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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF HUMBOLDT

IDA LOU BRANCH, by and through her Successor in Interest, David Branch

Plaintiffs

vs.

ROCKPORT ADMINISTRATIVE SERVICES. PACIFIC REHABILITATION & WELLNESS CENTER, LP; BOARDWALK WEST FINANCIAL SERVICES, LLC; and DOES 1 through 250, inclusive,

Defendants.

CASE NO. DR170754

1) Elder Abuse (Pursuant to the Elder Adult and Dependent Adult Civil Protection Act *Welfare & Institutions Code* §§15600, *et seq.*)
2) Negligent Hiring and Supervision (CACI 426)

Assigned to Hon. Dept.

Action Filed: TBD
Trial Date: None Set

COMES NOW Plaintiff and alleges upon information and belief as follows:

THE PARTIES

1. Plaintiff IDA LOU BRANCH (herein sometimes referred to as "Plaintiff") was at all times relevant hereto a resident of the County of Humboldt, State of California. Plaintiff brings this action by and through her Successor in Interest, David Branch.

2. Defendants PACIFIC REHABILITATION & WELLNESS CENTER, LP and DOES 1 through 50 (hereinafter referred to as the "FACILITY") were at all relevant times in the business of providing long-term custodial care as a 24-hour skilled nursing facility under the fictitious name Pacific Rehabilitation and Wellness Center located at 2211 Harrison Avenue, Eureka, CA 95501, 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 ROCKPORT ADMINISTRATIVE SERVICES, BOARDWALK WEST FINANCIAL SERVICES, LLC; 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.

4. SHLOMO RECHNITZ, is the managing agent and/or controlling owner of BOARDWALK WEST FINANCIAL SERVICES, LLC. and PACIFIC REHABILITATION & WELLNESS CENTER, LP. and either through BOARDWALK WEST FINANCIAL SERVICES, LLC or some other phantom vehicle created and maintained to hid his total and complete operational control of the FACILITY owns in excess of 50% of the FACILITY and is its true and actual operator and director. And through such schemes SHLOMO RECHNITZ directs the expenditures of the FACILITY to his companies so that he can unlawfully profit from the operations of the FACILITY at the expense of the legally mandated care the residents of the FACILITY, including IDA LOU BRANCH require and deserve. Further that SHLOMO RECHNITZ intentionally hides his involvement of this multi-tier profiteer effort through manipulation of multiple companies, shell operators and refusal to report related party transactions to the State of California rules, laws and regulations. (Hereinafter the FACILITY and the MANAGEMENT DEFENDANTS are collectively sometimes referred to as "DEFENDANTS").

5. Due to the DEFENDANTS' direct conduct, as well as their practice of aiding and abetting the wrongful acts and omissions alleged herein and at the direction of the true owner, operator and director of the FACILITY SHLOMO RECHNITZ, IDA LOU BRANCH suffered the significant injuries more fully alleged herein as well as other injuries according to proof at trial which proximately caused her wrongful death. These injuries were not the product of isolated failure but rather the result of prolonged neglect and abuse that arose out of four (4) calculated business practices by DEFENDANTS at the direction of the true owner, operator and director of the FACILITY, SHLOMO RECHNITZ;

a) understaffing;

b) relentless marketing and sales practices to increase resident census despite

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knowledge of ongoing care deprivation;

c) ongoing practice of utilizing unqualified and untrained employees who, by law, were forbidden by law to administer nursing care to residents;

d) ongoing practice of recruiting heavier care residents for which the nursing home received higher reimbursements, despite the dangerous levels of staff who were incapable of meeting the needs of the existing resident population.

6. IDA LOU BRANCH has reason to believe that critical operational decisions having impact on the FACILITY'S revenues and expenditures were centrally made and controlled by the DEFENDANTS at a corporate level at the direction of the true owner, operator and director of the FACILITY SHLOMO RECHNITZ; more particularly, the DEFENDANTS determined and controlled: the numbers of staff allowed to work in their chain of nursing homes; the expenditures for staffing at their nursing homes; the revenue targets for each nursing home in which SHLOMO RECHNITZ was involved; the census mix; and, census targets for each nursing home, as well as the patient recruitment programs at each nursing home. In sum, at all material times, all cash management functions, revenues and expenditure decisions at the nursing home level were tightly controlled at the corporate level by the aforesaid DEFENDANTS at the direction of the true owner, operator and director of the FACILITY SHLOMO RECHNITZ,. This was the case at the FACILITY.

7. The DEFENDANTS, by and through the corporate officers and directors including, SHLOMO RECHNITZ, Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing), Chaim Kolodny (Manager); and others presently unknown to IDA LOU BRANCH 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 IDA LOU BRANCH, 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 Health Services as alleged herein. That notwithstanding this knowledge, these officers, directors, and/or managing agents meaningfully disregarded the issues even though they knew the understaffing could, would and did lead to unnecessary injuries to residents of their FACILITY, including IDA LOU BRANCH.

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8. DEFENDANTS were fully aware that the delivery of essential care services in each of its nursing homes hinged upon two fundamental fiscal and operational decisions: (1) the determination of the numbers and expenditures on staffing levels; and (2) the determination of the census levels within the nursing home and census mix. IDA LOU BRANCH has reason to believe that DEFENDANTS determined, controlled and enforced each of these critical decisions at every nursing home in which SHLOMO RECHNITZ was involved, including the FACILITY. IDA LOU BRANCH has reason to believe that the control by DEFENDANTS over the revenue and expenditure streams at their nursing homes grew out of: a) the dependency of DEFENDANTS upon credit; and, b) the annual incentive compensation and bonuses established by the Executive Compensation Committee of DEFENDANTS for their SHLOMO RECHNITZ and his hidden investors, executive offices and key managerial employees, including short-term incentive compensation based upon performance goals, long term incentive compensation, special performance awards and stock options and stock-based compensation granted in recognition of successful execution of the business initiatives of said DEFENDANTS.

9. Significantly, IDA LOU BRANCH has reason to believe that the control exercised by the DEFENDANTS at the direction of the true owner, operator and director of the FACILITY SHLOMO RECHNITZ, over financial decisions that determined the delivery of care rendered at the FACILITY and its other nursing homes, grew out of the revolving credit and guaranty agreements; credit facility agreement, loan agreements; letters of credit; and other agreements granting security interest and liens in the accounts receivables, property and assets of the SHLOMO RECHNITZ as the borrower, which were entered into between said DEFENDANTS and its lenders and agents of said lenders.

10. IDA LOU BRANCH 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 IDA LOU BRANCH 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 IDA LOU BRANCH.

11. More specifically, it is IDA LOU BRANCH'S belief that as a fundamental condition of

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the credit and financing extended to DEFENDANTS, said DEFENDANTS were required to meet threshold levels of revenues, expenses and cash flows. DEFENDANTS were required to furnish their lenders and/or said lenders' agents detailed operating reports on a routine basis.

12. IDA LOU BRANCH has reason to believe that SHLOMO RECHNITZ continually exerted pressure upon the FACILITY and their other nursing homes to: a) hit financial targets necessary to trigger the rich executive incentive compensation and bonuses and cash rewards and the senior management performance compensation cash bonuses; and, b) to meet the minimum financial threshold requirements established in the credit agreements.

13. IDA LOU BRANCH 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 IDA LOU BRANCH 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 IDA LOU BRANCH.

14. IDA LOU BRANCH 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. IDA LOU BRANCH will seek leave of the Court to amend this Complaint to identify said Defendants when their identities are ascertained.

15. The liability of the DEFENDANTS for the abuse of IDA LOU BRANCH as alleged herein arises from their own direct misconduct as alleged herein as well as all other legal basis and according to proof at the time of trial.

16. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS, which led to the injuries to IDA LOU BRANCH 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 and directors enumerated in paragraph 7 of the complaint and others presently unknown and according to proof at time of trial.

17. That, based upon information and belief, SHLOMO RECHNITZ and DOES 101-110

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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 and 22 of the C.C.R. §70035 included BOARDWALK WEST FINANCIAL SERVICES, LLC which is owned, controlled and operated by SHLOMO RECHNITZ such as in recognition of the failure of BRIUS, LLC to comply with the requirements of a true corporation renders the de facto and actual Governing Body member of the FACILITY to be SHLOMO RECHNITZ. That these members, as executives, managing agents and/or owners of the FACILITY, were focused on unlawfully increasing the earnings in the operation of DEFENDANTS' businesses as opposed to providing the legally mandated minimum care to be provided to elder and/or infirm residents in their skilled nursing facilities, including IDA LOU BRANCH. That the focus of these individuals on their own attainment of profit played a part in the under-funding of the FACILITY which led to the FACILITY violating state and federal rules, laws and regulations and led to the injuries and to IDA LOU BRANCH as alleged herein.

18. The FACILITY, SHLOMO RECHNITZ 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.

19. At all relevant times, FACILITY, SHLOMO RECHNITZ 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 DEFENDANTS aided and abetted each other in accomplishing the acts and omissions alleged herein. (See Restatement (Second) of Torts §876 (1979)).

20. And the fact of the matter is that: (1) that there is such unity of interest and ownership between each of the DEFENDANTS in this action, that the legal separateness of the individual and alter ego no longer exists and (2) that the observance of the fiction of separate existence would under the circumstance promote fraud or injustice.

21. And in point of fact the MANAGEMENT DEFENDANTS and SHLOMO RECHNITZ controlled the FACILITY to such a degree that it was a "mere instrumentality" of the MANAGEMENT DEFENDANTS and SHLOMO RECHNITZ used for an improper purpose.

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22. Evidence for this reality exists in the exchange of directional documents and reports shared amongst the DEFENDANTS as to issues including staffing, census, interaction of the FACILITY with the State of California's Department of Public Health Services, and regulatory compliance which were utilized by the MANAGEMENT DEFENDANTS to make operational decisions as the true owners, operators and managers of the FACILITY. And for this effort, the MANAGEMENT DEFENDANTS siphoned off huge and unwarranted amounts of money through "Administrative" and "Lease and Rentals" accounts under the guise of providing administrative services and land leases as reported by the DEFENDANTS under penalty of perjury to the State of California's Office of Statewide Health Planning and Development. And in fact, in the last submission of the FACILITY to the State of California's Office of Statewide Health Planning and Development the FACILITY confirmed Related Party Transaction payments totaling $42,000 to Defendant BOARDWALK WEST FINANCIAL SERVICES, LLC for non-clinical phantom "Administrative Services" and inflated above-market rate rental payments totaling $539,907 to EUREKA-LET, LP. And in fact, in that same submission the FACILITY confirmed Related Party Transaction liabilities totaling $16,747 to EUREKA REHABILITATION & WELLNESS CENTER, LP. Again money taken from the right pocket of the alter ego organization and placed in the right such that the FACILITY was controlled by the MANAGEMENT DEFENDANTS to such a degree that it was a "mere instrumentality" of the MANAGEMENT DEFENDANTS.

FIRST CAUSE OF ACTION
ELDER ABUSE
[By IDA LOU BRANCH Against All Defendants]

23. IDA LOU BRANCH hereby incorporates the allegations asserted in paragraphs 1 through 22 above as though set forth at length below.

24. At all relevant times, IDA LOU BRANCH was over the age of 65 and thus was an "elder" as that term is defined in the *Welfare & Institutions Code* §15610.27.

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

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IDA LOU BRANCH.

26. That the DEFENDANTS "neglected" IDA LOU BRANCH 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.

27. Within five days of her admission to the FACILITY, IDA LOU BRANCH, an 84-year-old female, suffered entirely preventable aspiration that caused IDA LOU BRANCH to suffer pneumonia, respiratory failure as well as other injuries according to proof at trial, which proximately caused her death on September 12, 2016.

28. On or about September 7, 2016, IDA LOU BRANCH was admitted to the FACILITY after undergoing leg surgery necessitated by a fall at home. During the hospitalization, IDA LOU BRANCH was intubated for breathing assistance and aspiration prevention due to significant medical condition and a long-standing history of smoking. IDA LOU BRANCH was admitted to the FACILITY required extensive assistance with activities of daily living and special attention and care planning in the form of interventions to prevent and manage her high aspiration risk.

29. On or about September 12, 2016, IDA LOU BRANCH was found by her family barely alive at the FACILITY with significant changes in her mental status and breathing. By then, the FACILITY had still not provided IDA LOU BRANCH the breathing tube requested by family every day since admission. IDA LOU BRANCH's condition continued to decline until she passed away that same evening.

30. Upon IDA LOU BRANCH's admission to the FACILITY, DEFENDANTS were well aware, through assessment information, family information, as well as physician notes and orders provided to the FACILITY, that IDA LOU BRANCH suffered from significant breathing difficulties and a high aspiration risk and therefore required special care and assistance including 24-hour supervision and monitoring, assistance and monitoring with breathing and swallowing, the provision of safety and assistance devices to prevent accidents, immediate suctioning and lifesaving interventions such as intubation, assistance and monitoring with other activities of daily living, and the implementation of interventions to prevent further complications of aspiration.

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31. That notwithstanding this knowledge, and notwithstanding a full knowledge that the failure to create and implement proper care plans to prevent IDA LOU BRANCH from suffering further complications of aspiration created a high probability that IDA LOU BRANCH would suffer further complications of aspiration and resulting injury, over the five (5) day residency of IDA LOU BRANCH in the FACILITY the DEFENDANTS just simply ignored the needs of IDA LOU BRANCH. In doing so the DEFENDANTS knowingly disregarded this risk and failed to adequately assess, generate and implement an adequate plan of care for IDA LOU BRANCH and to implement adequate preventive measures for aspiration. That in so doing, DEFENDANTS failed to meet IDA LOU BRANCH's needs and failed to comply with the rules, laws and regulations governing their FACILITY. Moreover, DEFENDANTS knowingly exposed IDA LOU BRANCH to extreme health and safety hazards.

32. The DEFENDANTS were well aware that if they failed to provide IDA LOU BRANCH with the aforementioned care, supervision, and monitoring, there was a high probability that IDA LOU BRANCH would suffer injury. That DEFENDANTS consciously disregarded this risk and failed to provide IDA LOU BRANCH with the aforementioned required care, leading directly to IDA LOU BRANCH's injuries and death.

33. It is a statistical fact that elders such as IDA LOU BRANCH are at high risk of suffering aspiration and injury. Thus, skilled nursing facilities such as the FACILITY are to not only conduct assessments of high aspiration risk residents such as IDA LOU BRANCH, 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 IDA LOU BRANCH from suffering further complications of aspirations. These interventions include such innocuous interventions as oral suctioning as needed to reduce accumulation of secretions such as phlegm and mucus, to resident education on coughing, deep breathing and splinting techniques, to prompt notification to the resident physician of any significant changes in condition. The FACILITY did not provide any such services or interventions to IDA LOU BRANCH notwithstanding that IDA LOU BRANCH required such services.

34. The DEFENDANTS were aware, upon admission and during the residency of IDA LOU BRANCH, that IDA LOU BRANCH required a higher level of care and care interventions to

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prevent injury to IDA LOU BRANCH than the FACILITY could, or would, lawfully provide. And yet so as to unlawfully promote profits the DEFENDANTS admitted and retained IDA LOU BRANCH as a resident of the FACILITY even though the DEFENDANTS were fully aware that in so doing they exposed IDA LOU BRANCH to extreme health and safety hazards. In so doing the DEFENDANTS recklessly failed to provide to IDA LOU BRANCH required medical and custodial care thereby causing injury.

35. DEFENDANTS represented to the general public and to IDA LOU BRANCH and/or his legal representative, that the FACILITY was sufficiently staffed so as to be able to meet the needs of IDA LOU BRANCH 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.

36. That no one from the FACILITY informed IDA LOU BRANCH'S family, physician, or legal representative about her increasing signs and symptoms of aspiration or what was being done to treat them. In an unfortunate effort to conceal the FACILITY'S failure to provide required care, FACILITY nurses simply concealed these conditions from IDA LOU BRANCH'S family, physician, and legal representative and untruthfully stated that nothing was wrong. As a result of the FACILITY'S failure to provide required care and failure to bring these conditions to the attention of IDA LOU BRANCH'S family, physician, and legal representative IDA LOU BRANCH was allowed to suffer aspiration as well as related complications and other injuries to be adduced by time of trial that the FACILITY had ignored as the result of the inadequacy of FACILITY staff in both number and training, leading directly to IDA LOU BRANCH'S death.

37. 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 IDA LOU BRANCH and according to proof at time of trial, to IDA LOU BRANCH, 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 IDA LOU BRANCH that the

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FACILITY would be able to meet the needs of IDA LOU BRANCH. These representations of the nature and quality of services to be provided were, in fact, false.

38. DEFENDANTS owed a duty to IDA LOU BRANCH to "employ an adequate number of qualified personnel to carry out all of the functions of the facility" as set forth in 22 C.C.R. §72527(a)(24) and *Health and Safety Code* Section 1599.1(a). DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

39. DEFENDANTS owed a duty to IDA LOU BRANCH, to provide IDA LOU BRANCH 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 C.C.R. §72515(b). DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

40. DEFENDANTS owed a duty to IDA LOU BRANCH to respect his right to be free from mental and physical abuse, which right is protected by 22 C.C.R. §72527(a)(9). DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

41. The DEFENDANTS owed a duty to IDA LOU BRANCH to notify a physician of any sudden or marked adverse change in signs, symptoms or behavior exhibited by a patient, which right is protected by 22 C.C.R. §72311(3)(b). The DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

42. That at all times relevant hereto, the DEFENDANTS owed a duty to IDA LOU BRANCH to, and represented they would, provide services consistent with 42 U.S.C. §1396r(b)(4)(C) to provide custodial and professional services to IDA LOU BRANCH with sufficient budget and sufficient staffing to meet the needs of IDA LOU BRANCH. DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

43. That at all times relevant hereto, the DEFENDANTS owed a duty to, and represented they would, provide services to IDA LOU BRANCH pursuant to 42 C.F.R. §483.30 and 22 C.C.R. §72329 to have sufficient number of personnel on duty at the FACILITY on a 24-hour basis to provide appropriate custodial and professional services to IDA LOU BRANCH in accordance IDA LOU BRANCH'S resident care plans. The DEFENDANTS did not provide these legally required

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services. DEFENDANTS failed to meet this duty to IDA LOU BRANCH thereby causing IDA LOU BRANCH injury.

44. Title 22 C.C.R. §72311 mandates that a skilled nursing facility shall provide, and the DEFENDANTS promised to provide IDA LOU BRANCH with, nursing service which shall include an individual, written plan of care which indicates the care to be given, and the objectives to be accomplished and which shall be updated as frequently as necessary, including when a resident undergoes a change in condition. The DEFENDANTS represented that they would provide services consistent with the regulations yet failed to do so causing injury to IDA LOU BRANCH.

45. Title 22 C.C.R. §72315 mandates that a skilled nursing facility provide, and DEFENDANTS represented they provided each patient with good nutrition and with necessary fluids for hydration. The DEFENDANTS represented that they would provide services consistent with the regulations yet failed to do so causing injury to IDA LOU BRANCH.

46. Title 22 C.C.R. §72517 mandates that a skilled nursing facility have an ongoing education program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel which shall include: the prevention and control of infections, accident prevention and safety measures, and preservation of resident dignity. The DEFENDANTS represented that they would provide services consistent with the regulations yet failed to do so causing injury to IDA LOU BRANCH.

47. That the injuries and death suffered by IDA LOU BRANCH while a resident of the FACILITY were the result of DEFENDANTS' plan to cut costs at the expense of their residents such as IDA LOU BRANCH. 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 abuse and neglect of many residents of the FACILITY, and most specifically, IDA LOU BRANCH.

48. 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 IDA

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LOU BRANCH and according to proof at time of trial, ratified the conduct of their co-defendants and FACILITY, in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing of FACILITY, in both number and training, the relationship between understaffing and sub-standard provision of care to patients of FACILITY including IDA LOU BRANCH, 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 IDA LOU BRANCH 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 IDA LOU BRANCH and insufficiency of financial budgets to lawfully operate FACILITY. This ratification by the DEFENDANTS itself, is that ratification of the customary practice and usual performance of FACILITY as set forth in *Colonial Life & Accident Insurance Co. v. Superior Court* (1982) 31 Cal.3d 785, 791-792 and *Schanafelt v. Seaboard Finance Company* (1951) 108 Cal.App.2d 420, 423-424.

49. 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 IDA LOU BRANCH 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 paragraph 7 and others presently unknown to IDA LOU BRANCH and according to proof at time of trial, having power to bind 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.

50. The Corporate authorization and enactment of the DEFENDANTS, alleged in the preceding paragraphs, constituted the permission and consent of FACILITY'S misconduct by the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 7 and others presently unknown to IDA LOU BRANCH and according to proof at time of trial, who had

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within their power the ability and discretion to mandate that FACILITY employ adequate staff to meet the needs of their patients, including IDA LOU BRANCH, 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 IDA LOU BRANCH 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.

51. IDA LOU BRANCH has reason to believe that DEFENDANTS' staffing was not based on the acuity of the patient population but rather upon occupancy levels at its nursing homes including the FACILITY.

52. IDA LOU BRANCH has reason to believe that the DEFENDANTS' focus and intent to carry out the above strategies to increase revenues and profit margins caused widespread neglect of residents, including IDA LOU BRANCH.

53. Accordingly, decisions by DEFENDANTS as to staffing and census were made irrespective of patient population needs within the FACILITY, but rather, were determined by the financial needs of the company.

54. Evidence for DEFENDANTS' indifference for the acuity levels of the FACILITY'S patient population can be found through a comparison of the average registered nurses to resident ratios in California facilities verses the FACILITY. In fact, while at a time when the California ratios of registered nurses to residents in skilled nursing facilities was 51 minutes per resident, the "FACILITY" average 42 minutes per resident. By law, RNs must assess nursing home residents' needs. RNs and LPNs/LVNs work together to plan care, implement care and treatment, and evaluate residents' outcomes. Nurses must be licensed in the state. Registered nurses (RNs) have between 2 and 6 years of education. Licensed practical and vocational nurses (LPNs/LVNs) generally have 1 year of training. When there are insufficient licensed nurses on duty as was the case in the FACILITY during the residency of IDA LOU BRANCH, the case here, residents such as IDA LOU BRANCH suffer injury as IDA LOU BRANCH did here.

55. In fact, while at a time when the California ratios of licensed nurses to residents in skilled nursing facilities was 1 hour and 5 minutes per resident, the "FACILITY" average was 44

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minutes per resident. The services of licensed nurses are crucial to the health and safety of residents as by law, registered nurses must assess residents' needs. Registered nurses and Licensed Vocational Nurses work together to plan care, implement care and treatment, and evaluate residents' outcomes. Nurses must be licensed in the state and are on site to provide care to residents twenty-four hours per day, seven days a week. When there are insufficient licensed nurses on duty as was the case in the FACILITY during the residency of IDA LOU BRANCH, the case here, residents such as IDA LOU BRANCH suffer injury as IDA LOU BRANCH did here.

56. In fact, at a time when the California average for ratios of certified nurse's assistants to residents in skilled nursing facilities was 2 hours and 41 minutes per resident, the "FACILITY" average was 2 hours and 32 minutes per resident. The services of certified nursing assistants are crucial to the health and safety of residents as certified nursing assistants provide care on a twenty-four hour basis. They work under the direction of a licensed nurse to assist residents with activities of daily living, i.e., eating, grooming, hygiene, dressing, transferring, and toileting as was the case in the FACILITY during the residency of IDA LOU BRANCH, the case here, residents such as IDA LOU BRANCH suffer injury as IDA LOU BRANCH did here.

57. And, minimum staffing of personnel in the FACILITY was dependent by law upon the acuity (need) level of the residents of the FACILITY. Here, as is more fully set forth below, the FACILITY'S residents acuity level during the residency of IDA LOU BRANCH in the FACILITY were so high and that the "minimum" staffing ratios exceeded the numeric minimum of *Health and Safety Code* §1276.5 pursuant to the provisions of 22 C.C.R. §§72515(b), 72329 and 42 C.F.R. §483.30. During the residency of IDA LOU BRANCH in the FACILITY, the FACILITY did not meet these minimum staffing requirements.

58. The fact that the FACILITY was so woefully understaffed is underscored and rendered even more significant given the high acuity levels of the FACILITY residents as alleged below.

59. At a time when the average in California for long-term residents whose need for help with activities of daily living increased during a residency in a skilled nursing facility was a mere 10.6%, the FACILITY actually suffered from 12.9% ratio of its residents having these high acuity issues which required more, not less, staff on duty in the FACILITY. This is an important issue

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because residents in a skilled nursing facility value being able to take care of themselves. It is important that nursing home residents do as much as they can for themselves and in most cases, and here, it takes more staff time to allow residents to do these tasks for themselves. Residents who do perform these basic activities of daily living with little help feel better about themselves and stay more active. This affects their health in a beneficial manner. When residents stop taking care of themselves, it generally means their health has gotten worse during their stay in a skilled nursing facility. The resident's ability to perform activities of daily living is important in maintaining their current status and quality of life. The existence of higher ratio of residents with these high acuity problems in the FACILITY is a further indication of the substandard provision of care in the totality of the FACILITY. This high acuity need stretched the understaffed FACILITY beyond its abilities and caused injury to IDA LOU BRANCH.

60. At a time when the average in California for residents who suffer from moderate to severe pain in a skilled nursing facility was 3.2%, the FACILITY actually suffered from 26.3% ratio of its residents having these high acuity issues which required more, not less, staff on duty in the FACILITY. The existence of higher ratio of residents with these high acuity problems in the FACILITY is a further indication of the substandard provision of care in the totality of the FACILITY. This high acuity need stretched the understaffed FACILITY beyond its abilities and caused injury to IDA LOU BRANCH.

61. While the average in California skilled nursing facility residents who were more depressed or anxious since the last time they were checked was 0.8%, the FACILITY average was 14.5% having these high acuity issues which required more, not less, staff on duty in the FACILITY. Depression is a medical problem of the brain that can affect how you think, feel, and behave. Signs of depression may include fatigue, a loss of interest in normal activities, poor appetite, and problems with concentration and sleeping. Anxiety is excessive worry. Signs of anxiety can include trembling, muscle aches, problems sleeping, stomach pain, dizziness and irritability. Feeling depressed or anxious can lessen your quality of life and lead to other health problems. Nursing home residents are at a high risk for developing depression and anxiety for many reasons, such as loss of a spouse, family members or friends, chronic pain and illness, difficulty adjusting to the nursing home, and frustration

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with memory loss. Identifying depression and anxiety can be difficult in elderly patients because the signs may be confused with the normal aging process, a side effect of medication, or the result of a medical condition. Proper treatment should include medication, therapy, or an increase in social support all of which require more, not less attention and care from FACILITY staff. This high acuity need stretched the understaffed FACILITY beyond its abilities and caused injury to IDA LOU BRANCH.

62. At a time when the average in California of residents who have/had a catheter inserted and left in their bladder in skilled nursing facility was 2.1%, the FACILITY actually suffered from 5.0% ratio of its residents having these high acuity issues which required more, not less, staff on duty in the FACILITY. The existence of higher ratio of residents with these high acuity problems in the FACILITY is a further indication of the substandard provision of care in the totality of the FACILITY. This high acuity need stretched the understaffed FACILITY beyond its abilities and caused injury to IDA LOU BRANCH.

63. That at all times relevant hereto the DEFENDANTS were aware that where the residents of the FACILITY require care beyond that which the staff has either the time or the competency to provide, such as IDA LOU BRANCH did, the FACILITY would fail to provide to the residents, such as IDA LOU BRANCH, with the care which they required as specified by their own physicians, as well as all applicable laws and regulations.

64. That at all times relevant hereto the DEFENDANTS were aware that where there is insufficient staff in both number and competency to meet the needs of residents, as there was in the FACILITY during the period time which IDA LOU BRANCH was a resident, residents' needs would not be met and injuries such as those suffered by IDA LOU BRANCH as alleged herein, are not only likely but inevitable.

65. That were there sufficient staff at the FACILITY in both numbers and competency, then the injuries to IDA LOU BRANCH and IDA LOU BRANCH'S resulting death as alleged herein would not have occurred. Specifically, had there been sufficient staff to comply with applicable rules, laws, and regulations and to provide care to IDA LOU BRANCH as should have been specifically called for by the FACILITY Care Plan relating to IDA LOU BRANCH and physician orders and

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assessments, then IDA LOU BRANCH would not have been suffered the painful injuries alleged herein and would not have died; IDA LOU BRANCH would have received proper assistance so as prevent the suffering of the painful injuries alleged herein; IDA LOU BRANCH would have received adequate supervision to protect IDA LOU BRANCH from health and safety hazards; IDA LOU BRANCH would have received the physician-ordered care to prevent the injuries alleged herein; and IDA LOU BRANCH would have been treated with other interventions so as to prevent suffering of the painful injuries alleged herein. As a direct result of the DEFENDANTS' failure to comply with applicable rules, laws, and regulations, IDA LOU BRANCH did not receive the care set forth hereinabove which led to the injuries and resulting death alleged herein.

66. DEFENDANTS, and each of them, were aware (and thus had notice and knowledge) of the danger to their residents when they violated applicable rules, laws and regulations, yet they acted in conscious disregard of these known perils and at the expense of legally mandated minimum care to be provided to residents in skilled nursing facilities in the state of California.

67. That *prior* to the injuries as alleged herein the FACILITY was chronically under staffed so as to be in violation of applicable rules, laws, and regulations. This knowledge was transmitted to DEFENDANTS through their corporate officers named herein above through daily census reports, key factor summary reports, profit and loss reports, and other mechanisms presently unknown to IDA LOU BRANCH and according to proof at the time of trial.

68. The advance knowledge of their malfeasance as alleged in the immediately preceding paragraph was accomplished by many means, including lawsuits against the defendants alleging under staffing and violation of the Elder Abuse and Dependent Adult Civil Protection Act found at *Welfare and Institutions Code* §15600 et seq.

69. The advance knowledge of their malfeasance on the part of the DEFENDANTS as alleged herein was also acquired by way of the issuance of deficiencies to the FACILITY by the State of California's Department of Public Health. This systemic substandard care led to the injuries to IDA LOU BRANCH and IDA LOU BRANCH'S resulting death as alleged herein.

70. Notwithstanding the knowledge of DEFENDANTS, and their managing agents as alleged herein above, DEFENDANTS consciously chose not to increase staff, in number or training,

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at the FACILITY and as the direct result thereof IDA LOU BRANCH suffered injuries alleged herein. This ignorance, on the part of DEFENDANTS and their corporate officers named in paragraph 7, constituted at a minimum, a reckless disregard for the health and safety of IDA LOU BRANCH.

71. That DEFENDANTS as care custodians willfully caused and allowed IDA LOU BRANCH to be injured and maliciously, fraudulently, oppressively, willfully or recklessly caused IDA LOU BRANCH to be placed in situations such that his health would be in danger in doing the acts specifically alleged herein.

SECOND CAUSE OF ACTION
NEGLIGENT HIRING AND SUPERVISION
[By IDA LOU BRANCH Against All Defendants]

72. IDA LOU BRANCH hereby incorporates the allegations asserted in paragraphs 1 through 74 above as though set forth below.

73. That the DEFENDANTS negligently hired, supervised and/or retained employees including Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH but will be sought via discovery.

74. That in fact Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH 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 IDA LOU BRANCH.

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

76. The DEFENDANTS failed to properly and completely conduct a comprehensive pre-employment interview process and reference checks as to Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants,

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registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH 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.

77. 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 Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH 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.

78. That as the result of the unfitness of Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH but will be sought via discovery, IDA LOU BRANCH was injured in an amount and manner to be proven at time of trial.

79. That the DEFENDANTS' negligence in hiring, supervising and/or retaining Samantha L'allier (Administrator), Christine Crowl (Administrator), Mary E. Barker (Director Of Nursing) and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to IDA LOU BRANCH but will be sought via discovery, caused IDA LOU BRANCH injury in an amount and manner to be proven at time of trial.

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WHEREFORE, Plaintiffs pray for judgment and damages as follows:

1. For general damages according to proof;

2. For special damages according to proof;

3. For punitive and exemplary damages (as to the First Cause of Action only);

4. For attorneys' fees and costs as allowed by law according to proof at the time of trial (as to the First Cause of Action only);

5. For costs of suit; and

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

DATED: December 11, 2017 **GARCIA, ARTIGLIERE & MEDBY**

By: _____
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