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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

Assurhadoun G. Khofri by and through his Successor-in-Interest, Dorida Yaghoub, Dorida Yaghoub, individually,

Plaintiffs,

vs.

Golden Oak Holdings, LLC dba Vasona Creek Healthcare Center; Kaiser Foundation Hospitals dba Kaiser Foundation Hospital – San Jose; The Permanente Medical Group, Inc.; Kaiser Foundation Health Plan, Inc., and Does 1 through 200, inclusive,

Defendants,

CASE NO.:

COMPLAINT FOR DAMAGES

1. **ELDER ABUSE** (Pursuant to *Welfare and Institutions Code* §§15600, et. seq.)
2. **VIOLATION OF RESIDENTS RIGHTS** (Pursuant to *Health and Safety Code* §1430(b))
3. **WRONGFUL DEATH**

DEMAND FOR JURY TRIAL

Action Filed:
Trial Date:

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

THE PARTIES

1. Plaintiff ASSURHADOUN G. KHOFRI (herein referred to as "KHOFRI"), deceased, is an individual who at all relevant times herein alleged was a resident of the County of Santa Clara, State of California. KHOFRI died on January 31, 2018, and brings this action by and through his Successor-in-Interest, Dorida Yaghoub. Upon information and belief, during all relevant times, KHOFRI was under a continuous disability which caused the inability to clearly

communicate, and as such, was insane within the meaning of California *Code of Civil Procedure* §352.

2. Plaintiff DORIDA YAGHOUB is an individual who at all relevant times herein alleged was a resident of the County of Santa Clara, State of California and is the daughter of decedent KHOFRI. She brings this action as the decedent's Successor-in-Interest pursuant to *Welfare and Institutions Code* §15657.3(d), as defined in section 377.11 of the California *Code of Civil Procedure*, and succeeds to the decedent's interest in the instant proceeding in that as the decedent's surviving daughter, she is the beneficiary of the decedent's estate. She is therefore authorized to act on behalf of the decedent as her Successor-in-Interest and has complied with the filing requirements pursuant to *Code of Civil Procedure* section 377.32**.** She also brings the Wrongful Death cause of action individually on her own behalf.

3. Defendant, GOLDEN OAK HOLDINGS, LLC DBA VASONA CREEK HEALTHCARE CENTER (herein referred to as "VASONA") were at all relevant times in the business of providing long-term custodial care as a licensed 24-hour skilled nursing facility located at 16412 Los Gatos Blvd, Los Gatos, CA 95032 and were subject to the requirements of federal and state law governing the operation of skilled nursing facilities operating in the State of California.

4. Defendant, KAISER FOUNDATION HOSPITALS DBA KAISER FOUNDATION HOSPITAL – SAN JOSE (herein referred to as "SAN JOSE") were at all relevant times in the business of providing general acute care as a hospital located at 250 Hospital Pkwy, San Jose, Ca 95119, and were subject to the requirements of federal and state law governing the operation of general acute care hospitals in the State of California.

5. Defendant THE PERMANENTE MEDICAL GROUP, INC., (herein referred to as "PERMANENTE") located at 1950 FRANKLIN STREET, OAKLAND, CA 94612, was and is a corporation that employs all physicians at Kaiser Hospitals of Northern California.

6. Defendant KAISER FOUNDATION HEALTH PLAN, INC., (herein referred to as "KHP") located at ONE KAISER PLAZA, OAKLAND, CA 94612, was and is a corporation that owned, managed, controlled, maintained, and/or operated Kaiser Foundation Hospitals and

was subject to the requirements of federal and state law governing the operation of general acute care hospitals in the State of California.

7. Plaintiff is ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 200, and for that reason have sued those Defendants by such fictitious names. Plaintiffs will seek leave from the court to amend this Complaint to identify said Defendants when their identities are ascertained.

8. Defendant VASONA, by and through its corporate officers, directors, and managing agents presently unknown to Plaintiffs and according to proof at the time of trial, ratified the misconduct alleged herein in that they were aware of the understaffing of their skilled nursing facilities, in both number and training, the relationship between understaffing and sub-standard provision of care to residents and patients of their skilled nursing facilities, including KHOFRI, the unfitness of licensed and unlicensed nursing personnel employed at their skilled nursing facilities, the rash and truth of lawsuits against their hospitals and skilled nursing facilities, and their customary practice of not adequately responding to correct deficiencies issued by the State of California's Department of Public Health. 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 the residents and patients of their hospitals and skilled nursing facilities, including KHOFRI.

9. Defendants KAISER, PERMANENTE, KHP, by and through its corporate officers, directors, and managing agents, presently unknown to Plaintiffs and according to proof at the time of trial, ratified the misconduct alleged herein in that they were aware of the understaffing of their hospitals, in both number and training, the relationship between understaffing and sub-standard provision of care to residents and patients of their hospitals, including KHOFRI, the unfitness of licensed and unlicensed nursing personnel employed at their hospitals, the rash and truth of lawsuits against their hospitals, and their customary practice of not adequately responding to correct deficiencies issued by the State of California's Department of Public Health. 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 the residents and patients of their hospitals and skilled nursing facilities, including KHOFRI.

10. VASONA, KAISER, PERMANENTE, KHP and DOES 1-200 (sometimes collectively referred herein as "DEFENDANTS")

11. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS, which led to the injuries to KHOFRI as alleged herein, was the direct result and product of the financial and control policies and practices dictated by and forced upon the their hospitals and skilled nursing facilities by and through the corporate officers and directors enumerated in paragraph 9 and 10 of the complaint and others presently unknown and according to proof at time of trial.

12. Based upon information and belief, DOES 1 through 200 were members of the "Governing Body" of DEFENDANTS responsible for the creation and implementation of policies and procedures for the operation of their skilled nursing facilities and for supervising the administration of the same pursuant to 42 C.F.R. §483.75 . That these members, as executives, managing agents and/or owners of the DEFENDANTS, 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 KHOFRI . That the focus of these individuals on their own attainment of profit played a part in the underfunding of the skilled nursing facilities which led to DEFENDANTS violating state and federal rules, laws and regulations and led to the injuries and to KHOFRI as alleged herein.

13. The DEFENDANTS were the knowing agents and/or alter-egos of one another, and each of their officers, directors, and managing agents directed, approved and/or ratified all of the acts and omissions of each other, and their agents and employees, thereby making each of them vicariously liable for the acts and omissions of their co-defendants, their agents and employees, as is more fully alleged herein. Moreover, through their managing agents, DEFENDANTS and each of them, agreed, approved, authorized, ratified and/or conspired to commit all of the acts and omissions alleged herein.

14. At all relevant times, the 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 decreasing costs and increasing revenues from the operation of the hospitals and skilled nursing facilities by underfunding and understaffing with an insufficient number of care personnel, many of whom were not trained and qualified to care for the patients and residents. Moreover, the DEFENDANTS aided and abetted each other in accomplishing the acts and omissions alleged herein. (Restatement (Second) of Torts § 876 (1979)).

FIRST CAUSE OF ACTION

ELDER ABUSE

[Against All Defendants and DOES 1-200]

15. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 14 of this Complaint as though set forth at length below.

16. At all relevant times, KHOFRI was over 65 years old who resided in this state, had physical or mental limitations that restricted his or her ability to carry out normal activities, or to protect his or her rights, including, but not limited to, physical or developmental disabilities, and who was admitted as an inpatient to a 24-hour health facility pursuant to §1250.3 of the *California Health and Safety Code*, and was an "elder" as that term is defined in *California Welfare and Institutions Code* §15610.27.

17. That DEFENDANTS were to provide "care or services" to elders, including KHOFRI and were to be the "care custodians" of KHOFRI in a trust and fiduciary relationship with KHOFRI.

18. That the DEFENDANTS "neglected" KHOFRI 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 by denying or withholding goods or services necessary to meet the basic needs of KHOFRI as is more fully alleged herein.

19. As a result of the DEFENDANTS' wrongdoing, KHOFRI suffered physical harm, pain or mental suffering.

20. The DEFENDANTS had advance knowledge of the unfitness of their employees

and employed him or her with a conscious disregard of the rights or safety of others, "authorized or ratified the wrongful conduct," and the DEFENDANTS conduct was "on the part of an officer, director, or managing agent of the corporation." (Civ. Code, § 3294, subd. (b).)

Admission to DEFENDANTS

21. While under the care and treatment of DEFENDANTS, KHOFRI suffered from malnutrition, dehydration, sepsis, and other infections which led to his untimely death.

22. Based on KHOFRI'S prior medical history and assessments, DEFENDANTS, knew that KHOFRI'S health and safety would be put at great risk, especially because he was a dependent person, if he was not provided with necessary supervision as well as needed medical care and services. DEFENDANTS also knew that due to KHOFRI'S physical condition, he was unable to provide for his own basic needs and was dependent on them for meeting his basic needs such as nutrition, hydration, as well as medical care and health services, assistance and monitoring with feeding, the provision of safety and assistance devices to prevent infections. Nevertheless, not only was said care and services routinely withheld from KHOFRI but he was not even provided with the minimum care mandated by federal and/or state nursing home laws even though DEFENDANTS knew it was substantially certain that KHOFRI would suffer injury due to the failure to provide the care and services he needed and which was mandated by law. Moreover, the ongoing and repeated nature of DEFENDANTS' failure to provide such services and care demonstrates that DEFENDANTS acted with conscious disregard of the high probability that KHOFRI would suffer injury as a result of their failure to provide the care and services he needed which was mandated by law.

23. DEFENDANTS neglected to provide medical care for KHOFRI's physical and mental health needs by failing to take all the necessary steps to properly care for him. DEFENDANTS failed to adequately inform KHOFRI's physician of the nature and extent of him medical issues, and failed to adequately and completely carry out doctor's orders for their treatment and failed to adequately and appropriately document KHOFRI's plan of care.

24. DEFENDANTS' neglect of KHOFRI was reckless, oppressive, and malicious. Specifically, the individuals who cared for KHOFRI knew that taking the necessary precautions to prevent him from incurring malnutrition, dehydration, sepsis, and other infections, was critical to his health, well-being, and prognosis. By failing to address KHOFRI's patient care issues,

DEFENDANTS knew that it was highly probable that he would suffer injury.

25. KHOFRI's injuries would not have occurred had the DEFENDANTS simply adhered to applicable rules, laws and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility and general acute care hospitals.

26. DEFENDANTS were in violation of Title 42 C.F.R. 483.10(b)(1)&(11), Title 22 C.C.R. section 72311(a) and 72527(a)(3), DEFENDANTS' failed to report the status of the deteriorating and changing condition of KHOFRI's hydration and nutritional status to his attending physician or family. In further violation of Title 42 C.F.R. 483.20(k)(ii), neither KHOFRI's attending physician or family was asked to participate in an interdisciplinary team care plan meeting to ensure he was receiving the treatment he needed to stay properly hydrated and nourished.

27. In violation of 42 C.F.R. Section 483.75(j), DEFENDANTS' records containing KHOFRI's records were not complete or accurate. Additionally, neither the notes of the nurses complied with Title 22 C.C.R. Section 72547(a)(5). Moreover, DEFENDANTS' personnel consistently failed to document the true status of KHOFRI's decubitus ulcer, his hydration and/or the infection, which progressively worsened under the care of DEFENDANTS. As a result, he was denied the needed medical care because other health professionals and service providers detrimentally relied on the fraudulent, inaccurate and/or incomplete records in evaluating and ordering care and services and based on those records did not order necessary care and services that would have been ordered had the records been true, accurate and complete. Further, DEFENDANTS' staff failed to maintain KHOFRI's records with the appropriate and correct patient records.

28. That as a direct result of the chronic understaffing at DEFENDANTS' facilities in both number and training, DEFENDANTS failed to provide KHOFRI with proper care to prevent infections, and failed to ensure that KHOFRI received adequate hydration and nutrition to starve off infections, and failed to timely react to KHOFRI's emergent conditions including the development of entirely preventable and treatable infections. KHOFRI suffered these injuries because the DEFENDANTS' staff simply did not have adequate time or the inclination to provide

him with the required care and to document and address his emergent conditions. These injures were entirely preventable had there been sufficient staff on duty, in both number and competency, to actually implement the protections required by the DEFENDANTS' own Plan of Care and Physician Orders and assessments for KHOFRI. Unfortunately, there was not sufficient staff on duty at the DEFENDANTS's facilities to implement the protections called for in KHOFRI's Plan of Care and Physician Orders and assessments for KHOFRI and he suffered the painful and preventable injuries alleged herein.

29. That KHOFRI's infections, malnutrition, dehydration, went unnoticed or untreated by the facility staff simply because they did not have adequate staff, or adequately trained and supervised staff, and because staff was unfit to provide nursing care to elderly and dependent residents.

30. Accordingly, decisions by the DEFENDANTS as to staffing and census were made irrespective of patient and resident population needs within the facility and hospital, but rather, were determined by the financial needs of the companies.

31. Minimum staffing of personnel in VASONA was dependent by law upon the acuity (need) level of the patients of VASONA. VASONA residents' acuity level during the residency of KHOFRI in VASONA was so high that the required "minimum" staffing ratios exceeded the applicable numeric minimum requirement of *Health and Safety Code* §1276.5 pursuant to the provisions of Title 22 C.C.R. §§72515(b), 72329 and 42 C.F.R. §482.30. During the residency of KHOFRI in the VASONA, VASONA did not meet these minimum staffing requirements based on its residents' acuity levels, including KHOFRI.

32. DEFENDANTS represented to the general public and to KHOFRI and/or his family members, that DEFENDANTS were sufficiently staffed so as to be able to meet the needs of KHOFRI and that DEFENDANTS operated in compliance with all applicable rules, laws and regulations governing the operation of general acute care hospitals and skilled nursing facilities in the State of California. These representations were, and are, false.

33. In the operation of DEFENDANTS' facilities, DEFENDANTS and each of them, held themselves out to the general public via websites, brochures, admission agreements and other

mechanisms presently unknown to Plaintiffs and according to proof at time of trial, to KHOFRI and others 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 general acute care hospital and skilled nursing facility in the State of California. In the operation of DEFENDANTS' facilities, DEFENDANTS held itself out to KHOFRI and/or his family members that DEFENDANTS would be able to meet the needs of KHOFRI. These representations of the nature and quality of the nature of services to be provided were, in fact, false.

34. At all relevant times hereto, KAISER, PERMANENTE, KHP was aware of the legally mandated minimum staffing ratios and requirements of general acute care hospitals as set forth in Title 22 C.C.R. §70217. KAISER, PERMANENTE, KHP was also aware that where they failed to meet their regulatory requirement, injuries such as those suffered by KHOFRI could, would, and did occur. Notwithstanding their knowledge and requirement of law, DEFENDANTS failed to comply with their regulatory requirement proximately causing injury to KHOFRI.

35. That at all times relevant hereto, DEFENDANTS owed a duty to KHOFRI pursuant to Title 22 C.C.R. §70211 and promised to provide nursing service that was organized, staffed, equipped and supplied to meet the needs of KHOFRI. DEFENDANTS did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

36. That at all relevant times hereto, DEFENDANTS owed a duty to KHOFRI pursuant to Title 22 C.C.R. §70213, and promised to develop, maintain, and implement written policies and procedures for patient care including assessment, nursing diagnosis, planning, intervention, and evaluation. DEFENDANTS did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

37. KAISER owed a duty to KHOFRI pursuant to Title 22 C.C.R. §70215(a)(1) to provide an ongoing patient assessment. DEFENDANTS did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

38. KAISER owed a duty to KHOFRI to provide planning and delivery of KHOFRI'S care including assessment, diagnosis, planning, intervention, and evaluation pursuant to Title 22

C.C.R. §70215(b). DEFENDANTS did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

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39. KAISER owed a duty to KHOFRI to provide a written, organized in service education program for its patient care personnel pursuant to Title 22 C.C.R. §70214. DEFENDANTS did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

40. KAISER owed a duty to KHOFRI to provide services with a sufficient budget and staffing to meet KHOFRI'S care needs pursuant to Title 22 C.C.R. §70217 and 42 C.F.R. §482.23(b). KAISER did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

41. KAISER owed a duty to KHOFRI to protect KHOFRI's right to be free from all forms of abuse pursuant to 42 C.F.R. §482.13(c)(3). KAISER did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

42. KAISER owed a duty to KHOFRI 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. KAISER did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

43. KAISER owed a duty to KHOFRI pursuant to 42 C.F.R. §482.42 to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. KAISER did not comply with their requirement of law in their care of KHOFRI thereby causing injury to KHOFRI.

44. KAISER owed a duty to KHOFRI pursuant to 42 C.F.R. §482.28(b)(2) in that nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. KAISER did not comply with their requirement of law in their care of KHOFRI thereby causing injury to

KHOFRI.

45. The DEFENDANTS owed a duty to KHOFRI, to provide him 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). The facility failed to meet their duty to KHOFRI thereby causing him injury.

46. VASONA owed a duty to KHOFRI to respect his right to be free from mental and physical abuse, which right is protected by 22 C.C.R. §72527(a)(9). VASONA failed to meet their duty to KHOFRI thereby causing him injury.

47. VASONA owed a duty to KHOFRI to notify a physician of any sudden and marked adverse change in signs, symptoms, or behavior exhibited by a patient, which right is protected by 22 C.C.R. §72311(3)(b). VASONA failed to meet their duty to KHOFRI thereby causing him injury.

48. VASONA owed a duty to KHOFRI to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity pursuant to 42 C.F.R. §483.20. VASONA failed to meet their duty to KHOFRI thereby causing him injury.

49. The DEFENDANTS owed a duty to KHOFRI to, and represented they would, provide services consistent with 42 U.S.C. § 1396r(b)(4)(C), to provide custodial and professional services to KHOFRI with sufficient budget and sufficient staffing to meet the needs of KHOFRI . The DEFENDANTS failed to meet their duty to KHOFRI thereby causing him injury.

50. VASONA owed a duty to, and represented they would, provide services to KHOFRI pursuant to 42 C.F.R. §483.30 and 22 C.C.R. §72329 to have sufficient number of personnel on duty at the facilities on a 24-hour basis to provide appropriate custodial and professional services to KHOFRI in accordance with KHOFRI resident care plans. VASONA did not provide these legally required services. VASONA failed to meet their duty to KHOFRI thereby causing him injury.

51. Title 22 C.C.R. §72311 and 42 C.F.R. §483.20 mandates that a skilled nursing

facility, such as VASONA, shall provide, and VASONA promised to provide KHOFRI 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. VASONA represented that they would provide services consistent with the regulations yet failed to do so causing injury to KHOFRI.

52. Title 22 C.C.R. §72315 mandates that a skilled nursing facility, such as VASONA, provide, and VASONA represented that they would provide each patient with good nutrition and with necessary fluids for hydration. VASONA represented that they would provide services consistent with the regulations yet failed to do so causing injury to KHOFRI.

53. Title 22 C.C.R. §72517 mandates that a skilled nursing facility, such as VASONA, 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, and preservation of resident dignity. VASONA represented that they would provide services consistent with the regulations yet failed to do so causing injury to KHOFRI.

54. 42 C.F.R. §483.65 mandates that a skilled nursing facility, such as VASONA, establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. VASONA represented that they would provide services consistent with the regulations yet failed to do so causing injury to KHOFRI.

55. 42 C.F.R. §483.13 mandates that a skilled nursing facility, such as VASONA, shall report "all alleged violations of involving mistreatment, neglect, or abuse, including injuries of an unknown source" to the administrator of the skilled nursing facility. In addition, a skilled nursing facility must have evidence that all alleged violations are thoroughly investigated and the results of all investigations must be reported to the administrator and to state officials and the department of public health. VASONA represented that they would provide services consistent with the regulations yet failed to do so causing injury to KHOFRI.

56. While KHOFRI was in the care and custody of DEFENDANTS, DEFENDANTS

recklessly neglected KHOFRI by breaching their duties of care owed to KHOFRI in failing to provide KHOFRI with the care and treatment to which he was entitled as a dependent citizen of California. These failures included, but are not limited to: failing to prevent the development of infections and urinary tract infections, failing to report his change of condition and providing timely care, failing to developing and implementing care plans, failing to provide hydration support to prevent dehydration, failing to treat the infections, failing to assist with personal hygiene resulting in skin breakdown to KHOFRI's body, failing to provide staff with the knowledge, skills and competencies to care for residents with infection, and the risks that exist for potential weight loss, and failing to prevent KHOFRI from experiencing pain and suffering.

57. The injuries suffered by KHOFRI were the result of the DEFENDANTS' illegal and reckless plan and effort to cut costs in the operation of their facilities and in other ways as alleged, to usurp the sole legal responsibility of the facility Administrator and governing body in the planning and operation of the facilities, and thereby in the undertaking assumed all of the responsibilities of the facilities, including the duty of due care and compliance with all legal standards applicable to general acute care hospitals and skilled nursing facilities. In doing so, the DEFENDANTS knew or should have known that their staff would be unable to comply with the standards for care set forth above, and other legal standards, all at the expense of their residents such as KHOFRI. Integral to their plan was the practice and pattern of staffing 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 and patients and most specifically, KHOFRI.

58. At all times herein mentioned, the DEFENDANTS had actual and/or constructive knowledge of the unlawful conduct and business practices alleged herein, yet represented to the general public and KHOFRI that their facilities would provide care that met all applicable legal standards. Moreover, such unlawful business practices were mandated, directed, authorized, and/or personally ratified by the officers, directors and/or managing agents of the DEFENDANTS as set

forth in paragraph 9 and 10, and other management personnel whose names are presently unknown to the KHOFRI and according to proof at time of trial.

59. The DEFENDANTS, by and through the corporate officers, directors and managing agents set forth in paragraph 9 and 10, and other corporate officers and directors presently unknown to KHOFRI and according to proof at time of trial, authorized and ratified the conduct of their co-defendants in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing, in both number and training, the relationship between understaffing and sub-standard provision of care to the residents, including KHOFRI, and the DEFENDANTS practice of being issued deficiencies by the State of California's Department of Public Health in the State of California. Furthermore, the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 9 and 10, and others presently unknown to KHOFRI 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 the residents, including KHOFRI and insufficiency of financial budgets to lawfully operate their facilities. The ratification by the DEFENDANTS itself, is that ratification of the customary practice and usual performance of the DEFENDANTS as set forth in *Schnafel v. Seaboard Finance Company,* (1951) 108 Cal.App.2d 420, 423-424.

60. Upon information and belief, the DEFENDANTS enacted, established, and implemented the financial plan and scheme which led to their facilities being understaffed, in both number and training, by way of imposition of financial limitations on their facilities 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 KHOFRI. These choices and decisions were, and are, at the express direction of the management personnel including the corporate officers and directors enumerated in paragraph 9 and 10, and others presently unknown to KHOFRI and according to proof at time of trial, having power to bind as set forth in *McInerney v. United Railroads of San Francisco,* (1920) 50 Cal.App.538, 549; *Bertero v. National General Corporation* (1974) 13 Cal. 3d 43, 67.

61. The corporate authorization and enactment of the DEFENDANTS, alleged in the

preceding paragraphs, constituted the permission and consent of the facilities' misconduct by the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 9 and 10, and others presently unknown to KHOFRI and according to proof at time of trial, who had within their power the ability and discretion to mandate that they employ adequate staff to meet the needs of their patients, including KHOFRI, as required by applicable rules, laws and regulations governing the operation of general acute care hospitals and skilled nursing facilities in the State of California. The conduct constitutes ratification of the facilities'' misconduct by DEFFENDANTS, which led to injury to KHOFRI as set forth in *O'Hara v. Western Seven Trees Corp.,* (1977) 75 Cal.App.3d. 798, 11806 and *Kisesky v. Carpenters Trust for So. Cal* (1983) 144 Cal.App.3d 222,235.

62. Plaintiffs have reason to believe that the focus and intent to carry out the above strategies to increase revenues and profit margins and to decrease costs caused widespread neglect of patients, including KHOFRI.

63. Due to the DEFENDANTS' direct conduct, as well as their practice of aiding and abetting the wrongful acts and omissions alleged herein, KHOFRI suffered malnutrition, dehydration, sepsis, and other infections, and death. These injuries were not the product of isolated failures but rather the result of prolonged neglect and abuse that arose out of four (4) calculated business practices by DEFENDANTS: (1) Understaffing; (2) relentless marketing and sales practices to increase resident and patient census despite knowledge of ongoing care deprivation; (3) ongoing practice of utilizing unqualified and untrained employees who, by law, were forbidden by law to administer nursing care to residents; and (4) 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.

64. The injuries suffered by KHOFRI and the misconduct by the DEFENDANTS, and each of them, as alleged herein, resulted from the DEFENDANTS failure to provide basic custodial care to KHOFRI.

65. Thus, the specified acts of neglect alleged herein constitute neglect of "custodial"

duties, not “professional” duties. No professional license is required to ensure that KHOFRI was cleaned, supervised, monitored, and provided with preventative measures, provided with proper nutrition, provided with proper hydration or otherwise not neglected. No professional license is required to ensure that DEFENDANTS’ facilities not be underfunded or inadequately staffed. In sum, the acts and omissions alleged herein are acts or omissions related to "custodial" services, not “professional” services.

66. The violations of state and federal laws and regulations as specifically set forth herein as alleged against DEFENDANTS are not meant to limit the generality of the allegations contained herein, but are merely illustrative of the depth of the DEFENDANTS’ malicious, oppressive, fraudulent and/or reckless conduct.

67. The state and federal regulations set forth hereinabove set the standard of care in the nursing home industry and help define the care duty to patients, and said regulations are appropriate in determining whether the facilities conduct amounted to physical abuse, neglect, recklessness, oppression, or malice. (*Lindsey Fenimore v. Regents of the University of California* (2016) 245 Cal.App.4th 1339, *Norman v. Life Care Centers of America, Inc.* (2003) 107 Cal.App.4th 1233, and *Gregory v. Beverly Enterprises* (2000) 80 Cal.App. 4th 514).

68. As a direct result of the DEFENDANTS conduct as alleged herein, DEFENDANTS allowed KHOFRI to suffer pain, indignity, humiliation, and injury, which were entirely preventable had DEFENDANTS provided enough sufficiently trained staff at their facilities to provide KHOFRI with the amount of care, monitoring, and supervision that state and federal regulations required.

69. In addition to their direct liability for the abuse and neglect of KHOFRI, the DEFENDANTS ratified the mistreatment of KHOFRI. Knowing of KHOFRI’s injuries, and knowing of his neglect, DEFENDANTS failed to terminate, discipline, reprimand, or otherwise repudiate the acts and omissions of any employee due to or based upon the care, treatment, monitoring or supervision, or lack thereof, rendered to KHOFRI.

70. KHOFRI suffered pain and suffering as a result of the DEFENDANTS’ abuse and neglect as alleged herein. DEFENDANTS are responsible for that pain and suffering as well as all

subsequent damages and expenses that were incurred in treating KHOFRI for the injuries she suffered at the hands of DEFENDANTS.

SECOND CAUSE OF ACTION

VIOLATION OF RESIDENTS RIGHTS

[Against VASONA and DOES 1-100]

71. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 70 above as though set forth below.

72. *Health and Safety Code* §1430(b) provides that "a current or former resident or patient of a skilled nursing facility as defined in subdivision (c) of section 1250 . . . may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients' Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations [which incorporates *Health and Safety Code* §1599.1], or any other right provided for by federal or state law or regulation."

73. At all relevant times, GOLDEN OAK HOLDINGS, LLC was the licensee of skilled nursing facility known as VASONA CREEK HEALTHCARE CENTER.

ALLEGATIONS AGAINST VASONA

74. For the reasons set forth above and incorporated herein by reference, and for further reasons as will be presented at trial, VASONA failed to treat KHOFRI with respect, consideration, and full recognition of dignity in care of her personal needs as required by the Patient's Bill of Rights and other rights provided by federal or state law or regulation. VASONA and violated these rights of KHOFRI, including, but not limited to:

a. Title 22 C.C.R. §72527(a)(12), which mandates that a resident shall be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs. VASONA violated this regulation by failing to prevent TAMAIZO from developing pressure ulcers during her residency at VASONA.

b. Title 22 C.C.R. §72527(a)(25), which incorporates by reference the rights enumerated in *Health and Safety Code* §1599.1, which mandates that the "facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility ." (*Health*

and Safety Code §1599.1(a)). VASONA violated this regulation by understaffing it's facility in quality and quantity of staff during KHOFRI's residency.

c. Title 22 C.C.R. §72527(a)(25), which incorporates by reference the rights enumerated in *Health and Safety Code* §1599.1, which mandates that "The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders." (*Health and Safety Code* §1599.1(c). VASONA violated this regulation by failing to prevent KHOFRI from developing malnutrition, dehydration, sepsis, and other infections during his residency at VASONA.

d. Title 42 C.F.R. §483.25, which mandates that a skilled nursing facility, such as the facility, must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. VASONA violated this regulation by failing to prevent KHOFRI from developing malnutrition, dehydration, sepsis, and other infections during his residency at VASONA.

e. Title 42 C.F.R. §483.10(b)(11), stating that residents have the right to have all significant changes of condition reported to them, their families, and their physicians immediately. VASONA violated this regulation by failing to advise KHOFRI's family of the existence and nature of his malnutrition, dehydration, sepsis, and other infections during his residency at VASONA.

f. Title 22 C.C.R. §72315(g), which mandates that a skilled nursing facility provide that each patient requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating. VASONA violated this regulation by failing to prevent KHOFRI from becoming malnourished, dehydrated during his residency at VASONA.

g. Title 22 C.C.R. §72315(h), which mandates that a skilled nursing facility provide that each patient shall be provided with good nutrition and with necessary fluids for hydration. VASONA violated this regulation by failing to prevent KHOFRI from becoming malnourished

and dehydrated during his residency at VASONA.

75. While a resident of VASONA, KHOFRI's rights were repeatedly violated. KHOFRI developed malnutrition, dehydration, sepsis, and other infections as a result of the above mentioned violations by VASONA.

76. Most notably while at VASONA, KHOFRI developed and suffered from malnutrition, dehydration, sepsis, and other infections.

77. These injuries would not have occurred had VASONA simply adhered to the applicable rules, laws, and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility.

78. One of the purposes of *Health and Safety Code* §1430(b) is to protect against the type of injuries that KHOFRI sustained.

79. KHOFRI is a member of a group of persons that *Health and Safety Code* §1430(b) is intended to protect.

80. Among other remedies, *Health and Safety Code* §1430(b) authorizes the recovery of damages up to $500.00 and mandatory attorneys' fees and costs. These remedies are cumulative to any other remedies provided by law.

THIRD CAUSE OF ACTION

WRONGFUL DEATH

[Against All Defendants, and DOES 1-200]

81. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 80 above as though set forth below.

82. Dorida Yaghoub, individually, is the surviving heirs of decedent KHOFRI.

83. DEFENDANTS owned statutory and common law duties to KHOFRI as more fully set forth above.

84. That the DEFENDANTS failed to meet their statutory and common law duties to KHOFRI as more fully set forth above.

85. As a proximate result of negligence and "neglect" as that term is defined in *Welfare & Institutions Code* §15610.57 as more particularly alleged above perpetrated by all of the

DEFENDANTS, and each of them, KHOFRI died on January 31, 2018.

86. Prior to the death of KHOFRI, Dorida Yaghoub, individually, enjoyed the love, society, comfort, and attention of KHOFRI.

87. As a proximate result of the negligent acts (both negligence and neglect as that term is defined in *Welfare & Institutions Code* §15610.57) of all of the DEFENDANTS as alleged herein, DORIDA KHOFRI, individually, has sustained loss of the society, comfort, attention, and love of KHOFRI in a sum according to proof at trial and within the jurisdictional limits of this Court

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 attorney's fees and costs pursuant to *Welfare and Institutions Code* §15657(a) (As to the First Cause of Action only);
4. For exemplary and punitive damages pursuant to *Civil Code* §3294 (As to the First Cause of Action only);
5. For attorney's fees and costs pursuant to *Health and Safety Code* §1430(b) (As to the Second Cause of Action only);
6. For costs of suit; and
7. For such other and further relief as the Court deems just and proper.

DATED: January 22, 2019

PECK LAW GROUP, APC

By: _____

Adam J. Peck, Esq.
Attorneys for Plaintiffs