officers, directors and/or managing agents enumerated in paragraph 7 of the complaint and others presently unknown and according to proof at time of trial.

9. That, based upon information and belief, Shlomo Rechnitz, Sharrod Brooks, Dana Webb, Lisa Spaugy, and DOES 101-120 were members of the "Governing Body" of the FACILITY responsible for the creation and implementation of policies and procedures for the operation of the FACILITY pursuant to 42 C.F.R. §483.75.

10. That rather than provide the required services mandated by law as members of the "Governing Body," Shlomo Rechnitz, Sharrod Brooks, Dana Webb, Lisa Spaugy, and DOES 101-120, as executives, board members, managing agents and/or owners of the FACILITY, were focused on unlawfully limiting necessary expenditures in the operation of the DEFENDANTS' businesses as opposed to providing the legally mandated minimum care to be provided to elder and/or dependent patients, including MARIE WHITE, the net effect of which was, and is, to deny required services to FACILITY patients including MARIE WHITE.

11. The FACILITY and the MANAGEMENT DEFENDANTS operated in such a way as to make their individual identities indistinguishable, and are therefore, the mere alter-egos of one another.

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12. At all relevant times, the FACILITY and the MANAGEMENT DEFENDANTS and each of their tortious acts and omissions, as alleged herein, were done in concert with one another in furtherance of their common design and agreement to accomplish a particular result, namely maximizing profits from the operation of the FACILITY by underfunding and understaffing the FACILITY. Moreover, the FACILITY and the MANAGEMENT DEFENDANTS aided and abetted each other in accomplishing the acts and omissions alleged herein. (See Restatement (Second) of Torts §876 (1979)).

FIRST CAUSE OF ACTION
ELDER ABUSE
[By MARIE WHITE Against All Defendants]

13. MARIE WHITE hereby incorporates the allegations asserted in paragraphs 1 through 12 above as though set forth at length below.

14. At all relevant times, MARIE WHITE was over the age of 65 and thus was an "elder" as that term is defined in the *Welfare and Institutions Code* §15610.27.

15. That DEFENDANTS were to provide "care or services" to MARIE WHITE and were to be "care custodians" of MARIE WHITE and in a trust and fiduciary relationship with MARIE WHITE. That the DEFENDANTS provided "care or services" to dependent adults and the elderly, including MARIE WHITE, and housed dependent adults and the elderly, including the MARIE WHITE.

16. That the DEFENDANTS "neglected" MARIE WHITE as that term is defined in *Welfare and Institutions Code* §15610.57 in that the DEFENDANTS themselves, as well as their employees, failed to exercise the degree of care that reasonable persons in a like position would exercise as is more fully alleged herein.

17. While a resident of the FACILITY, the DEFENDANTS wrongfully and repeatedly withheld required care from MARIE WHITE. As the abject result of the failure of the DEFENDANTS to take action with required interventions to protect MARIE WHITE from health and safety hazards, MARIE WHITE suffered multiple preventable falls including one which caused a fracture of her left arm, malnourishment leading to a weight loss of twenty-four pounds in under four months, all of which was fraudulently concealed by the DEFENDANTS from MARIE WHITE'S family and legal

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representative which directly contributed to the occurrence and worsening of MARIE WHITE'S injuries. As a result of DEFENDANTS' repeated withholding of required care, MARIE WHITE is now unable to walk and does not have the full use of her arm.

18. MARIE WHITE was admitted to the FACILITY for rehabilitation and 24-hour care and supervision after her physician recommended she no longer live at home along any longer after developing dementia and sundowner's syndrome and suffering a few falls at home, one of which resulted in MARIE WHITE fracturing her hip. Upon MARIE WHITE'S admission to the FACILITY, the DEFENDANTS were well aware of MARIE WHITE'S prior history of falls through assessment information, family information, as well as physician notes and orders provided to the FACILITY. In addition, as a result of suffering from dementia, sundowner's syndrome and a fractured hip, upon admission to the FACILITY, MARIE WHITE required assistance with mobility, transferring, ambulation, as well as all other activities of daily living. Therefore upon MARIE WHITE'S admission to the FACILITY, the DEFENDANTS were well aware, through assessment information, family information, as well as physician notes and orders provided to the FACILITY, that MARIE WHITE was at high risk of suffering falls, and therefore required special care and assistance including 24-hour supervision and monitoring, assistance and monitoring with ambulation and transferring, the provision of safety and assistance devices to prevent accidents, assistance and monitoring with other activities of daily living, and the implementation of interventions to prevent further falls

19. The DEFENDANTS knew prior to the admission of MARIE WHITE that it is a statistical fact known to all in long term care including the FACILITY, as determined and forewarned by the Centers for Disease Control and Prevention, that "among older adults falls are the leading cause of both fatal and non-fatal injuries."[1] And that "twenty-thirty percent of people who fall suffer moderate to severe injuries…"[2] Further, that "[M]any people who fall…..develop a fear of falling."[3]

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[1] Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. Injury Prevention 2006a;12:290–5.

[2] Sterling DA, O'Connor JA, Bonadies J. Geriatric falls: injury severity is high and disproportionate to mechanism. Journal of Trauma–Injury, Infection and Critical Care 2001;50(1):116–9.

Alexander BH, Rivara FP, Wolf ME. The cost and frequency of hospitalization for fall–related injuries in older adults. American Journal of Public Health 1992;82(7):1020–3.

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This fear will likely cause the elder adult, such as MARIE WHITE, "to limit their activities, which leads to reduced mobility and loss of physical fitness"[4]

20. Accordingly, and a fact well known to the DEFENDANTS, elders such as MARIE WHITE have a propensity to wander, and are a high risk to suffer further falls and injury. Thus, skilled nursing facilities such as the FACILITY are to not only conduct assessments of high fall risk residents such as MARIE WHITE, but also are to update the assessments as frequently as necessary to determine the specific interventions that should be put in place to prevent a resident such as MARIE WHITE from suffering falls.

21. That notwithstanding this knowledge, and notwithstanding a full knowledge that the failure to create, implement update proper care plans to prevent MARIE WHITE from suffering falls created a high probability that MARIE WHITE would suffer further falls and resulting injury, the DEFENDANTS knowingly disregarded this risk and wrongfully withheld required care from MARIE WHITE including 24-hour supervision and monitoring, assistance and monitoring with ambulation and transferring, the provision of safety and assistance devices to prevent accidents, assistance and monitoring with other activities of daily living, and the implementation of interventions and failing to have competently trained staff assist MARIE WHITE in transfer and locomotion to prevent falls.

22. Thus, on or about January 26, 2017, MARIE WHITE was at the FACILITY being assisted to the bathroom by a FACILITY staff member. The FACILITY employee then left MARIE WHITE completely unattended. Not surprisingly due to DEFENDANTS withholding the required attention and supervision of MARIE WHITE, MARIE WHITE fell in the bathroom, striking her head on the toilet and sustaining a fractured neck and wrist. Unfortunately and sadly, MARIE WHITE cannot withstand the anesthesia required for surgery so was placed in a neck brace and case and will be transferred to another skilled nursing facility for rehabilitation.

23. That the Department of Public Health investigated MARIE WHITE'S multiple falls

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[3] Bell AJ, Talbot-Stern JK, Hennessy A. Characteristics and outcomes of older patients presenting to the emergency department after a fall: a retrospective analysis. Medical Journal of Australia 2000;173(4):176–7.

[4] Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of falling and restriction of mobility in elderly fallers. Age and Ageing 1997;26:189–193.

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while at the FACILITY as well as the multiple falls of numerous other residents of the FACILITY, and issued to the FACILITY a Class A Citation to the FACILITY, finding that DEFENDANTS' violations of applicable regulations in their care of MARIE WHITE "presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result" to MARIE WHITE.[5] and multiple deficiencies, finding that the multiple falls of MARIE WHITE and other residents of the FACILITY were caused by understaffing at the FACILITY which in turn caused multiple other failures.

24. As it relates to MARIE WHITE (referred to as "Resident 1" in the DPH citation), the DPH issued three Class A citations relating to the care of MARIE WHITE found that DEFENDANTS violated 42 C.F.R. §483.25(d)(1) and (2) which requires that the FACILITY ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Specifically, the DPH found the following with respect to DEFENDANTS' repeated withholding of care from MARIE WHITE:

> The facility failed to maintain an accident hazard free environment and provide adequate supervision and assistance for Resident 1 when: Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture, which required admission to an acute care

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[5] Class A citations are the most serious type of violation that is not the direct proximate cause of a resident death. California Health & Safety Code §1424 provides in relevant part:

> (d) Class "A" violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a long-term health care facility may constitute a class "A" violation. The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the state department, is required for correction. Except as provided in Section 1424.5, a class "A" citation is subject to a civil penalty in an amount not less than one thousand dollars ($1,000) and not exceeding ten thousand dollars ($10,000) for each and every citation.

Health & Saf. Code, § 1424

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hospital for treatment.

(Exhibit “1” at p. 1-2.)

Resident 1 's admission record indicated Resident 1 was admitted to the facility on 1/22/16, with diagnoses including blindness in both eyes, difficulty in walking, and generalized muscle weakness.

(Exhibit “1” at p. 2.)

Resident 1's minimum data set (MDS, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 7/29/16, revealed a BIMS (brief interview for mental status) score of 14, which indicated Resident 1 was cognitively intact. The MDS assessment indicated Resident 1 required limited assistance of one person with physical assistance for walking in the corridor and toilet use.

(Exhibit “1” at p. 2.)

The fall risk assessment, dated 7/27/16, indicated Resident 1 was at high risk for fall due to multiple problems including intermittent confusion, one to two falls in the past three months, and being legally blind.

(Exhibit “1” at p. 2.)

Resident 1's care plan for fall risk prevention and management, initiated on 1 /22/16, and re-evaluated on 7/16, indicated approaches for fall risk prevention and management including, "Orient resident to environment each time changes are made and provide an environment that supports minimized hazards over which the Facility has control..." The care plan did not specify how the facility would provide supervision to prevent the resident from falling.

(Exhibit “1” at p. 2-3.)

Resident 1's care plan for visual impairment, initiated on 1/22/16, indicated, "Provide environment with items kept in consistent location, free from obstacles and clutter ... uses handrails in hallway ... " The care plan for activities of daily Jiving initiated on 1/22/16, indicated Resident 1 required assistance for toilet use.

(Exhibit “1” at p. 3.)

The Nurse’s Note, dated 8/28/16, revealed Resident 1 had an unwitnessed fall at 9:10 a.m., when Resident 1 was ambulating to the restroom and walked onto a wet floor sign.

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(Exhibit "1" at p. 3.)

> The IDT (interdisciplinary team) Conference Record, dated 8/29/16, indicated on 8/28/16, at 9:10 a.m., Resident 1 walked to the bathroom and stopped at the restroom doorway. Resident 1 's hands grabbed the spring rod, which the housekeeper placed in the doorway for cleaning, and simultaneously leaned her weight backward expecting the rad to be stable like a hand rail. Resident 1 fell to her left side and had left shoulder pain and left hip discomfort. Resident 1 was sent to an Emergency Department and was admitted to an acute care hospital.

(Exhibit "1" at p. 3.)

> The CT (computerized tomography, combines of X-ray images using computer process to create Images) examination result, dated 8/28116, and the History and Physical Report from the acute care hospital, dated 8/28/16, indicated Resident 1 sustained a non-operable left humeral neck (upper arm bone) fracture and was admitted to the hospital for pain control and evaluation.

(Exhibit "1" at p. 4.)

> During an interview on 10/26/16 at 10:02 a.m., regarding Resident 1 's fall on 8/28/16, Licensed Staff A stated Resident 1 usually used the handrails in the hallway when Resident 1 was walking. Licensed Staff A stated Resident 1 had visual impairment. Resident 1 liked to grab the handrail and leaned backward while talking to the staff or other residents. licensed Staff A stated, on the day Resident 1 fell, Resident 1 walked to the restroom in the hallway and grabbed the spring rod, which the housekeeper placed in the doorway for cleaning. Licensed Staff A stated Resident 1 thought the rod was the handrail, so Resident 1 leaned her body backward while grabbing the rod. Licensed Staff A stated Resident 1 fell on the floor because the rod was not stable and fell off the doorway. Licensed Staff A stated no staff walked with Resident 1 because it was Resident 1 's routine to walk to the restroom by herself using the handrails. Licensed Staff A stated the biggest mistake was lack of communication. Licensed Staff A stated the housekeeper did not tell her (Licensed Staff A) about placing the rod in the restroom doorway, otherwise she would have educated Resident 1 and let her feel the rod or walked with her. Licensed Staff A stated the rod was a new product, but they should not use it on the floor because it was dangerous.

(Exhibit "1" at p. 4-5.)

> During an interview on 10/26/16 at 11 :50 a.m., regarding Resident 1 's fall on 8/28/16, Housekeeping Staff P stated after she cleaned the

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> restroom, she left the rod with a sign across the restroom doorway and went to another hall. Housekeeping Staff P stated she did not tell Resident 1 that the rod was left in the doorway. Housekeeping Staff P stated she did not tell any staff about the rod because they could see it. Housekeeping Staff P stated from the beginning of using this type of rod, she told the housekeeping supervisor that the rod was terrible and not good for use because the rod did not have a spring and was easy to fall off. She stated the rod was not stable and when people grabbed the rod, the rod fell.

(Exhibit "1" at p. 5.)

> During a concurrent observation and interview on 10/26/16, at 11 :25 a.m., in the Housekeeping Supervisor's office, Housekeeping Supervisor Q showed a yellow rod with a yellow sign, "CLOSED FOR CLEANING" hanging to the rod. Housekeeping Supervisor Q stated this was the rod with the sign Housekeeping Staff P used when she cleaned the restroom where Resident 1 fell. Housekeeping Supervisor Q stated the housekeeper put the rod across the doorway to indicate the room was being cleaned. Housekeeping Supervisor Q stated the housekeeper should tell the nurse when the rod was placed. Housekeeping Supervisor Q stated the rod was light metal and was not strong. Housekeeping Supervisor Q stated the facility had been using the rod for about six to seven months, but they did not have a policy and procedure regarding the use of the rod.

(Exhibit "1" at p. 5-6.)

> Upon request for the manufacturer's guidelines for the rod, Housekeeping Supervisor Q provided a page documentation titled, "FACILITY MAINTENANCE," undated, indicated under, "A. Site Safety Hanging Sign," which did not indicate how to use the rod and sign safely.

(Exhibit "1" at p. 6.)

> Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance for Resident 1 when:
> Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture which required admission to an acute care hospital for treatment.

(Exhibit "1" at p. 6.)

> The violation of the regulation had presented either imminent danger that death or serious harm would result or a substantial probability

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that death or serious physical harm would result.

(Exhibit "1" at p. 6.)

25. Specifically, the DPH found that the DEFENDANTS violated Title 42 C.F.R. §483.32(a)(1)-(4)

> The facility failed to ensure adequate nursing staff to provide quality care, which caused harm to their residents as evidenced by:
> 1. The facility did not provide adequate supervision and assistance, revise fall risk care plans and implement the care plans, follow fall protocol for post-fall assessment and management to prevent falls and Injuries for Residents 1, 2, 3, 4, 5, 6, and Resident Council when:·
>
> a. Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture which required admission to an acute care hospital for treatment.
>
> b. *Resident 2 had five falls during a one month period* from 8/12/16 to 9/14/16. Resident 2 sustained a head injury from the last fall on 9/14/16, which required Resident 2 to be sent to an acute care hospital for evaluation and treatment. After 9/14/16, Resident 2 had three more falls on 10/26/16, 11 /5/16, and 11/26/16.
>
> c. Staff did not follow their fall protocol for post-fall assessment and notify the physician of a fall when Resident 3 reported having fallen on 10/20/16. This resulted In Resident 3 not being evaluated after the fall until 10/25116 (five days later).
>
> d. *Resident 5 had six falls during a six and one-half months period* from 5/24/16 to 12/6/16. On 5/24/16, Resident 5 fell and sat on the floor in the bathroom which was wet with urine. A fall on 11/23/16, resulted In Resident 5 sustaining a small skin tear on the top ridge of the nose on 11/23/16 at 9:35 p.m. (This was the second fall that day)
>
> e. Resident 4 had three falls during a one-month period from 8/16/16 to 9/17/16. Resident 4 sustained a skin tear on the right hand from a fall on 8/16/16, and re-opened a skin tear on the right hand from a fall on 8/21/16. Resident 4 had three more falls during a one-week period from 10/13/16 to 10/17/16, which resulted In a nasal bone (nose) fracture from a fall on 10/13/16.
>
> f. Resident 6 had multiple falls In a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head, which required eight staples from the fall on 10/13/16. Resident 6 sustained a

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> laceration on the right side of the head from the fall on 11/25/16.
>
> g. Licensed Staff did not revise Resident 14's (who had one unwitnessed fall on 11/4/16, which resulted in a skin tear to the left elbow and a fractured pelvis), "Fall Care Plan" to indicate Resident 14 was to be on, "one-on-one" with staff at all times starting 11/5/16, per physician's order. *This failure to revise Resident 14's, "Fall Care Plan" had the potential for Resident 14 to fall again causing injury or even death*.
>
> 2. Residents' care needs were not being met when call lights were not answered in a timely manner for Resident 17 and 18, and Resident 17's need of getting out of the bed earlier in the morning was not honored. These failures resulted in Resident 17 staying wet with the urine and feeing bad, and potentially compromised residents' physical and psychosocial well-being.
>
> The violation of the regulation had presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

(Exhibit "2" at p. 51-53.)

26. As it relates specifically to understaffing, the DPH's findings including the FACILITY staff interviews upon which the DPH based its findings, are staggering. For example, according to the DPH Statement of Deficiencies:

> Unlicensed Staff L stated they did not have enough CNAs. Unlicensed Staff L stated the facility reduced the number of CNAs from three to two CNAs on B wing (a memory unit for residents who have memory problems). Unlicensed Staff L stated it was very stressful because Unlicensed Staff L could not do things for the residents as he wanted to do (i.e. brush their teeth, wash their hands, giving a bed bath, and other things) because of short staffing. Unlicensed Staff L stated they were not able to check residents as frequently as they would, to prevent residents from falling. Unlicensed Staff L stated two CNAs were not enough, and they needed three CNAs. Unlicensed Staff L stated the Hall Monitors (staff) could not provide any resident care; they just watched the residents and walked with the residents.

(Exhibit "2" at p. 41.)

27. During an interview with a FACILITY staff member, the DPH investigator asked a FACILITY staff member to itemize the routine tasks the staff member was required to do during her shift along with the time it took to complete each required routine task. Remarkably, the FACILITY

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reported that it took her *over 200 more minutes than she actually worked* to complete only the routine tasks she was required to complete during her shift. The DPH statement of deficiencies states as follows:

> The calculation revealed: One CNA had a total of 510 minutes per shift from 2:45 p.m. to 11:15 p.m., including breaks. A minimum of 710 minutes were required to complete the routine tasks in one work shift Including breaks. This 710 minutes did not include the time for hand washing, answering call lights, reporting change of condition, and other unexpected circumstances. *There were 200 minutes short for the staff to complete the routine tasks*.

(Exhibit "2" at p. 44, emphasis added.)

> Unlicensed Staff PP stated *they needed adequate staffing to feed residents properly and ensure safety and prevent falls*. When asked about the tasks and time for one work shift, Unlicensed Staff PP provided the time for the routine tasks. The calculation of the time required for completion of the routine tasks revealed a minimum of 754 minutes for AM shift and 1052 minutes for PM shift, including all tasks and breaks. The CNAs shifts (AM, PM, & Nights) consisted of a total of 510 minutes, which included the breaks. ***There were a minimum of 244 minutes short for AM shift and 542 minutes short for PM shift***. This calculation did not include time tor hand washing, answering call lights, reporting change of condition, other unexpected situations, and toileting, as she stated toileting required 6-10 minutes per one resident, and she assisted different residents throughout eight hours.

(Exhibit "2" at p. 44-45, emphasis added.)

> During an interview on 12/7/16, at 11:45 a.m., Unlicensed Staff BB, who worked In B wing, stated they, "never·staffed sufficiently. Unlicensed Staff BB stated they had two CNAs, and she had 12 residents. Unlicensed Staff BB stated they needed at least three CNAs.

(Exhibit "2" at p. 45.)

28. Perhaps even more troubling and reflecting the DEFENDANTS' conscious disregard for the health and safety of the Plaintiff is the fact that the FACILITY staff coordinator responsible for scheduling the CNAs and RNAs (Restorative Nursing Assistants) stated that:

> Staffing Coordinator DD stated the staffing one CNA to 12 to 22 residents was, "doable" because the resident census and care fluctuated. She stated she was also a CNA. When asked about the routine tasks required for one CNA in one work shift, Staffing Coordinator DD provided time required for each routine task. She stated AM and PM shifts were about the same. *The calculation of the time revealed a minimum of 850 minutes for one CNA to complete the*

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> *routine tasks in a given AM or PM shift; each CNA had a total of 510 minutes per shift,* ***which was 340 minutes short***. Staffing Coordinator DD did not provide details of all tasks for night shift but stated the tasks for night shift were more on repositioning, toileting, catheter care, and peri care (cleaning the urinary, vaginal, and rectal areas). Upon request for the days and shifts when Staff Coordinator DD scheduled more CNAs than a routine schedule because of, "a lot of falls" twice on-12/8/16 at 10:35 am., and 6:40 p.m., Staff Coordinator DD did not provide the days and shifts.

(Exhibit "2" at p. 46, emphasis added.)

29. Remarkably, one CNA interviewed informed the DPH investigator it took her *three times* the amount of time she actually worked to complete all of the routine tasks she was required to perform during each of her shifts. The CNA first stated as follows:

> Unlicensed Staff QQ stated they usually had two CNAs on morning shift and each CNA had 14 residents, and she had 14 residents this day. Unlicensed Staff QQ stated they needed more staff for each shift to provide good care for the residents. Unlicensed·Staff QQ also stated they needed adequate staffing to feed, shower, and bathe residents properly and ensure safety and prevent falls. When asked about the tasks and time required for caring the residents for one work shift, Unlicensed Staff QQ stated it was a lot of work and it was very hard to complete all the work adequately.

(Exhibit "2" at p. 46-47, emphasis added.) The DPH investigator then asked this CNA to calculate the time it took her to complete all the routine tasks she was required to perform during each of her shifts. According to the DPH Statement of Deficiencies, the calculation revealed the following:

> The calculation indicated a minimum of 1593 minutes were required for one CNA to complete all the tasks, including breaks, for an AM shift. The 510 minutes allotted for the morning Shift starting from 7:15 a.m. to 2:45 p.m. was not enough; ***it required more than 3 times of that (1593) minutes to provide an adequate care for the residents***.

Exhibit "2" at p. 48, emphasis added.)

30. During its investigation, the DPH also uncovered evidence that the DEFENDANTS fraudulently decreased the workload of nurses only when the state was there:

> During an Interview on 12/8/16, 2:45 p.m., Unlicensed Staff SS stated she worked morning shifts on B wing for a long time, and she always had 12 residents except this week. *Unlicensed Staff SS stated this week she had eight residents because the State was there. Unlicensed Staff SS stated they needed to have more staffing on the B Wing because there were a lot of confused residents who required more help and care*. Unlicensed Staff SS added even though there were Hall Monitors on the floor, they could not do a lot of things the CNAs could do such as caring, cleaning, bathing, assisting residents

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> to bed, and making beds.

(Exhibit "2" at p. 49, emphasis added.)

31. Yet another FACILITY staff member "MM" stated as follows:

32.

> The Calculation revealed, if Unlicensed-Staff MM was to perform all the above PM tasks on her own during a total of 510 minutes per shift from 2:45 p.m. to 11:15 p.m., including breaks for 13 residents, it would have taken her a minimum of 593 min. This did not account for hand washing in between each resident, reporting change of condition, repositioning residents every two hours (Unlicensed Staff MM had two bedridden residents), answering call lights, and other unexpected circumstances.

(Exhibit "2" at p. 50-51.)

33. Remarkably, despite all the foregoing, when interviewed by the DPH, the administrator of the FACILITY contended the FACILITY did not have a staffing problem! The DPH Statement of Deficiencies states:

> During a concurrent interview and record review on 12/8/16, at 3 p.m., regarding QAA for staffing, the Administrator stated their target for staffing was to have six to seven CNAs (Certified Nursing Assistants) in the whole building for AM (morning) and PM (afternoon/evening) shifts so each CNA took care of 9 – 11 residents in an eight-hour shift. When asked if a CNA had sufficient time to take care of 9 - 11 residents, the Administrator stated, "yes" because the activity staff, scheduler, and RNA (Restorative Nursing Assistant) were also CNAs and helped for dining. The Administrator further stated one CNA had more than 15 residents on night shift. *The Administrator stated the QAA did not have an action plan for staffing because the facility did not have staffing problems*.

(Exhibit "3" at p. 52, emphasis added.) Exposing the fraudulent misrepresentations of the FACILITY administrator is the reality of the following:

> During an interview on 12/7/16, at 11 :45 a.m., Unlicensed Staff BB stated there was no communication from the management to, "us" [Certified Nursing Assistants].
>
> Unlicensed Staff BB stated they just put up signs in the utility room and in the resident's room and, "hoping us to know" what was going on. Unlicensed Staff BB stated when she looked at the sign with a picture of a bed without written instructions in Resident 2's room, she thought it was the instruction to put the head of the bed down with feet up and so she did. Unlicensed Staff BB stated after that they wrote, "keep bed low, keep bed at an angle."

(Exhibit "3" at p. 52.)

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34. The DEFENDANTS' misconduct and repeated withholding of care to MARIE WHITE was not limited to her; DEFENDANTS exhibited a pattern of recklessness with respect to resident falls. The DPH issued a Class A Citation to the FACILITY for violating 42 C.F.R. §483.25(d) for failing to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Specifically, the DPH Statement of Deficiencies states as follows:

> The facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance and implement Resident 6's care plan when: Resident 6 had multiple falls in a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head which required eight staples from the fall on 10/13/16. Resident 6 sustained a laceration on the right side of the head from the fall on 11/25/16.

(Exhibit "4" at p. 1-2, emphasis added.)

> Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance and implement Resident 6's care plans when:
>
> Resident 6 had multiple falls in a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head, which required eight staples from the fall on 10/13/16. Resident 6 sustained a laceration on the right side of the head from the fall on 11 /25/16. The violation of the regulation had presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

(Exhibit "4" at p. 4-5.)

35. Perhaps even more troubling than the aforementioned violations alleged herein above, and in knowing and conscious disregard of the health and safety of their residents and in what can only be considered despicable conduct in that the DEFENDANTS were aware of the probable dangerous consequences of their conduct and deliberatively failed to avoid those consequences, the DEFENDANTS failed to take corrective action to address the aforementioned violations as specifically found by the DPH. Specifically, DPH found the following:

> The facility's quality assessment and assurance or the manager of their committee (QAA) failed to:

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1. Develop formal corrective action plans or implement the action plans to prevent falls, which caused harm to residents as evidenced by: The facility did not provide adequate supervision and assistance, revise fall risk care plans and implement the care plan, follow fall protocol for post-fall assessment and management to prevent falls and injuries for Residents 1, 2, 3, 4, 5, 6, and 14 when:

a. Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture which required admission to an acute care hospital for treatment.

b. *Resident 2 had five falls during a one month period* from 8/12/16 to 9/14/16. Resident 2 sustained a head injury from the last fall on 9/14/16, which required Resident 2 to be sent to an acute care hospital for evaluation and treatment. After 9/14/16, Resident 2 had three more falls on 10/26/16, 11 /5/16, and 11/26/16.

c. Staff did not follow their fall protocol for post-fall assessment and notify the physician of a fall when Resident 3 reported having fallen on 10/20/16. This resulted In Resident 3 not being evaluated after the fall until 10/25116 (five days later).

d. *Resident 5 had six falls during a six and one-half months period* from 5/24/16 to 12/6/16. On 5/24/16, Resident 5 fell and sat on the floor in the bathroom which was wet with urine. A fall on 11/23/16, resulted In Resident 5 sustaining a small skin tear on the top ridge of the nose on 11/23/16 at 9:35 p.m. (This was the second fall that day)

e. Resident 4 had three falls during a one-month period from 8/16/16 to 9/17/16. Resident 4 sustained a skin tear on the right hand from a fall on 8/16/16, and re-opened a skin tear on the right hand from a fall on 8/21/16. Resident 4 had three more falls during a one-week period from 10/13/16 to 10/17/16, which resulted In a nasal bone (nose) fracture from a fall on 10/13/16.

f. Resident 6 had multiple falls In a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head, which required eight staples from the fall on 10/13/16. Resident 6 sustained a laceration on the right side of the head from the fall on 11/25/16.

g. Licensed Staff did not revise Resident 14's (who had one unwitnessed fall on 11/4/16, which resulted in a skin tear to the left elbow and a fractured pelvis), "Fall Care Plan" to indicate Resident 14 was to be on, "one-on-one" with staff at all times starting 11/5/16, per physician's order. *This failure to revise Resident 14's, "Fall Care Plan" had the potential for Resident 14 to fall again causing injury or even death*.

(Exhibit "3" at p. 54-55.)

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> 2. Identify staffing issues and ensure sufficient nursing staff to provide quality resident care, which caused harm to their residents, as evidenced by resident falls and injuries (refer to 1a - 1g) and residents' care needs were not being met when call lights were not answered in a timely manner for Resident 17 and 18, and Resident 17's need of getting out of the bed earlier In the morning was not honored. These failures resulted In Resident 17- staying wet with the urine and feeling bad, and
> potentially compromised residents' physical and psychosocial well-being.
>
> 3. Communicate QM minutes to the staff. These failures also prevented the QAA committee from implementing and evaluating action plans to correct quality deficiencies and therefore was not able to determine effectiveness of changes to be implemented.
> The violation of the regulation had presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

(Exhibit "3" at p. 56.)

36. The DEFENDANTS were well aware that where they failed to provide MARIE WHITE with the aforementioned care, supervision, and monitoring, there was a high probability that MARIE WHITE would suffer injury. That DEFENDANTS consciously disregarded this risk and failed to provide MARIE WHITE with the aforementioned required care, leading directly to MARIE WHITE's injuries.

37. Unfortunately, as the result of the DEFENDANTS wrongfully withheld required care from MARIE WHITE including 24-hour supervision and monitoring, assistance and monitoring with ambulation and transferring, the provision of safety and assistance devices to prevent accidents, assistance and monitoring with other activities of daily living, and the implementation of interventions and failing to have competently trained staff assist MARIE WHITE in transfer and locomotion to prevent falls, MARIE WHITE was ignored by the DEFENDANTS' staff and was allowed to suffer a fall as the result of the ignorance of the needs of MARIE WHITE.

38. While a patient of the FACILITY, MARIE WHITE suffered an entirely preventable fall that caused MARIE WHITE to suffer a a fractured neck and fractured wrist as alleged herein as a result of DEFENDANTS' wrongful withholding of required care and services from MARIE WHITE.

39. Specifically, and without limiting the generality of that to be proven at time of trial, the DEFENDANTS just refused to create and/or implement a proper care plan for the needs and maladies for which MARIE WHITE was admitted into the FACILITY as mandated by 22 California

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Code of Regulations §72311. This care plan is the most basic and fundamental of services to be provided by a skilled nursing facility such as the FACILITY in that it serves as the basis by which required care is to be determined in a skilled nursing facility.[6]

40. Specifically, and without limiting the generality of that to be adduced through discovery and according to proof at time of trial, the FACILITY wrongfully withheld from MARIE WHITE required care which included, and without limiting the generality of the foregoing and according to proof at time of trial:

a. Wrongfully withholding from MARIE WHITE required care in the form special care and assistance including 24-hour supervision and monitoring, assistance and monitoring with ambulation and transferring, the provision of safety and assistance devices to prevent

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[6] Section 72311 mandates as follows:

(a) Nursing service shall include, but not be limited to, the following:
(1) Planning of patient care, which shall include at least the following:
(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.
(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.
(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.
(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.
(3) Notifying the attending licensed healthcare practitioner acting within the scope of his or her professional licensure promptly of:
(A) The admission of a patient.
(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.
(C) An unusual occurrence, as provided in Section 72541, involving a patient.
(D) A change in weight of five pounds or more within a 30-day period unless a different stipulation has been stated in writing by the patient's licensed healthcare practitioner acting within the scope of his or her professional licensure.
(E) Any untoward response or reaction by a patient to a medication or treatment.
(F) Any error in the administration of a medication or treatment to a patient which is life threatening and presents a risk to the patient.
(G) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.
(b) All attempts to notify licensed healthcare practitioners acting within the scope of his or her professional licensure shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any. If the attending licensed healthcare practitioner acting within the scope of his or her professional licensure or his or her designee is not readily available, emergency medical care shall be provided as outlined in Section 72301(g).
(c) Licensed nursing personnel shall ensure that patients are served the diets as ordered by the attending licensed healthcare practitioner acting within the scope of his or her professional licensure.

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accidents, assistance and monitoring with other activities of daily living, and the implementation of interventions to prevent falls;

b. Wrongfully withholding from MARIE WHITE required care by failing to timely, accurately and properly create Plans of Care so as to provide assistance to MARIE WHITE when ambulating and/or transferring so as to prevent falls;

c. Wrongfully withholding from MARIE WHITE required care by failing to timely, accurately and properly implement Plans of Care so as to provide assistance to MARIE WHITE when ambulating and/or transferring so as to prevent falls;

d. By wrongfully withholding required timely and accurate monitoring of MARIE WHITE progress and/or complications after surgery thereby failing to timely and accurately record medical and nursing observations of MARIE WHITE so that physicians could, and would, adopt and implement proper and required interventions to protect MARIE WHITE;

e. By wrongfully withholding the provision of nursing services to MARIE WHITE which were organized, staffed and equipped to meet the needs of MARIE WHITE, thereby causing injury to MARIE WHITE as alleged herein;

f. By wrongfully withholding the required nurse staff development programs to those nurses who provided services to MARIE WHITE on behalf of the FACILITY, thereby causing injury to MARIE WHITE as alleged herein;

g. By wrongfully withholding the provision of nursing services to MARIE WHITE in accordance with Nursing Service Policies and Procedures which met required standards, thereby causing injury to MARIE WHITE as alleged herein;

h. By wrongfully withholding the required services to MARIE WHITE by failing to have a governing body which operated the FACILITY so that the services wrongfully withheld from MARIE WHITE would not be wrongfully withheld thereby causing injury to MARIE WHITE as alleged herein;

41. The Defendants failed to notify MARIE WHITE'S physician that MARIE WHITE suffered a fall in the FACILITY in accordance with the requirements of 22 *Code of Regulations* §72311(a)(3). Defendants further failed to MARIE WHITE'S responsible party of the fall as well.

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42. The accumulated and consistent withholding of required care to MARIE WHITE by the DEFENDANTS included, and subject to that learned in discovery and according to proof at time of trial:

- Wrongfully withholding from MARIE WHITE required care by failing to timely, accurately and properly create Plans of Care so as to provide assistance to MARIE WHITE when ambulating and/or transferring so as to prevent falls;
- Wrongfully withholding from MARIE WHITE required care by failing to timely, accurately and properly implement Plans of Care so as to provide assistance to MARIE WHITE when ambulating and/or transferring so as to prevent falls;
- Wrongfully withholding from MARIE WHITE required care by failing to timely and properly provide assistance to MARIE WHITE with ambulation and/or transferring so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to timely, accurately and competently perform assessments of the care needs of MARIE WHITE as required by 22 California *Code of Regulations* §72311 so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to timely and accurately notify MARIE WHITE 'S physician of sudden and/or marked adverse changes in the signs, symptoms or behavior by MARIE WHITE as required by 22 California *Code of Regulations* §72311 so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to treat her with dignity and respect as required by 22 California *Code of Regulations* §72315;
- The wrongful withholding of required care to MARIE WHITE answer MARIE WHITE'S call signals promptly as required by 22 California *Code of Regulations* §72315 so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to have employed and on duty sufficient staff to provide the necessary nursing services for MARIE WHITE as required by 22 California *Code of Regulations* §72329 so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to have employed and on duty staff with required qualifications to provide the necessary nursing services for patients admitted care as required by 22 California *Code of Regulations* §72329 so as to prevent falls;
- The wrongful withholding of required care to MARIE WHITE in failing to provide MARIE WHITE with the necessary custodial and professional care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, as required by 22 California *Code of Regulations* §72515(b) so as to prevent falls;

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- The wrongful withholding of required care to MARIE WHITE in failing to ensure that MARIE WHITE'S environment remains as free of accident hazards as is possible as required by 42 C.F.R. §483.25 (h)(1) so as to prevent falls;

  The wrongful withholding of required care to MARIE WHITE in failing to ensure that MARIE WHITE receives adequate supervision and assistance devices to prevent accidents as required by 42 C.F.R. §483.25 (h)(2) so as to prevent falls.

43. The DEFENDANTS wrongfully withheld this required care to MARIE WHITE due to their refusal to provide services to her with sufficient budget and sufficient staffing to meet the needs of MARIE WHITE consistent with the requirements of 42 U.S.C. §1396r(b)(4)(C).

44. The DEFENDANTS wrongfully withheld this required care to MARIE WHITE due to their refusal to provide services to MARIE WHITE with a sufficient number of personnel on duty at the FACILITY on a 24-hour basis to provide appropriate custodial and professional services to MARIE WHITE in accordance MARIE WHITE'S resident care plans as required by 42 C.F.R. §483.30 and 22 C.C.R. §72329.

45. The DEFENDANTS knew that where their skilled nursing facility suffered from understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in capacity and competency, this inevitably led to the improper withholding of required medical and/or custodial services to residents of the FACILITY such as MARIE WHITE as alleged herein and injury was not only likely, but inevitable. The FACILITY ignored this known peril which led to the wrongful withholding of required care to MARIE WHITE which led to the injuries of MARIE WHITE.

46. The DEFENDANTS knew that where their skilled nursing facility suffered from understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in capacity and competency, this inevitably led to the improper withholding of required medical and/or custodial services to residents of the FACILITY such as MARIE WHITE as alleged herein and injury was not only likely, but inevitable. The FACILITY ignored this known peril which led to the wrongful withholding of required care to MARIE WHITE which led to her injuries.

47. That prior to and during the admission of MARIE WHITE in the FACILITY, the DEFENDANTS knew that where their skilled nursing facilities, such as the FACILITY suffered from understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in

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capacity and competency, inevitably led to the improper withholding of required medical and/or custodial services to residents of the FACILITY such as MARIE WHITE and such as alleged above.

48. Notwithstanding the fact that the DEFENDANTS knew that it was highly probable that their conduct in the FACILITY as to understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in capacity and competency inevitably led to the improper withholding of required medical and/or custodial services to residents of the FACILITY and resulting harm, the DEFENDANTS disregarded this risk in favor of untoward economic gain at the expense of the provision of required care to infirm and dependent adults such as MARIE WHITE.

49. The DEFENDANTS represented to the general public and to MARIE WHITE and/or her legal representative, that the FACILITY was sufficiently staffed so as to be able to meet the needs of MARIE WHITE and the FACILITY operated in compliance with all applicable rules, laws and regulations governing the operation of skilled nursing facilities in the State of California. These representations were, and are, false.

50. That as the direct result of the wrongful withholding of required care to MARIE WHITE alleged above, contributed to by the chronic understaffing and lack of training of the FACILITY staff which led to the chronic withholding of required care, MARIE WHITE suffered an entirely preventable fall and resulting fractured neck and fractured wrist.

51. In the operation of the FACILITY, DEFENDANTS, and each of them, held themselves out to the general public via websites, brochures, admission agreements and other mechanisms presently unknown to MARIE WHITE and according to proof at time of trial, to the MARIE WHITE, and other similarly situated, that their skilled nursing facilities provided services which were in compliance with all applicable federal and state laws, rules and regulations governing the operation of a skilled nursing facility in the State of California. In the operation of the subject facility, the DEFENDANTS, and each of them, held themselves out to MARIE WHITE that the FACILITY would be able to meet the needs of MARIE WHITE. These representations of the nature and quality of the nature of services to be provided were, in fact, false.

52. That the wrongful withholding of required services to MARIE WHITE was the result of DEFENDANTS' plan to cut costs at the expense of their residents such as MARIE WHITE.

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Integral to this plan was the practice and pattern of staffing the FACILITY with an insufficient number of service personnel, many of whom were not properly trained or qualified to care for the elders and/or dependent adults, whose lives were entrusted to them. The "under staffing" and "lack of training" plan was designed as a mechanism as to reduce labor costs and predictably and foreseeably resulted in the wrongful withholding of required services to many residents of the FACILITY, and most specifically, MARIE WHITE.

53. At all times herein mentioned DEFENDANTS had actual and/or constructive knowledge of the unlawful conduct and business practices alleged herein, yet represented to the general public and MARIE WHITE that the FACILITY would provide care which met legal standards. Moreover, such unlawful business practices were mandated, directed, authorized, and/or personally by the officers, directors and/or managing agents of the DEFENDANTS as set forth in paragraph 7 and other management personnel of the DEFENDANTS whose names are presently unknown to the MARIE WHITE and according to proof at time of trial.

54. The DEFENDANTS, by and through the corporate officers, directors and managing agents set forth in paragraph 7, and other corporate officers and directors presently unknown to MARIE WHITE and according to proof at time of trial, ratified the conduct of their co-defendants and the FACILITY, in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing of the FACILITY, in both number and training, the relationship between understaffing and sub-standard provision of care to patients of the FACILITY including MARIE WHITE, and the FACILITY'S practice of being issued deficiencies by the State of California's Department of Public Health as to all skilled nursing facilities in the State of California. Furthermore, the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 7, and others presently unknown to MARIE WHITE and according to proof at time of trial, ratified the conduct of themselves and their co-defendants in that they were aware that such understaffing and deficiencies would lead to injury to patients of FACILITY, including MARIE WHITE and insufficiency of financial budgets to lawfully operate the FACILITY. This ratification by the DEFENDANTS the and FACILITY itself, is that ratification of the customary practice and usual performance of FACILITY as set forth in *Schanafelt v. Seaboard Finance Company,* (1951) 108

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Cal.App.2d 420, 423-424.

55. Upon information and belief, the DEFENDANTS enacted, established and implemented the financial plan and scheme which led to the FACILITY being understaffed, in both number and training, by way of imposition of financial limitations on the FACILITY in matters such as, and without limiting the generality of the foregoing, the setting of financial budgets which clearly did not allow for sufficient resources to be provided to MARIE WHITE by the FACILITY. These choices and decisions were, and are, at the express direction of the DEFENDANTS management personnel including the corporate officers and directors enumerated in paragraphs 7 and others presently unknown to MARIE WHITE and according to proof at time of trial, having power to bind the DEFENDANTS as set forth in *Bertero v. National General Corporation* (1974) 13 Cal.3d 43, 67 and *McInerney v. United Railroads of San Francisco*, (1920) 50 Cal.App.538, 549.

56. The Corporate authorization and enactment of the DEFENDANTS, alleged in the preceding paragraphs, constituted the permission and consent of the FACILITY'S misconduct by the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 7 and others presently unknown to MARIE WHITE and according to proof at time of trial, who had within their power the ability and discretion to mandate that the FACILITY employ adequate staff to meet the needs of their patients, including MARIE WHITE, as required by applicable rules, laws and regulations governing the operation of skilled nursing facilities in the State of California. The conduct constitutes ratification of the FACILITY'S misconduct by the DEFENDANTS, which led to injury to MARIE WHITE as set forth in *O'Hara v. Western Seven Trees Corp.,* (1977) 75 Cal.App.3d. 798, 806 and *Kisesky v. Carpenters Trust for So. Cal* (1983) 144 Cal.App.3d 222, 235.

57. MARIE WHITE has reason to believe that the DEFENDANTS' focus and intent to carry out the above strategies to increase revenues and profit margins caused widespread withholding of required services to the FACILITY residents, including MARIE WHITE.

58. The advance knowledge of their malfeasance as alleged herein which led to the chronic and wrongful withholding of required care to residents in the FACILITY was accomplished by many means, including lawsuits against the DEFENDANTS alleging under staffing and elder/dependent adult abuse and by way of the issuance of deficiencies to the FACILITY by the State of California's

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Department of Public Health, reports on staffing, census, budget and regulatory violations all available to the FACILITY and yet substantially ignored.

59. Notwithstanding the knowledge of the DEFENDANTS, and their managing agents as alleged herein above, the DEFENDANTS consciously chose not to increase staff, in number or training, at the FACILITY and as the direct result thereof wrongfully withheld required service to MARIE WHITE causing her to suffer the injuries alleged herein. This ignorance, on the part of the DEFENDANTS and their corporate officers named in paragraph 7, constituted at a minimum, a reckless disregard for the health and safety of MARIE WHITE.

60. That the DEFENDANTS as care custodians willfully caused and allowed MARIE WHITE to be injured and maliciously, fraudulently, oppressively, willfully or recklessly caused MARIE WHITE to be placed in situations such that her health would be in danger in doing the acts specifically alleged herein.

SECOND CAUSE OF ACTION
NEGLIGENT HIRING AND SUPERVISION
[By MARIE WHITE Against DEFENDANTS and DOES 1-250.]

61. MARIE WHITE hereby incorporates the allegations asserted in paragraphs 1 through 60 above as though set forth below.

62. That the DEFENDANTS negligently hired, supervised and/or retained employees including Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery.

63. That in fact Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery, were unfit to perform their job duties and the DEFENDANTS knew, or should have known, that that they were unfit and that this unfitness created a risk to elder and infirm residents of the FACILITY such as MARIE WHITE.

64. This knowledge on the part of the DEFENDANTS was, or should have been, acquired by the DEFENDANTS through various mechanisms including the pre-employment interview process,

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reference checks, probationary period job performance evaluations, other periodic job performance evaluations and/or disciplinary processes.

65. The DEFENDANTS failed to properly and completely conduct a comprehensive pre-employment interview process and reference checks as to Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery. Had the DEFENDANTS done so they would have discerned that these persons were unfit to perform their job duties in a licensed skilled nursing facility in California.

66. The DEFENDANTS failed to properly and completely conduct, and thereafter ignored the content of, probationary period job performance evaluations, other periodic job performance evaluations and/or disciplinary processes as to Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery, and had the DEFENDANTS done so they would have discerned that these persons were unfit to perform their job duties in a licensed skilled nursing facility in California.

67. That as the result of the unfitness of Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery, MARIE WHITE was injured in an amount and manner to be proven at time of trial.

68. That the DEFENDANTS negligence in hiring, supervising and/or retaining Dana Webb, Administrator of the FACILITY; Lisa Spaugy, Director of Nursing of the FACILITY; and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to MARIE WHITE but will be sought via discovery, caused MARIE WHITE injury in an amount and manner to be proven at time of trial.

/ / /

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THIRD CAUSE OF ACTION
VIOLATION OF RESIDENT RIGHTS (Health & Saf. Code §1430(b))
BY PLAINTIFF AGAINST EUREKA REHABILITATION & WELLNESS CENTER, LP

69. Plaintiffs refer to, and incorporate herein by this reference, paragraphs 1 through 68 above, as though fully set forth herein.

75. It is alleged that the concealments by DEFENDANTS alleged above were intended to deceive Plaintiff, and others similarly situated, into believing that DEFENDANTS' facilities were properly operated to induce Plaintiffs and class members into becoming residents of DEFENDANTS' facilities. That Plaintiffs and members of the class, all in infirm health, elderly, and/or in need of skilled nursing care and members of one of the most vulnerable segments of our society, were unsophisticated and unknowledgeable in the operation of skilled nursing facilities in the State of California and had no knowledge of the facts concealed by DEFENDANTS and could not have discovered those concealed facts due to, among other things, their extremely vulnerable status. Had the concealed facts been disclosed to Plaintiffs and members of the class, they would not have become residents of DEFENDANTS' facilities and would not have paid, or had monies paid on their behalf, for the substandard skilled nursing care at DEFENDANTS' facilities.

76. Before, during, and after the admissions processes of Plaintiff , and others similarly situated, the DEFENDANTS actively and intentionally concealed from Plaintiff , and others similarly situated, that DEFENDANTS did not devote sufficient financial resources to the proper operation of their skilled nursing facilities, did not devote sufficient financial resources to protect the health and safety of residents and ensure resident rights were not violated, and instead diverted those resources to create ill-begotten profits for DEFENDANTS. It is alleged that this concealment by DEFENDANTS was intended to deceive Plaintiff , and others similarly situated, into believing that the FACILITY was properly operated to induce Plaintiff , and others similarly situated, into becoming a residents of the FACILITY. That Plaintiff , and others similarly situated, in infirm health, elderly, and/or in need of skilled nursing care and members of one of the most vulnerable segments of our society, were unknowledgeable and unsophisticated in the operation of skilled nursing facilities in the State of California and had no knowledge of the facts concealed by DEFENDANTS and could not have discovered those concealed facts due to, among other things, their extremely vulnerable status. Had

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the concealed facts been disclosed to Plaintiff , and others similarly situated, he would not have become residents of the FACILITY and would not have paid, or had monies paid on his behalf, for the substandard skilled nursing care at the FACILITY.

77. Before, during, and after the admissions processes of Plaintiff , and others similarly situated, the DEFENDANTS actively and intentionally concealed from Plaintiff , and others similarly situated, that DEFENDANTS chronically understaffed the FACILITY with an inadequate number of staff to carry out the function of their facilities as more fully alleged herein, and in so doing and as a result thereof, the DEFENDANTS have violated the rights afforded to all residents of skilled nursing facilities under *Health & Safety Code* §1599.1(a) and 22 C.C.R. §72527(a)(12) and (a)(25), most specifically the right "to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs" and to live in a facility that employs "an adequate number of qualified personnel to carry out all of the functions of the facility." It is alleged that this concealment by DEFENDANTS was intended to deceive Plaintiff , and others similarly situated, into believing that DEFENDANTS' facilities were properly staffed to induce the FACILITY into becoming a resident of the FACILITY. That Plaintiff , and others similarly situated, all in infirm health, elderly, and/or in need of skilled nursing care and members of one of the most vulnerable segments of our society, were unknowledgeable and unsophisticated in the operation of skilled nursing facilities in the State of California and had no knowledge of the facts concealed by DEFENDANTS and could not have discovered those concealed facts due to, among other things, their extremely vulnerable status. Had the concealed facts been disclosed to Plaintiff, and others similarly situated,, they would not have become a resident of the FACILITY and would not have paid, or had monies paid on his behalf, for the substandard skilled nursing care at the FACILITY.

78. In reality, in direct contradiction to the representation in their uniform admission agreement that their facilities would "employ an adequate number of qualified personnel to carry out all functions of the facility" and to meet the needs of their residents, the FACILITY was chronically understaffed and chronically failed to meet the particularized standards as set forth in the Resident Bill of Rights relating to the mandatory requirements of California *Health & Safety Code* §1599.1(a) as set forth in Title 22 C.C.R. §72527(a)(25) and Title 22 C.C.R. §72527(a)(12), as is more fully alleged

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below. Thus, DEFENDANTS have misrepresented in their admission agreement that entering into the admission agreement with DEFENDANTS conferred or involved rights, remedies, or obligations which the transaction did not have or involve, or which was prohibited by law, in violation of *Civil Code* §1770(a)(14).

79. Plaintiffs and the class members, as persons unknowledgeable and unsophisticated in the operation of skilled nursing facilities in the State of California and having no knowledge of the material concealments by DEFENDANTS alleged herein, justifiably relied on the material terms of, and the representations set forth in, the DEFENDANTS' uniform Admission Agreement in entering into the admission agreement and becoming residents of DEFENDANTS' skilled nursing facilities thereby assuming the obligation of payment to the DEFENDANTS. Most specifically, Plaintiff , and others similarly situated, relied on the following material term of the California Standard Admission Agreement relating to resident rights:

> **IV. Your Rights as a Resident**. Residents of this Facility keep all their basic rights and liberties as a citizen or resident of the United States when, after, they are admitted. Because these rights are so important, both federal and state laws and regulations describe them in detail, and state law requires that a comprehensive Resident Bill of Rights be attached to this Agreement.
>
> Attachment F, entitled "Resident Bill of Rights," lists your rights as set forth in State and Federal law. For your information, the attachment also provides the location of your rights in statute.
> You should review the attached "Resident Bill of Rights" very carefully. To acknowledge that you have been informed of the "resident Bill of Rights," please sign here: _ _____.

In requiring their residents to specifically and separately acknowledge receipt of DEFENDANTS' representations regarding the minimum standards of care as set forth in the Resident Bill of Rights, DEFENDANTS knew, or should have known, that Plaintiff , and others similarly situated, were reasonably and justifiably relying on said representations.

80. It is alleged that Plaintiff , and others similarly situated, suffered injury in fact and concrete harm in that they relied on the representations of the DEFENDANTS that they would be provided with minimum standards of care consistent with the requirements of Title 22 C.C.R. §72527(a)(12) and *Health & Safety Code* §1599.1(a) as incorporated into Title 22 C.C.R. §72527(a)(25), yet did not receive this promised standard of care and suffered pecuniary harm by

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being deprived of the value of payments made for skilled nursing services when these services were not actually rendered consistent with the DEFENDANTS' representations.

81. In addition, Plaintiff , and others similarly situated, made monetary payments to the DEFENDANTS in return for skilled nursing services of the standard promised by the DEFENDANTS in the uniform Admission Agreement and its attachments which are incorporated into the Admission Agreement as alleged above. Plaintiff , and others similarly situated, has suffered pecuniary harm in that the Defendants did not provide such services of the standard represented. In addition, Plaintiff , and others similarly situated, have suffered pecuniary harm in that DEFENDANTS misrepresented that entering into an admission agreement with DEFENDANTS conferred the statutory resident right under *Health & Safety Code* §1599.1 of Plaintiff , and others similarly situated, to reside in facilities that employ "an adequate number of qualified personnel to carry out all of the functions of the facility" when in fact the transaction of entering into an admission agreement with DEFENDANTS did not confer such right.

82. That is, simply by entering into an admission agreement with a resident, the DEFENDANTS represent in writing as an exhibit or addendum attached to the admission agreement of Plaintiffs, and all others similarly situated, that the DEFENDANTS will provide services of the standard and quality consistent with the Resident Bill of Rights as set forth in Title 22 *California Code of Regulations* §72527(a)(25) to wit, California *Health & Safety Code* §1599.1.

83. That is, simply by entering into an admission agreement with a resident, the DEFENDANTS represent in writing as an exhibit or addendum attached to the admission agreement of Plaintiff , and others similarly situated, that the transaction conferred the statutory resident rights afforded to all residents of skilled nursing facilities under *Health & Safety Code* §1599.1(a) and 22 *California Code of Regulations* §72527(a)(12) and (a)(25), most specifically the right "to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs" and to live in a facility that employs "an adequate number of qualified personnel to carry out all of the functions of the facility" when in fact the transaction of entering into an admission agreement with DEFENDANTS did not confer such right in direct violation of *Civil Code* §1770(a)(14).

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84. The representations of DEFENDANTS as incorporated into their admissions contracts are false and known by the DEFENDANTS to be false when made. Plaintiffs and the class relied on these misrepresentations into becoming residents of the FACILITY. In reliance of these misrepresentations, the Plaintiff , and others similarly situated, made payments to the DEFENDANTS in return for these services as promised. Plaintiff , and others similarly situated, suffered pecuniary harm in the form of lost payments and lost services when the DEFENDANTS actually failed to provide these promised skilled nursing services as represented.

85. It is alleged that DEFENDANTS' representations set forth in their uniform resident admission agreements that they would ensure their residents' right to live in adequately staffed facilities were false because, instead of providing the represented standard of care, at all times herein relevant the DEFENDANTS intentionally concealed from Plaintiff , and others similarly situated, that the MANAGEMENT DEFENDANTS conceived and implemented a plan to wrongfully increase business profits at the expense of the rights and health of residents such as Plaintiff, and others similarly situated through the chronic understaffing and under-funding of the FACILITY which prevented the defendant facilities from ensuring their residents' statutory right to live in adequately staffed facilities that would meet the needs of the residents, rendering the representations of the DEFENDANTS as to the nature and quality of their services as false.

86. It is alleged that federal and California regulations require skilled nursing facilities to provide adequate, qualified staffing to meet resident needs and to carry out all functions at the facility, regardless of whether adequate staffing would require more staff than any required bare numeric ratios. Specifically, as it relates to federal law, 42 *Code of Federal Regulations* § 483.30 states that a skilled nursing facility "must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 *Code of Federal Regulations* §483.30 further states that a skilled nursing facility "must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel." 42 *Code of Federal Regulations* §

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483.30(a)(1).

87. It is specifically alleged that the regulations enacted pursuant to the California *Health and Safety Code*[7] also require that a skilled nursing facility maintain staffing at levels sufficient to meet the needs of residents, even if that required staffing level is more than the bare minimum numeric ratio of 3.2 NHPPD required by *Health & Safety Code* §1276.5. "The Department may require the licensee to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional personnel is needed *to provide for the health and safety of patients*." Title 22 *California Code of Regulations* § 72501(g) (italics added). "Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. The Department may require a facility to provide additional staff as set forth in Section 72501(g)." Title 22 *California Code of Regulations* § 72329(a).

88. It is alleged that minimum staffing of personnel in the FACILITY is dependent by law upon the acuity (need) level of the residents of the Facilities. As alleged more fully below, the Facilities' resident acuity levels during the class period were so high and that the "minimum" staffing ratios exceeded the numeric minimum of *Health & Safety Code* §1276.5 pursuant to the provisions of Title 22 *California Code of Regulations* §§72515(b), 72329 and 42 C.F.R. §483.30.

89. Thus, it is specifically alleged that DEFENDANTS, as operators of skilled nursing facilities must, pursuant to statutes and regulations with which DEFENDANTS are required to comply, know that sufficient nursing staff is required to meet the needs of residents and to ensure the health and safety of residents. Conversely, DEFENDANTS, as operators of skilled nursing facilities must also know that a failure to maintain sufficient staffing to meet the needs of residents will endanger the health and safety of FACILITY residents. The DEFENDANTS, as operators of skilled nursing facilities, cannot claim ignorance of these regulatory requirements without endangering their

[7] These regulations set the standard of care with which skilled nursing facilities must comply. See Cal. *Health & Saf. Code* §1276(a) ("The building standards published in the State Building Standards Code by the Office of Statewide Health Planning and Development, and the regulations adopted by the state department shall, as applicable, prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified licensed personnel, and of services, based on the type of health facility and the needs of the persons served thereby.").

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very licensure. Skilled nursing facilities have the "responsibility to see to it that the license is not used in violation of law." (*California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 295.); see also *California Code of Regulations*, §72501, subd. (a) (skilled nursing facilities "shall be responsible for compliance with the licensing requirements and for the organization, management, operation and control of the licensed facility.").

90. It is alleged that at all times relevant hereto, in addition to mandating minimum staffing, the California Legislature also has specifically recognized and declared that failing to maintain sufficient staffing may result in death or serious physical harm to residents. As specifically alleged hereinabove, operators of skilled nursing facilities such as the DEFENDANTS are required to comply with (and hence have knowledge of) these statutes and regulations. California *Health and Safety Code* §1276.65, which requires the development of regulations setting forth staffing ratios as explained above, also provides that "[a] violation of the regulations developed pursuant to this section may constitute a class "B," "A," or "AA" violation pursuant to the standards set forth in Section 1424." (*Health & Saf. Code*, §1276.65, subd. (g)(2).) That is, simply understaffing a facility may constitute a class "B," "A," or "AA" citation. In turn, Section 1424, subdivisions (c), (d), and (e), defines the classifications of citations in relevant part as follows:

> (c) Class "AA" violations are violations that meet the criteria for a class "A" violation and that the state department determines to have been a *direct proximate cause of death of a patient or resident* of a long-term health care facility.
>
> (d) Class "A" violations are violations which the state department determines present either (1) *imminent danger that death or serious harm* to the patients or residents of the long-term health care facility would result therefrom, or (2) *substantial probability that death or serious physical harm to patients or residents* of the long-term health care facility would result therefrom.
>
> (e) Except as provided in paragraph (4) of subdivision (a) of Section 1424.5, class "B" violations are violations that the state department determines have a *direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents*, other than class "AA" or "A" violations.

(*Health & Safety Code*, §1424, italics added.)

91. Thus, it is alleged that at all times relevant hereto, the DEFENDANTS were required to know pursuant to applicable statues and regulations (or risk forfeiture of licensure) that understaffing

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their skilled nursing facilities creates a high risk of harm to residents of that facility. That at all times relevant hereto the DEFENDANTS consciously disregarded that knowledge and continued to maintain insufficient staffing levels.

92. The analysis of whether a skilled nursing facility provides adequate staffing entails three basic steps: a) determining the collective acuity level of the residents at the facility; b) determining the staffing levels at the facility; and c) comparing the collective acuity and staffing levels at the facility in light of recognized minimum staffing requirements. It is alleged that a facility's acuity level is based upon the average resident acuity in the population for whom care is being provided. It is alleged that it is not necessary to determine whether all residents individually receive a certain number of hours of nursing care per day, but rather whether the facility – as a whole – is adequately staffed to account for the facility's collective acuity level. It is alleged that although a facility's acuity level can vary from day to day, the acuity rates can be determined by taking the average facility acuity over the course of several months. This process provides a reliable index of a facility's average patient nursing needs, a key for determining adequate staffing requirements.

93. The staffing analysis described above is done at a facility-level. Thus, it does not require any individualized inquiry into how many hours of direct nursing care any specific resident received on any given day. Rather, the proper analysis is whether the *facility as a whole* employed an adequate number of qualified staff to competently care for the collective needs of its residents. It is specifically alleged that the United States Centers for Medicare & Medicaid Services ("CMS") *has already determined* the level of staffing required to meet the needs of residents based on the collective acuity levels of the residents via the CMS Agency Patient-Related Characteristics Report (formerly the Case Mix Report), which is the average resident need score based on resident assessment data that CMS *has already collected and calculated*. A self-authenticating link to a portion of this staffing information is at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/staffingdatafile.zip.

94. It is specifically alleged that if a skilled nursing facility's staffing levels are lower than the level of staffing required to meet the needs of residents as determined by their collective acuity, that facility has violated its residents' statutory, affirmative and actionable right to reside in a skilled

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nursing facility that employs "an adequate number of qualified personnel to carry out all of the functions of the facility." California *Health & Safety Code* §1599.1(a). Upon information and belief, it is alleged that each of DEFENDANTS' facilities was inadequately staffed in violation of *Health & Safety Code* §1599.1(a).

95. The representations DEFENDANTS made in their uniform admission agreement were false and known to be false when made as set forth more fully in paragraphs 80 through 96 inclusive of this Complaint.

96. Plaintiffs and the class relied on these misrepresentations into becoming residents of the DEFENDANTS' facilities. In reliance of these misrepresentations, the Plaintiffs and the class made payments to the DEFENDANTS in return for these services as promised. Plaintiffs and the class suffered pecuniary harm in the form of lost payments and lost services when the DEFENDANTS actually failed to provide these promised skilled nursing services as represented.

97. As a result, Defendants have violated and continue to violate the Consumer Legal Remedies Act, *Civil Code* §1770 et seq. ("CLRA") in at least the following respects:

a. In violation of section 1770(a)(5), the defendants' acts and practices constitute misrepresentations that the skilled nursing care that they purport to provide had characteristics, standards, performance and level of quality which it did not have; and

b. In violation of section 1770(a)(7), the defendants have misrepresented that the skilled nursing care that they purport to provide is of a particular standard, quality and/or grade, when it is not.

c. In violation of section 1770(a)(9), the defendants have misrepresented the nature of their skilled nursing services with the intent not to sell them as represented.

c. In violation of section 1770(a)(14), the defendants have misrepresented that the transaction of entering into admission agreement with Defendants conferred or involved rights, remedies, or obligations which the transaction did not have or involve, or which was prohibited by law.

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98. Plaintiffs and members of the class are "senior citizens" as defined by Section 1761(f) and meet the requirements of Section 1780(b).

FOURTH CAUSE OF ACTION
VIOLATIONS OF THE CONSUMER LEGAL REMEDIES ACT (Civil Code §1750, et seq.)
[By PLAINTIFF Against All DEFENDANTS]

99. Plaintiffs refer to, and incorporate herein by this reference, paragraphs 1 through 98 above, as though fully set forth herein.

100. The DEFENDANTS make representations to prospective residents and their families, and others similarly situated via their uniform admission agreements as set forth more fully above.

101. These representations by DEFENDANTS were intended to induce and lure elderly residents (and their representatives) into agreeing to be admitted to their skilled nursing facilities based on false and misleading representations without disclosing that DEFENDANTS cannot and do not provide the represented level and quality of care to residents in that the DEFENDANTS LICENSEES were in chronic, knowing and concealed violation of applicable rules, laws and regulations..

102. The representations DEFENDANTS made in their uniform admission agreement were false and known to be false when made.

103. Plaintiff relied on these misrepresentations into becoming residents of the DEFENDANTS' facilities. In reliance of these misrepresentations, the Plaintiffs payments to the DEFENDANTS in return for these services as promised. Plaintiffs suffered pecuniary harm in the form of lost payments and lost services when the DEFENDANTS actually failed to provide these promised skilled nursing services as represented.

104. As a result, Defendants have violated and continue to violate the Consumer Legal Remedies Act, *Civil Code* §1770 et seq. ("CLRA") in at least the following respects:

a. In violation of section 1770(a)(5), the defendants' acts and practices constitute misrepresentations that the skilled nursing care that they purport to provide had characteristics, standards, performance and level of quality which it did not have; and

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b. In violation of section 1770(a)(7), the defendants have misrepresented that the skilled nursing care that they purport to provide is of a particular standard, quality and/or grade, when it is not.

c. In violation of section 1770(a)(9), the defendants have misrepresented the nature of their skilled nursing services with the intent not to sell them as represented.

d. In violation of section 1770(a)(14), the defendants have misrepresented that the transaction of entering into admission agreement with Defendants conferred or involved rights, remedies, or obligations which the transaction did not have or involve, or which was prohibited by law.

105. Plaintiffs is a member of the class as a "senior citizens" as defined by Section 1761(f) and meet the requirements of Section 1780(b) to be entitled to an award of $5,000 in addition to the other remedies available under the CLRA.

106. The Defendants' conduct as alleged in this cause of action was, and is, malicious, oppressive and/or fraudulent.

FIFTH CAUSE OF ACTION SECOND CAUSE OF ACTION
VIOLATION OF THE *BUSINESS & PROFESSIONS CODE* §§17200 AND 17500
AGAINST ALL DEFENDANTS

107. Plaintiff refers to, and incorporate herein by this reference, paragraphs 1 through 106 above, as though fully set forth herein.

108. The conduct of the DEFENDANTS, as alleged, is part of a general business practice of the DEFENDANTS, and all facilities owned, managed and/or operated by these DEFENDANTS, in the State of California, conceived and implemented by DEFENDANTS. This practice exists in part because the Defendants unreasonably expect few adverse consequences will flow from the mistreatment of their elderly and vulnerable clientele, and DEFENDANTS made a considered decision to promote profit at the expense of their statutory and regulatory obligations, as well as their moral, legal and ethical obligations to their residents. This practice exists so as to maximize profit by retaining monies that were paid to the DEFENDANTS for the care and services to be provided to residents of DEFENDANTS' facilities. That is, DEFENDANTS, for a period of four years preceding

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the filing of the complaint in this matter, received payment from, and/or on behalf of, Plaintiffs and class members for services which were not rendered as represented, granting DEFENDANTS a windfall of profit derived from violation of law.

109. It has been expressly acknowledged by the California State Legislature that elder and infirm adults are a disadvantaged class of citizens. That it serves an important and vital State interest to protect these elders from financial abuse and pecuniary as defined in California law.

110. That in their entering into admission agreements with Plaintiffs and in light of the DEFENDANTS LICENSEES chronic, knowing and concealed failure to meet the minimum staffing rations mandated by *Health & Safety Code* §1276.5, the DEFENDANTS violated, without limitation to that adduced through the discovery process, *Health & Safety Code* §§1430(b), and 1599.1(a), as well as *Civil Code* §1750, et seq., and Title 22 *Code of Regulations* §72527(a)(12) and (a)(25) through their chronic, knowing and concealed, violation of *Health & Safety Code* §1276.5. The DEFENDANTS failed to meet these duties to Plaintiff, in violation of law.

111. These practices constitute unfair, unlawful and fraudulent business practices within the meaning of *Business and Professions Code* §§17200, et seq.

112. That in misrepresenting and making "false claims" as to the services to be provided to their residents, the DEFENDANTS have engaged in deceptive and fraudulent business practices within the meaning of *Business and Professions Code* §§17500, et seq.

SIXTH CAUSE OF ACTION
FRAUD
(*Randi W. v. Muroc* (1997) 14 Cal.4th 1066; *McCall v. Pacifcare of Cal. Inc.* (2001) 25 Cal.4th. 412)
[By THOMAS R. BLACKBURN JR. Against SPRING VALLEY POST ACUTE LLC; KNOLLS CONVALESCENT HOSPITAL, INC. and DOES 1-50]

113. MARIE WHITE hereby incorporates the allegations asserted in paragraphs 1 through 112 above as though set forth below.

114. Defendants make representations to the California Department of Public Health (DPH) in order to secure their annual "renewal license" to operate the FACILITY.

115. To renew their license Defendants affirm that they "accept responsibility to comply with health and safety codes and regulations concerning licensing…" under penalty of perjury.

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116. The assertions and representations by the DEFENDANTS under penalty of perjury that they "accept responsibility to comply with health and safety codes and regulations concerning licensing…" were, and are, false and knowingly false when made by the DEFENDANTS.

117. The truth of the matter was that FACILITY was in chronic violation of applicable rules, laws and regulations and yet routinely failed to report these violations to the DPH as required by 22 *Code of Regulations* §72541 in an effort to fraudulently conceal this reality.[8] An example of such a failure is the failure to properly report the "unusual occurrence" that threatened the welfare, safety or health MARIE WHITE as alleged in above. This is but one small example of a systemic effort by the DEFENDANTS to fraudulently conceal their abject and continuing violation of applicable, rules, laws and regulations in the operation of the FACILITY.

118. Another example is the tool utilized by the DEFENDANTS to fraudulently conceal the rampant "unusual occurrences" in the FACILITY and DOES 1-250 to attempt to hide the "unusual occurrence" and their failure to report same to DPH as required by 22 *Code of Regulations* §72541 by asserting meritless and legally unsupportable assertions of "privilege" from disclosing this information by improper and baseless assertions of a "quality assurance privilege." In point of act these baseless assertions of a "quality assurance privilege" are made by the DEFENDANTS simply to hide the high prevalence of the "unusual occurrences" in the FACILITY from DPH.

119. That the intentional concealment of events in the FACILITY which fall within the provisions of 22 *Code of Regulations* §72541, was intentional and knowing and done with an intention to conceal the truth from the DPH.

120. The an additional methodology of fraudulent concealment rests in the failure of the FACILITY to actually implement their submitted Plans of Correction in response to DPH findings of

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[8] **§ 72541. Unusual Occurrences.**

Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

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violations of applicable rules, laws and regulations in the DPH "survey" and "complaint" process.[9]

121. At intermittent intervals the DPH conducts a "survey" of the FACILITY. When those "surveys" find violations of applicable rules, laws and/or regulations, the DPH issues a "deficiency" finding and/or a "citation." The issuance of the "deficiency" finding and/or a "citation" now compels the FACILITY to create a "Plan of Correction" as to the violations of applicable rules, laws and/or regulations. Accordingly, the FACILITY was required to do so as to those violations of applicable rules, laws and/or regulations as determined by the DPH.

122. These misrepresentations without limitation to that to be proven at time of trial, misrepresentations of action in submitted Plans of Correction executed by an authorized and managing agent of the FACILITY misrepresenting that the FACILITY would, in response to violations of applicable rules, laws and/or regulations, generate and implement policies and procedures to address and correct the violations of applicable regulations, including further in-service training of staff to address the problem, and adequate auditing and monitoring of the corrective action to ensure the continuing nature of the corrective action.

123. That as part of their fraudulent intent and concealment included in the Plan of Correction was an assertion that the findings of these efforts would be provided to the "CQI", whereby the FACILITY could hide their fraud behind a legally meritless assertion of quality assurance privilege.

124. That the DPH relied upon the accuracy of these representations in granting licensure to the FACILITY.

125. Had the DPH in fact known that these representations by the FACILITY were false they would not have granted licensure to the FACILITY and accordingly, the FACILITY would not have then been able to admit and injure MARIE WHITE. as alleged above.

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[9] At intermittent intervals the DPH conducts a "survey" of the FACILITY. When those "surveys" find violations of applicable rules, laws and/or regulations, the DPH issues a "deficiency" finding and/or a "citation." The issuance of the "deficiency" finding and/or a "citation" now compels the FACILITY to create a "Plan of Correction" as to the violations of applicable rules, laws and/or regulations.

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126. When making these representations to DPH, the DEFENDANTS knew and could reasonably foresee that persons seeking care and services at a skilled nursing facility, such as MARIE WHITE, would rely on the fact that the FACILITY were licensed by DPH in choosing a facility in which to reside.

127. The FACILITY, as care custodians for MARIE WHITE. and other persons similarly situated, owed a duty of care to MARIE WHITE and other persons similarly situated not to misrepresent the FACILITY'S ability to care for their residents and its compliance with applicable regulations in their statements to DPH in their initial licensing and licensing renewal applications. The FACILITY owed a duty of care to MARIE WHITE. and other persons similarly situated not to intentionally conceal events in the FACILITY which fall within the provisions of 22 *Code of Regulations* §72541.

128. The FACILITY made the misrepresentations to the DPH alleged herein with the intent to induce MARIE WHITE and others similarly situated to be admitted to or remain in the FACILITY in that the FACILITY knew and could reasonably foresee that potential residents of the FACILITY such as MARIE WHITE and others similarly situated would not have paid, or had paid on their behalf, monies to reside at an unlicensed skilled nursing facility.

129. MARIE WHITE did rely on the fact that the FACILITY was licensed in being placed as a resident at the FACILITY. MARIE WHITE would not have agreed to become a resident at the FACILITY if the true facts had been known, nor would any reasonable person.

130. That the reliance by MARIE WHITE was justified. Further, a reasonable person would have relied upon the alleged misrepresentations regarding the FACILITY'S licensure status, such that justifiable reliance by MARIE WHITE can also be inferred.

131. As the direct result of said breaches by the DEFENDANTS MARIE WHITE suffered injury in an amount and manner more specifically alleged above and according to proof at time of trial.

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WHEREFORE, PLAINTIFFS pray for judgment and damages as follows:

1. For general damages according to proof as to all causes of action except the Fourth Cause of Action;

2. For special damages according to proof as to all causes of action except the Fourth Cause of Action;

3. For punitive and exemplary damages (as to the First, Third and Sixth Causes of Action only);

4. For attorney's fees and costs as allowed by law according to proof at the time of trial (as to the First, Third and Fourth and Fifth and Sixth Causes of Action only);

5. As to the Third, Fourth, and Fifth Causes of Action only; For an Order permanently enjoining defendants, and each of them, from violating residents' rights pursuant to *Health & Safety Code* §1430(b). For an injunction, requiring that:

   a. the Defendants report to DPH all incidents of actual or suspected abuse or neglect (as defined by law) of which it has learned in the last three (3) years at each of their facilities, which were not reported to DPH, Adult Protective Services and/or Law Enforcement;

   b. the Defendants provide proof to the Court of compliance with the reporting requirements over the last three (3) years for any and all such incidents in the form of a copy of the report submitted to DPH;

   c. the Defendants facilities each conduct quarterly, confidential surveys of *all* residents and residents' representatives inquiring whether any conduct which may be deemed suspected abuse and/or neglect, and/or a violation of residents' rights has occurred (with a clear, court approved definition of these terms included, with examples), and requiring that the responses to these surveys be turned over to the Long Term Care Ombudsman assigned to the pertinent facility for review. Further, after providing confidential surveys in unredacted form to the Ombudsman, the facilities shall than redact only the name of the individual residents who completed the survey (or on whose behalf the survey was completed) from the surveys, and maintain copies of those surveys for a period of five (5) years, and that the surveys be made available (with names

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redacted) to any prospective resident, or their representative, any current resident, or their representative, or any past resident, or their representative, within 24 hours of a request;

d. the Defendants' facilities each notify all current residents of this injunction by providing a copy of the injunction to them and their power of attorney/responsible party and/or personal representative, if any;

e. the Defendants' facilities each notify all future residents (at the time the admission agreement is signed) by providing a copy of this injunction during the period for which this injunction is in force to any new resident and to his or her power of attorney/responsible party and/or personal representative, if any;

f. That this injunction shall remain in full force and effect until the earlier of either of the following; (1) ten years from the date of entry of judgment, or (2) five years if no other violations of the injunction have been found by this or any other Court of competent jurisdiction regarding Defendants' facilities. The burden of proof to obtain the shorter period shall be on the Defendants;

g. This injunction shall be enforced by the Court upon motion of any interested party (i.e., plaintiffs or any other current or former resident (and/or their power of attorney/responsible party and/or personal representative, if any, or any employee of the Defendants' facilities) and/or the filing of a new action of any such interested party. Each separately identifiable violation of this injunction shall be punishable by a $5,000 fine payable to the person filing the motion or bringing the action and a payment of all reasonable attorney's fees and costs incurred by the person bringing the motion or action against the Facility for violation of the injunction.;

h. the Defendants' shall each draft a policy and procedure to the satisfaction of the Court covering the handling of suspected abuse and neglect reporting as well as the obligation to asses and document patients' needs *immediately* upon arrival and when an emergency occurs; and on staffing; and

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i. the Defendants' shall each prepare a training program to the satisfaction of the Court to train its staff on the new policies and procedures; and shall submit verification, under oath, of compliance with that training program by all employees of each of the facilities within 12 months, and then repeated annually during the term of this judgment;

6. For costs of suit; and

7. For such other and further relief as the Court deems just and proper.

DATED: May 10, 2017

GARCIA, ARTIGLIERE, MEDBY & FAULKNER

By: _____

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