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STEPHEN H. NASH
CLERK OF THE SUPERIOR COURT
CONTRA COSTA, CA
BY _____ DEPUTY

PER LOCAL RULE 5 THIS CASE IS ASSIGNED TO DEPT 9

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF CONTRA COSTA, TAYLOR COURTHOUSE

ALLEN WAYNE PRUITT,

Plaintiff,

vs.

KAISER FOUNDATION HOSPITALS - ANTIOCH dba KAISER PERMANENTE ANTIOCH MEDICAL CENTER,

Defendant.

CASE NO. C16-00821

COMPLAINT FOR DAMAGES

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

Trial Date: None Set

COMES NOW ALLEN WAYNE PRUITT and allege upon information and belief as follows:

THE PARTIES

1. Plaintiff ALLEN WAYNE PRUITT (hereinafter sometimes referred to as "PLAINTIFF") was at all times relevant hereto a resident of the County of Los Angeles, State of California. ALLEN WAYNE PRUITT brings this action by and through his Successor in Interest, Sonja PRUITT.

2. Defendants KAISER FOUNDATION HOSPITALS - ANTIOCH dba KAISER PERMANENTE ANTIOCH MEDICAL CENTER and DOES 1 through 50 (hereinafter referred to as the "HOSPITAL") were at all relevant times in the business of providing care as a general acute care hospital under the fictitious name Kaiser Permanente Antioch Medical Center which is located at 4501

BY FAX

Sand Creek Rd, Antioch, CA 94531, and were subject to the requirements of federal and state law regarding the operation of general acute care hospitals operating in the State of California.

3. Defendants DOES 51 through 100 (hereinafter the "PARENT DEFENDANTS") were at all relevant times the HOSPITAL'S owners, operators, parent company, and/or management company of the HOSPITAL and actively participated and controlled the business of the HOSPITAL and thus provided care as a general acute care hospital (hereinafter the HOSPITAL and the PARENT DEFENDANTS are collectively sometimes jointly referred to as "DEFENDANTS").

4. ALLEN WAYNE PRUITT 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 ALLEN WAYNE PRUITT 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 ALLEN WAYNE PRUITT.

5. Plaintiff 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. Plaintiff will seek leave of the Court to amend this Complaint to identify said Defendants when their identities are ascertained.

6. The liability of the PARENT DEFENDANTS for the abuse of ALLEN WAYNE PRUITT as alleged herein arises from their <u>own</u> direct misconduct as alleged herein as well as all other legal basis and according to proof at the time of trial.

7. The DEFENDANTS, by and through the corporate officers and directors including, David Hoffmeister, Daniel Garcia, Thomas Chapman, William Graber, Eugene Grigsby, Kim Kaiser, Philip Marineau, Jeffrey Epstein, Judith Johansen, Cynthia Telles, Margaret Porfido, Edward Pei, Christine Cassell, Bernard Tyson, Richard Shannon and others presently unknown to Plaintiff and according to proof at time of trial, ratified the conduct of their co-defendants and the HOSPITAL, in that they were aware of the understaffing of the HOSPITAL, in both number and training, the relationship between understaffing and sub-standard provision of care to patients of the HOSPITAL,

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including ALLEN WAYNE PRUITT, the rash, and truth, of lawsuits against the DEFENDANTS general acute care hospitals including the HOSPITAL, and the HOSPITAL'S customary practice of being issued deficiencies by the State of California's Department of Public Health 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 patients of their HOSPITAL, including the ALLEN WAYNE PRUITT.

8. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS, which led to the injuries to ALLEN WAYNE PRUITT as alleged herein, was the direct result and product of the financial and control policies and practices forced upon the HOSPITAL by the financial limitations imposed upon the HOSPITAL by the PARENT 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.

9. That, based upon information and belief, DOES 101-110 were members of the "Governing Body" of the HOSPITAL responsible for the creation and implementation of policies and procedures for the operation of the HOSPITAL pursuant to 22 C.C.R. §§70201 et seq., 70491 through 70499, and 70701 et seq.

10. That than provide the required services mandated by law as members of the "Governing Body," DOES 101-110, as executives, managing agents and/or owners of the HOSPITAL, were focused on unlawfully limiting necessary expenditures in the operation of DEFENDANTS' businesses as opposed to providing the legally mandated minimum care to be provided to elder and/or dependent patients in their HOSPITAL, including ALLEN WAYNE PRUITT, the net effect of which was, and is, to deny required services to HOSPITAL patients including ALLEN WAYNE PRUITT as more fully set forth herein.

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

12. At all relevant times, the HOSPITAL and PARENT 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

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from the operation of the HOSPITAL by underfunding and understaffing the HOSPITAL. Moreover, the 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 ALLEN WAYNE PRUITT Against All Defendants]

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

14. At all relevant times, ALLEN WAYNE PRUITT was a "dependent adult" as defined in the *Welfare and Institutions Code* §15610.23 in that he is a person between the ages of 18 and 64 who has physical or mental limitations that restricted her ability to carry out normal activities or to protect his rights which includes but is not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age admitted as an inpatient to a 24-hour health care facility, as defined in *Health and Safety Code* §§1250, 1250.2, and 1250.3, to wit, DEFENDANTS' HOSPITAL.

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

16. That each DEFENDANT "neglected" ALLEN WAYNE PRUITT 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. That the DEFENDANTS as care custodians willfully caused and allowed ALLEN WAYNE PRUITT to be injured and maliciously, fraudulently, oppressively, willfully and/or recklessly caused ALLEN WAYNE PRUITT to be placed in situations such that his health would be in danger in doing the acts specifically alleged herein.

18. At the time of admission to the HOSPITAL, ALLEN WAYNE PRUITT'S skin was

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free and clear of pressure ulcers. It was well known to the HOSPITAL when ALLEN WAYNE PRUITT was admitted to the HOSPITAL he had reduced mobility and loss of physical fitness which in turn made him highly likely to develop debilitating pressure sores and infection if all required care to prevent same was not provided to ALLEN WAYNE PRUITT.

19. On January 26, 2016, ALLEN WAYNE PRUITT was admitted to the HOSPITAL emergency room with elia elitmus (bowel blockage), cellulitis and Strep-B in his left leg; the infection had entered his blood stream.

20. During this admission to the HOSPITAL, ALLEN WAYNE PRUITT was extremely weak and fatigued as a result of his multiple infections, he was thus entirely dependent in that he needed 100% assistance in his Activities of Daily Living ("ADLs"). ALLEN WAYNE PRUITT was bedbound, incontinent of both bowel and bladder, non-ambulatory and had zero bed-mobility in that he was completely unable to turn and reposition himself to relieve pressure from his bony prominences.

21. DEFENDANTS were fully aware upon ALLEN WAYNE PRUITT'S admission to the HOSPITAL, through assessment information, as well as physician notes and orders provided to the HOSPITAL that ALLEN WAYNE PRUITT was at high risk for skin breakdown and the development and deterioration of pressure sores due to ALLEN WAYNE PRUITT'S medical conditions.

22. DEFENDANTS warranted that they were aware of ALLEN WAYNE PRUITT'S condition and were sufficiently staffed and equipped with the resources to manage ALLEN WAYNE PRUITT'S care while he was in his coma in accordance with the fragile condition this series of surgeries left him in. HOSPITAL falsely and fraudulently made such promises as they knew that once ALLEN WAYNE PRUITT was in his helpless state after the surgery, he was nothing more a source of revenue for the HOSPITAL. In short, HOSPITAL had no intent to provide the care ALLEN WAYNE PRUITT so desperately needed. Knowing he was completely helpless, and confident they could sufficiently deceive ALLEN WAYNE PRUITT'S family into believing that he was receiving the care that he needed, HOSPITAL utterly disregarded the needs of ALLEN WAYNE PRUITT and withheld from ALLEN WAYNE PRUITT required care so as to cause ALLEN WAYNE PRUITT to

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develop a painful, infected and avoidable pressure ulcer.

23. The HOSPITAL at one point promised that they were going to put ALLEN WAYNE PRUITT into a special bed and were turning and repositioning him regularly. While the HOSPITAL may have made such promised to the family to ease their concerns and quell any action taken by them which would lead to administrative discipline from the governing state and federal agencies, HOSPITAL knew full well that it had no intention or resources necessary to render such care as they were physically limited by the stringent financial constraints placed on it by the governing body in order to promote the HOSPITAL'S own financial gain.

24. The HOSPITAL through their Governing Body has engaged in an objective to limit costs so as to maximize profit at the expense of the health and safety of residents like HOSPITAL. Through such cost limitation, the HOSPITAL systematically fails to have the resources or the staff on hand to manage the care of residents like ALLEN WAYNE PRUITT. As a result, the HOSPITAL is repeatedly issued deficiencies by the Department of Public Health for failure to provide the patient care they have promised and are required to perform as a licensed healthcare facility. Once again however, HOSPITAL has managed to keep these deficiencies from the public view. These deficiencies are a prima facie illustration of the HOSPITAL'S intent to willfully and systematically withhold the care and treatment which is necessary to preserve the health and safety of their residents. ALLEN WAYNE PRUITT was no exception to this policy to systematically withhold care from residents in favor of profit maximization.

25. At the time of his admission, ALLEN WAYNE PRUITT was 6 feet 2 inches tall and weighing about 320 pounds. Notwithstanding his size, and aware that ALLEN WAYNE PRUITT did not have the requisite bed mobility necessary to turn and reposition himself, DEFENDANTS placed him in a bed which was too small for him. Only six feet in length, the bed was unable to accommodate his six foot, two inch height. The small bed coupled with his weakness and fatigue from the infection made him completely immobile to the extent that he could not even adjust his body in the slightest. As a result of this lack of accommodations, ALLEN WAYNE PRUITT spent his entire admission at the HOSPITAL in chronic pain and discomfort. ALLEN WAYNE PRUITT'S family complained to the DEFENDANTS that his bed was too small, however, DEFENDANTS did

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nothing in response to these complaints.

26. ALLEN WAYNE PRUITT'S family expressed concern about his well-being, specifically in regards to his bed mobility and his ability to relieve pressure from his bony prominences. Furthermore, ALLEN WAYNE PRUITT had frequent spells of diarrhea while at the facility as a result of the antibiotics he was on. ALLEN WAYNE PRUITT'S family addressed the fact that he was often left unattended and rarely did they witness any assistance with his nutrition, hydration, or toileting needs. Again, in response to these complaints the DEFENDANTS did nothing. And after each spell of diarrhea, despite complaining to HOSPITAL staff and notifying them that he needed toileting assistance, ALLEN WAYNE PRUITT was often ignored and left to sit in his own feces.

27. HOSPITAL knew ALLEN WAYNE PRUITT required care to prevent the formation and worsening of pressure sores however, specifically, and without limiting the generality of these allegations and according to proof at time of trial, during his admission, the HOSPITAL DEFENDANTS just flat out ignored the known needs of ALLEN WAYNE PRUITT and wrongfully withheld required services required by the standard of practice which included timely attention and care so as to not leave ALLEN WAYNE PRUITT in his own urine and feces for extended periods of time, provide adequate and proper assistance with personal hygiene, ensuring that ALLEN WAYNE PRUITT was turned and repositioned at least every two hours so as to relieve pressure from ALLEN WAYNE PRUITT'S bony prominences, providing ALLEN WAYNE PRUITT with adequate nutrition and hydration so as to stave off skin breakdown, properly and competently evaluating ALLEN WAYNE PRUITT as to clinical conditions, providing and implementing defined interventions to address the likelihood of pressure sore development and once developed to prevent worsening of the pressure sores, revising defined interventions to address the likelihood of pressure sore development and once developed to prevent worsening of the pressure sores were, as was the case here, clearly not working, ensuring adherence to physician orders and timely communication as to emergent medical conditions with the physician, to prevent the foreseeable development of pressure ulcers on ALLEN WAYNE PRUITT.

28. Specifically, and without limitation to that to be adduced in discovery and according to

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proof at time of trial, the HOSPITAL DEFENDANTS wrongfully withheld required care to ALLEN WAYNE PRUITT by failing to ensure that that his need for constant attention and care to for his skin via interventions such as turning and repositioning of ALLEN WAYNE PRUITT'S body at least every two hours to relieve pressure on bony prominences.

29. Specifically, and without limitation to that to be adduced in discovery and according to proof at time of trial, the HOSPITAL DEFENDANTS wrongfully withheld required care to ALLEN WAYNE PRUITT by failing to ensure that ALLEN WAYNE PRUITT was being provided with pressure-relieving devices so as to prevent skin breakdown.

30. Specifically, and without limitation to that to be adduced in discovery and according to proof at time of trial, the HOSPITAL DEFENDANTS wrongfully withheld required care to ALLEN WAYNE PRUITT, by failing to ensure that ALLEN WAYNE PRUITT was properly hydrated and received sufficient nutrition to fight off the development of pressure sores.

31. Specifically, and without limitation to that to be adduced in discovery and according to proof at time of trial, the HOSPITAL DEFENDANTS wrongfully withheld required care to ALLEN WAYNE PRUITT, HOSPITAL by failing to ensure that staff provided ALLEN WAYNE PRUITT with care and interventions which were called for by HOSPITAL Care Plan and physician orders and assessments.

32. When ALLEN WAYNE PRUITT was discharged from the HOSPITAL on February 10, 2016, he was sent to a skilled nursing facility for rehabilitation treatment. The facility staff noted that ALLEN WAYNE PRUITT had a large bruise on his coccyx which was determined to be deep tissue injury resulting from having sat motionless in his undersized bed while at the HOSPITAL from January 26, 2016 through February 10, 2016, due to the DEFENDANT'S having systematically failed to implement any of the interventions defined above in paragraphs 25-31 herein.

33. Realizing his risk for developing pressure ulcers, the facility where he was discharged gave him a large bed and an air mattress to relive pressure from his bony prominences. The staff had also come in every two hours to turn and reposition him. Unfortunately, however, these efforts were to little too late. The sore had already tunneled through the tissue below his skin and the bruise eventually opened up, as the skin was necrotic and non-viable, revealing a Stage IV decubitus ulcer.

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34. In March of 2016, ALLEN WAYNE PRUITT underwent debridement surgery for the wound and was placed on a wound V.A.C. for negative pressure wound therapy. He was instructed by his physician that he would require this therapy for the next year. On March 28, 2016, the wound became infected with cellulitis and ALLEN WAYNE PRUITT was again put on antibiotics.

35. ALLEN WAYNE PRUITT continues to take antibiotics to stave off recurrent infections from his coccygeal pressure ulcer, which cause him to have chronic diarrhea. As a result, he is often dehydrated and undernourished. He is currently in diapers and still using a urinary catheter. The infections have become more frequent now as doctors have found that his wound is now tunneling in different directions throughout the tissue below his skin.

36. ALLEN WAYNE PRUITT will ultimately require skin grafting surgery for his wound.

37. Despite the HOSPITAL being fully aware upon ALLEN WAYNE PRUITT'S admission to the HOSPITAL, through assessment information, as well as physician notes and orders provided to the HOSPITAL that ALLEN WAYNE PRUITT was at high risk for skin breakdown and the development and deterioration of pressure sores due to ALLEN WAYNE PRUITT'S medical conditions, and that as a direct result of the chronic understaffing at the HOSPITAL in both number and training, the HOSPITAL failed to provide ALLEN WAYNE PRUITT with adequate personal hygiene, failed to ensure that ALLEN WAYNE PRUITT received adequate hydration and nutrition to stave off infections and skin breakdown, and failed to timely react to ALLEN WAYNE PRUITT'S emergent conditions including the development of avoidable pressure ulcers on his back, and buttocks.

38. The parade of horrible does not end there, also upon admission, ALLEN WAYNE PRUITT was put on a urinary catheter. The DEFENDANTS never strapped the catheter to ALLEN WAYNE PRUITT'S leg which caused it to tear the opening of his penis. According to ALLEN WAYNE PRUITT'S urologist, ALLEN WAYNE PRUITT will never be able to urinate normally again due to this tear. Furthermore, ALLEN WAYNE PRUITT will require surgery for this injury in an attempt to reconstruct the damage.

39. As a matter of accepted practice this renders the horrific pressure sores developed by

ALLEN WAYNE PRUITT in the HOSPITAL as defintionally "avoidable."[1] And, as determined by the United States Government in the promulgation of the Deficit reduction Act of 2005 (42 U.S.C. §11395ww(d)4(D) and Centers for Medicare and Medicaid Services (CMS) Rule 1390-F as well as the final rule of CMS on "provider-preventable conditions" addressing the Affordable Care Act §2702, has determined that a "never event" includes a HOSPITAL acquired Stage 3 or 4 pressure sore and generally does not happen in the absence of the provision of proper care by the HOSPITAL.

40. That at all times relevant hereto, the HOSPITAL owed a duty to ALLEN WAYNE PRUITT pursuant to Title 22 C.C.R. §70211 to provide nursing service that was organized, staffed, equipped and supplied to meet the needs of ALLEN WAYNE PRUITT. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

41. That at all times relevant hereto, the HOSPITAL owed a duty to ALLEN WAYNE PRUITT pursuant to Title 22 C.C.R. §70213 to develop, maintain and implement written policies and procedures for patient care including assessment, nursing diagnosis, planning, intervention, and

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[1] In 2010 the National Pressure Ulcer Advisory Panel convened a meeting of 24 stakeholders. The voting panel consisted of 24 professionals with expertise in pressure ulcer prevention and treatment primarily from North America and the Pan Pacific region. Specialties included geriatric medicine, surgery, specialty nursing, physical therapy, and nutrition. The panel represented professional wound organizations, accrediting bodies, hospitals, rehabilitation agencies, long-term care, hospice, and home care, all stakeholders in the issue of pressure ulcers. The stakeholders included American Association of Homes and Services for the Aging (AAHSA), American Association of Long Term Care Nursing, American Dietetic Association (ADA), Association for the Advancement of Wound Care (AAWC), American Health Care Association (AHCA), American Medical Directors Association (AMDA), American Physical Therapy Association (APTA), American Professional Wound Care Association (APWCA), American Society of Plastic Surgeons (ASPS), Association of Operating Room Nurses (AORN), Australian Wound Management Association (AWMA), Canadian Association of Enterostomal Therapy (CAET), Canadian Association of Wound Care (CAWC), Hong Kong Enterostomal Therapy Association, National Alliance of Wound Care (NAWC), National Association for Home Care and Hospice, National Pressure Ulcer Advisory Panel (NPUAP), Ontario Wound Care Interest Group, Rehabilitative Engineering and Assistive Technology Society (RESNA), The Joint Commission (TJC), Veterans Health Administration, US Department of Veterans' Affairs (VA), World Council of Enterostomal Therapists, Wound Healing Society (WHS)Wound Ostomy and Continence Nurses Society (WOCN).

An 80% agreement was set as a criterion for determining consensus on any given question because this amount was deemed to be "significantly" greater than the level of agreement that could be obtained by chance alone. This level of agreement also was based on the size of the group from which consensus is needed and a prediction of a reasonable level of agreement needed to obtain consensus. Thus, when 80% consensus was achieved the next question was posed.

After discussion the Panel determined that determined that a pressure sore is defintionally avoidable when the provider did not do one or more of the following: evaluate the individual's clinical condition and pressure ulcer risk factors; define and implement interventions consistent with individual needs, individual goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

evaluation. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

42. That the HOSPITAL owed a duty to ALLEN WAYNE PRUITT pursuant to 22 C.C.R. §70215(a)(1) to provide an ongoing patient assessment. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

43. That the HOSPITAL owed a duty to ALLEN WAYNE PRUITT to provide planning and delivery of ALLEN WAYNE PRUITT'S care including assessment, diagnosis, planning, intervention, and evaluation pursuant to 22 C.C.R. §70215(b). The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

44. That the HOSPITAL owed a duty to ALLEN WAYNE PRUITT to provide a written, organized in-service education program for its patient care personnel pursuant to 22 C.C.R. §70214. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

45. That the HOSPITAL owed a duty to ALLEN WAYNE PRUITT to provide services with a sufficient budget and staffing to meet ALLEN WAYNE PRUITT'S care needs pursuant to 42 C.F.R. §482.23(b) and 22 C.C.R. §70217. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

46. That the HOSPITAL owed a duty to ALLEN WAYNE PRUITT to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient in accordance with a written plan of care pursuant to 22 C.C.R. §70709. The HOSPITAL wrongfully withheld this required service to ALLEN WAYNE PRUITT, thereby causing injury to ALLEN WAYNE PRUITT as alleged herein.

47. In sum, the HOSPITAL wrongfully withheld required services to ALLEN WAYNE PRUITT by failing to timely and/or accurately inform ALLEN WAYNE PRUITT'S family, physician, or legal representative about the development and worsening of preventable pressure sores

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or what was being done, or more accurately not done, to treat them. In an unfortunate effort to conceal the HOSPITAL'S failure to provide required care, HOSPITAL staff concealed these conditions from ALLEN WAYNE PRUITT'S family and physician, and untruthfully represented the scope, nature and cause of the injuries. As a result of the HOSPITAL'S failure to provide required care and failure to bring these conditions to the attention of ALLEN WAYNE PRUITT'S family and physician, ALLEN WAYNE PRUITT was allowed to suffer horrendous pressure sores that the HOSPITAL had ignored as the result of the inadequacy of HOSPITAL staff in both number and training.

48. Accordingly, and notwithstanding the HOSPITAL DEFENDANT'S knowledge that ALLEN WAYNE PRUITT was an extreme risk for the rapid progression of pressure sores and resulting infection, the HOSPITAL DEFENDANTS did not provide ALLEN WAYNE PRUITT with the proper care he required and ultimately the pressure ulcers became infected.[2]

49. In an effort to fraudulently conceal their neglect of ALLEN WAYNE PRUITT The HOSPITAL failed to report ALLEN WAYNE PRUITT'S pressure sores to the Department of Public Health pursuant to *Health & Safety Code* §1279.1. Instead the DEFENDANTS failed to provide this required report so that they could fraudulently conceal their ignorance of ALLEN WAYNE PRUITT'S needs. And the DEFENDANTS took this course recognizing fully that if they did report the event as required by law, they would not get paid—once again the DEFENDANTS place improper profit over the needs of their patients.[3]

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[2] A pressure sore is a skin wound. Pressure sores usually develop on bony parts of the body such as the tailbone, hip, ankle, or heel. They are usually caused by constant pressure on one part of the skin. Pressure sores are sometimes called bedsores. These sores can be caused from the pressure on the skin from chairs, wheelchairs, or beds. Severe pressure sores may take a long time to heal. **Stage I** – A persistent area of skin redness (without a break of the skin) that does not disappear when pressure is relieved. **Stage II** – A partial loss of thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater. **Stage III** – A full thickness of skin is lost, exposing the subcutaneous tissues – presents as a deep crater with or without undermining adjacent tissue. **Stage IV** – A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

[3] The CMS exercised its authority under section 5001(c) of the Deficit Reduction Act by announcing that Medicare will no longer pay the extra cost of treating the following categories of conditions that occur while the patient is in the hospital.

pressure ulcer stages III and IV;
falls and trauma;
surgical site infection after bariatric surgery for obesity, certain orthopedic procedures, and bypass surgery (mediastinitis);
vascular-catheter associated infection;

(footnote continued)

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50. That the HOSPITAL knew prior to the admission of ALLEN WAYNE PRUITT that when the HOSPITAL failed to provide the required care set forth above, that there was a high probability that patients such as ALLEN WAYNE PRUITT would suffer serious injury. That the HOSPITAL consciously disregarded this risk and failed to provide ALLEN WAYNE PRUITT with the aforementioned required care, leading directly to ALLEN WAYNE PRUITT'S injuries as alleged herein.

51. In the operation of the HOSPITAL, DEFENDANTS, and each of them, held themselves out to the general public, to ALLEN WAYNE PRUITT, and others similarly situated, that their general acute care hospital provided services which were in compliance with all applicable federal and state laws, rules and regulations governing the operation of a general acute care hospital in the State of California. In the operation of the subject HOSPITAL, the DEFENDANTS, and each of them, held themselves out to ALLEN WAYNE PRUITT that the HOSPITAL would be able to meet the needs of ALLEN WAYNE PRUITT These representations of the nature and quality of services to be provided were, in fact, false, and ALLEN WAYNE PRUITT suffered injuries as fully alleged herein.

52. The HOSPITAL DEFENDANTS, by and through the corporate officers, directors and managing agents set forth above, and other corporate officers and directors presently unknown to ALLEN WAYNE PRUITT and according to proof at time of trial, ratified the conduct of their co-defendants and HOSPITAL, in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing of HOSPITAL, in both number and training, the relationship between

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catheter-associated urinary tract infection;
administration of incompatible blood;
air embolism; and
foreign object unintentionally retained after surgery.

Beginning October 1, 2008, Medicare no longer paid the higher MS-DRG for these conditions. In the 2009 Medicare Inpatient Prospective Payment System Update Regulation (CMS-1390-F), Medicare announced that certain categories of conditions would be covered under the HAC policy effective October 1, 2008. Newly added conditions include deep vein thromboses and pulmonary emboli associated with knee and hip replacements, and certain manifestations of poor glycemic control. In addition, Medicare is announcing it is initiating the National Coverage Determination process to review Medicare coverage of three Never Events (surgery on wrong body part, surgery on wrong patient, and performing the wrong surgery on a patient).

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understaffing and sub-standard provision of care to patients of the HOSPITAL including ALLEN WAYNE PRUITT, and the HOSPITAL'S practice of being issued deficiencies by the State of California's Department of Public Health. Furthermore, the HOSPITAL DEFENDANTS, by and through the corporate officers and directors enumerated above and others presently unknown to ALLEN WAYNE PRUITT 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, deficiencies, and insufficiency of financial budgets to lawfully operate the HOSPITAL would lead to injury to patients of the HOSPITAL, including ALLEN WAYNE PRUITT. This ratification by the DEFENDANTS itself, is that ratification of the customary practice and usual performance of HOSPITAL as set forth in *Colonial Life & Accident Ins. 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.

53. Upon information and belief, the DEFENDANTS enacted, established and implemented the financial plan and scheme which led to the HOSPITAL being understaffed, in both number and training, by way of imposition of financial limitations on the HOSPITAL 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 ALLEN WAYNE PRUITT by the HOSPITAL. These choices and decisions were, and are, at the express direction of the DEFENDANTS' management personnel including the corporate officers and directors enumerated above and others presently unknown to ALLEN WAYNE PRUITT 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.

54. The Corporate authorization and enactment of the DEFENDANTS, alleged in the preceding paragraphs, constituted the permission and consent of HOSPITAL'S misconduct by the DEFENDANTS, by and through the corporate officers and directors enumerated above and others presently unknown to ALLEN WAYNE PRUITT and according to proof at time of trial, who had within their power the ability and discretion to mandate that the HOSPITAL employ adequate staff to meet the needs of their patients, including ALLEN WAYNE PRUITT, as required by applicable

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rules, laws and regulations governing the operation of general acute care hospitals in the State of California. The conduct constitutes ratification of the HOSPITAL'S misconduct by the DEFENDANTS, which led to injury to ALLEN WAYNE PRUITT 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.

55. That were there sufficient staff at the HOSPITAL in both numbers and competency, then the injuries to ALLEN WAYNE PRUITT 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 ALLEN WAYNE PRUITT as should have been specifically called for by the HOSPITAL Care Plan relating to ALLEN WAYNE PRUITT and physician orders and assessments, then ALLEN WAYNE PRUITT would not have been suffered the painful injuries alleged herein; ALLEN WAYNE PRUITT would have received proper assistance so as prevent the suffering of the painful injuries alleged herein; ALLEN WAYNE PRUITT would have received adequate supervision to protect ALLEN WAYNE PRUITT from health and safety hazards; ALLEN WAYNE PRUITT would have received the physician-ordered care to prevent the injuries alleged herein; and ALLEN WAYNE PRUITT would have been treated with other interventions so as to prevent suffering of the painful injuries alleged herein. As a direct result of the HOSPITAL DEFENDANTS' failure to comply with applicable rules, laws, and regulations, ALLEN WAYNE PRUITT did not receive the care set forth hereinabove which led to the injuries alleged herein.

56. The HOSPITAL DEFENDANTS, and each of them, were aware (and thus had notice and knowledge) of the danger to their patients 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 patients in general acute care hospitals in the state of California.

57. That *prior* to the injuries as alleged herein the HOSPITAL DEFENDANTS was chronically under staffed so as to be in violation of applicable rules, laws, and regulations. This knowledge was transmitted to HOSPITAL DEFENDANTS through their corporate officers named herein above through daily census reports, key factor summary reports, profit and loss reports, and

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other mechanisms presently unknown to ALLEN WAYNE PRUITT and according to proof at the time of trial.

58. Notwithstanding the knowledge of HOSPITAL DEFENDANTS, and their managing agents as alleged herein above, HOSPITAL DEFENDANTS consciously chose not to increase staff, in number or training, at the HOSPITAL and as the direct result thereof ALLEN WAYNE PRUITT suffered injuries alleged herein. This ignorance, on the part of HOSPITAL DEFENDANTS and their corporate officers named above, constituted at a minimum, a reckless disregard for the health and safety of ALLEN WAYNE PRUITT.

59. That HOSPITAL DEFENDANTS as care custodians willfully caused and allowed ALLEN WAYNE PRUITT to be injured and maliciously, fraudulently, oppressively, willfully or recklessly caused ALLEN WAYNE PRUITT to be placed in situations such that his health would be in danger in doing the acts specifically alleged herein.

60. That at all times relevant hereto the HOSPITAL DEFENDANTS knew that by wrongfully withholding required services to ALLEN WAYNE PRUITT occasioned by understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in capacity and competency and the improper withholding of required medical and/or custodial services to residents of the HOSPITAL that it was highly probable that the HOSPITAL DEFENDANTS conduct would cause injury to ALLEN WAYNE PRUITT And notwithstanding this known probability, the HOSPITAL DEFENDANTS wrongfully withheld required services to ALLEN WAYNE PRUITT occasioned by understaffing, lack of training, failure to allot sufficient economic resources, unfitness of staff in capacity and competency and the improper withholding of required medical and/or custodial services to residents of the HOSPITAL DEFENDANTS thereby knowingly disregarded the known risk of injury to ALLEN WAYNE PRUITT which led to the wrongful withholding of required care to ALLEN WAYNE PRUITT

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

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SECOND CAUSE OF ACTION
NEGLIGENCE
[By ALLEN WAYNE PRUITT Against All Defendants.]

62. ALLEN WAYNE PRUITT hereby incorporates the allegations asserted in paragraphs 1 through 61 above as though set forth below.

63. The DEFENDANTS owed statutory, regulatory, and common law duties of care to ALLEN WAYNE PRUITT .

64. The DEFENDANTS breached their statutory, regulatory, and common law duties of care to ALLEN WAYNE PRUITT as more fully alleged above.

65. As the proximate result of the DEFENDANTS' breach of their statutory, regulatory, and common law duties of care to ALLEN WAYNE PRUITT he suffered injury in an amount and manner more specifically alleged above and according to proof at time of trial.

THIRD CAUSE OF ACTION
NEGLIGENT HIRING AND SUPERVISION
[By ALLEN WAYNE PRUITT Against All Defendants.]

66. ALLEN WAYNE PRUITT hereby incorporates the allegations asserted in paragraphs 1 through 65 above as though set forth below.

67. That the DEFENDANTS negligently hired, supervised and/or retained employees including Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT but will be sought via discovery.

68. That in fact Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT 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 HOSPITAL such as ALLEN WAYNE PRUITT.

69. 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

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evaluations and/or disciplinary processes.

70. The DEFENDANTS failed to properly and completely conduct a comprehensive pre-employment interview process and reference checks as to Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT 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 HOSPITAL in California.

71. 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 Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT 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 HOSPITAL in California.

72. That as the result of the unfitness of Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT but will be sought via discovery, ALLEN WAYNE PRUITT was injured in an amount and manner to be proven at time of trial.

73. That the DEFENDANTS negligence in hiring, supervising and/or retaining Bernard Tyson, Gregory Adams, Colleen Mckeown and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to ALLEN WAYNE PRUITT but will be sought via discovery, caused ALLEN WAYNE PRUITT 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 and Fourth 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 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: April 29, 2016

GARCIA, ARTIGLIERE & MEDBY

By: _____

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