McNULTY LAW FIRM
827 Moraga Drive
Bel Air, California 90049
Telephone: (310) 471-2707
Facsimile: (310) 472-7014
Peter J. McNulty, SBN: 89660
Sarvnaz Mackin, SBN: 261232
Attorneys for Plaintiff

P. Jauregui

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA 113CV241604

WILLIE MAE PENNINGTON, by and through her Guardian ad Litem, TERESA PENNINGTON,

Plaintiffs,

vs.

KAISER PERMANENTE- SANTA CLARA, KAISER FOUNDATION HEALTH PLAN, INC., VALLEY HOUSE REHABILITATION CENTER, and DOES 1 through 100, Inclusive.

Defendants.

CASE NO.:

COMPLAINT FOR DAMAGES AGAINST:

KAISER PERMANENTE- SANTA CLARA, KAISER FOUNDATION HEALTH PLAN, INC. and DOES 1 THROUGH 50 FOR:
(1) NEGLIGENCE;

VALLEY HOUSE REHABILITATION CENTER AND DOES 51 THROUGH 98 FOR:
(2) NEGLIGENCE; and
(3) ELDER ABUSE/DEPENDENT ADULT CIVIL PROTECTION ACT ["EADACPA"]

COME NOW the Plaintiff, WILLIE MAE PENNINGTON, by and through her Guardian ad Litem, TERESA PENNINGTON, who alleges as follows:

PARTIES

1. At all times material, Plaintiff TERESA PENNINGTON was the guardian of WILLIE MAE PENNINGTON (hereinafter "Ms. Pennington"), who is a resident of Milpitas, California. TERESA PENNINGTON, at all times material, was the daughter of WILLIE MAE PENNINGTON.

2. At all times material, Defendants KAISER PERMANENTE- SANTA CLARA and KAISER FOUNDATION HEALTH PLAN, INC. ("KAISER") were a California corporation engaged in the business of providing care and treatment at 700 Lawrence Expressway, Santa Clara, CA 95051. Ms. Pennington was a patient at KAISER from April 10, 2012 through April 21, 2012 and from May 7, 2012 through May 22, 2012.

3. At all times material, Defendant VALLEY HOUSE REHABILITATION CENTER ("V.H.R.C.") was a California corporation engaged in the business of providing care and treatment at 991 Clyde Avenue, Santa Clara, CA 95054. Ms. Pennington was a patient at V.H.R.C. from April 21, 2012 through May 7, 2012.

4. The true names and capacities, whether individual, corporate, associate, or otherwise, of the Defendants designated herein as DOES 1 through 100, inclusive, are presently unknown to Plaintiff, who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereupon alleges, that each of the Defendants designated herein as a "Doe" is legally responsible for the events and happenings hereinafter referred to, and proximately caused or contributed to the injuries and damages as hereinafter described. Plaintiff will seek leave of the Court to amend this complaint, in order to show the true and names and capacities of such parties, when each has been ascertained.

5. At all times herein mentioned, some of the Defendants were the agent, partner, joint venture, and/or employee of the remaining Defendants, and were acting within the course and scope of such agency, partnership, joint venture, and/or employment. Furthermore, in engaging in the conduct described below, the Defendants were all acting with the knowledge, consent, approval, and/or ratification of their co-Defendants. Once these defendants are identified, the Complaint will be amended accordingly.

6. Defendants and each of them, were at all relevant times, "care custodians" of Ms. Pennington as defined in §15610.170 of the Welfare & Institutions Code.

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FIRST CAUSE OF ACTION

(NEGLIGENCE Against Defendants KAISER PERMANENTE- SANTA CLARA, KAISER FOUNDATION HEALTH PLAN INC., and DOES 1 through 50, Inclusive)

7. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1 through 6 above as though fully set forth herein.

8. On or about April 10, 2012, Ms. Pennington was admitted to KAISER as an 80-year old elder with diabetes and gangrene to her left foot and to her right big toe who had recently suffered a stroke (causing the right side of her face to droop). As a result of these conditions, Ms. Pennington had weakness to all her extremities and was unable to ambulate. Additionally, on April 18, 2012, Ms. Pennington became non-verbal and was unable to make her needs and thoughts known. All of the above conditions rendered her totally dependent on staff employees from KAISER for all Activities of Daily Living ("ADLs") including bathing, grooming, hygiene, turning and repositioning, pressure relief, nutrition, hydration, care planning and wound care.

9. At all times material KAISER's staff were under a duty to use the care and skill ordinarily exercised in like cases by reputable members of the medical profession practicing under the similar circumstances in providing standard medical care and standard custodial care to Ms. Pennington. Furthermore, at all times material, Defendant KAISER's staff were under a duty to use such skill, prudence, and diligence as other similar individuals and institutions commonly possess and exercise in the assessment, care and treatment of residents.

10. While Ms. Pennington was under KAISER's staff's primary care, KAISER's staff and DOES 1 through 50 failed to exercise such skill, prudence and diligence in the assessment, care, and treatment of Ms. Pennington. As a direct and proximate result of said conduct, Ms. Pennington endured unnecessary and avoidable pain and suffering from the injuries described below.

11. When Ms. Pennington was admitted to KAISER on April 10, 2012, she did not have any decubitus or pressure ulcers. However, while Ms. Pennington was a patient at KAISER

from April 10, 2012 to April 21, 2012, KAISER's staff failed to provide her assistance with all activities of daily living, including, but not limited to, pressure relief, wound care and daily hygiene. As a result, Ms. Pennington developed a Stage II sacral decubitus ulcer measuring 2.8 x 2.0 cm during her short 11-day admission to KAISER. Decubitus ulcers are wholly avoidable and develop as a result of the patient being subjected to unrelieved pressure for prolonged periods of time. Patients, like Ms. Pennington, who are completely reliant on staff for assistance with ADLs develop decubitus ulcers when staff fail to turn and reposition a patient, fail to provide pressure relief, fail to provide wound care and fail to provide daily hygiene.

12. On or about April 21, 2010, Ms. Pennington was discharged from KAISER to V.H.R.C. Although Ms. Pennington was discharged with a Stage II sacral decubitus ulcer measuring 2.8 x 2.0 cm, KAISER's Discharge Summary and Notes failed to document the existence of any pressure sores on Ms. Pennington at the time of discharge or throughout her entire admission at KAISER. Nonetheless, upon her admission to V.H.R.C. on April 21, 2010, staff documented that Ms. Pennington had a 2.8 x 2.0 cm Stage II sacral decubitus ulcer. As Ms. Pennington did not have any decubitus or pressure ulcers upon her admission to KAISER, it is clear that she developed this Stage II decubitus ulcer while she was under KAISER's staff's primary care. Ms. Pennington developed this Stage II decubitus on her sacrum which was not treated nor documented at KAISER and eventually developed into a serious Stage IV decubitus ulcer measuring 9.0 x 10.0 cm that required painful surgical debridement.

13. As a result of KAISER's staff's inability to provide adequate custodial care to Ms. Pennington as described herein, she was not turned and repositioned regularly, received inadequate pressure relief, received inadequate skin assessments, and did not receive adequate daily hygiene, nutrition, hydration or wound care.

14. As a proximate result of KAISER's staff's repeated failures to provide adequate care, Pennington continues to suffer from the decubitus ulcer she developed at KAISER which contributed to her pain and suffering. All of the above noted injuries developed while Ms. Pennington was a resident at KAISER, highly contributed to her pain and suffering, and increased permanently Ms. Pennington's morbidity.

15. At all times material, Defendant KAISER, through its agents and employees, was under a duty to use such skill, prudence, and diligence as others similar institutions commonly possess and exercise in the assessment, care and treatment of patients.

16. Between the above dates, KAISER, through its agents and employees, and DOES 1 through 50 failed to exercise such skill, prudence and diligence in the assessment, care, and treatment of Mrs. Pennington. As a direct and proximate result of said KAISER's staffs acts and omissions, Mrs. Pennington suffered from the development of a Stage II sacral decubitus ulcer measuring 2.8 x 2.0 cm.

17. As a further direct and proximate result of said KAISER's staff's acts and omissions, Ms. Pennington incurred economic damages in a sum to be determined according to proof, and Ms. Pennington's physical condition continued to decline to such a degree that today, she remains in constant pain.

18. Defendant KAISER's staff's acts and omissions in failing to provide care planning, turning and repositioning, wound care, pressure relief and daily hygiene and failure to hire adequately trained professionals to provide necessary services and goods to Ms. Pennington fell far below the applicable standard of care for the community. Furthermore, KAISER's staff's failed to adequately document and treat Ms. Pennington's injuries described above by allowing her to develop avoidable skin breakdowns.

19. The name of the physicians employed by, partnered with, or agents of KAISER and/or DOES 6 through 15 are presently unknown to Plaintiff, who therefore designates these physicians as DOES 16 through 20. Plaintiff is informed and thereupon alleges that DOES 16 through 20 were negligent in their care and treatment of Ms. Pennington, including, but not limited to, their failure to provide and/or order timely and necessary medical treatment, failure to provide timely consultation/direction of care as to Ms. Pennington, failure to timely review Ms. Pennington's medical records, failure to timely ensure that Ms. Pennington was being administered the proper and adequate medications, and failure to properly and competently oversee Mrs. Pennington's medical treatment. DOES 16 through 20's negligent acts and

omissions fell below the applicable standard of care and proximately caused or contributed to the injuries and damages as described above.

SECOND CAUSE OF ACTION

(NEGLIGENCE Against Defendants VALLEY HOUSE REHABILTIATION CENTER and DOES 51 through 98, Inclusive)

20. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1 through 19 above as though fully set forth herein.

21. On or about April 21, 2012, Ms. Pennington was admitted to V.H.R.C. as an 80-year old elder with diabetes and gangrene to her left foot and to her right big toe who had recently suffered a stroke (causing the right side of her face to droop). As a result of these conditions, Ms. Pennington had weakness to all her extremities and was unable to ambulate. Additionally, on April 18, 2012, Ms. Pennington became non-verbal and was unable to make her needs and thoughts known. All of the above conditions rendered her totally dependent on staff employees from V.H.R.C. for all Activities of Daily Living ("ADLs") including bathing, grooming, hygiene, turning and repositioning, pressure relief, nutrition, hydration, care planning and wound care.

22. At all times material V.H.R.C., through its agents and employees, was under a duty to use the care and skill ordinarily exercised in like cases by reputable members of the profession practicing under the similar circumstances in providing standard medical care and standard custodial care to Ms. Pennington. Furthermore, at all times material, Defendant V.H.R.C. was under a duty to use such skill, prudence, and diligence as other similar individuals and institutions commonly possess and exercise in the assessment, care and treatment of residents.

23. While Ms. Pennington was under V.H.R.C.'s staff's primary care, V.H.R.C. and DOES 51 through 98 failed to exercise such skill, prudence and diligence in the assessment, care, and treatment of Ms. Pennington. As a direct and proximate result of said conduct, Ms.

Pennington endured unnecessary and avoidable pain and suffering from the injuries described below.

24. When Ms. Pennington was admitted to V.H.R.C. from KAISER on April 21, 2012, she had a Stage II sacral decubitus ulcer measuring 2.8 x 2.0 cm. Although Ms. Pennington was only a resident at V.H.R.C. for 16 days, her sacral decubitus ulcer significantly deteriorated in both size and stage during her short residency at the facility. By April 30, 2012, Ms. Pennington's 2.8 x 2.0 cm Stage II sacral decubitus ulcer had deteriorated in size to 4.2 x 4.0 cm and, by May 7, 2012, her ulcer deteriorate in both size and stage to an unstageable decubitus ulcer measuring a horrific 9.0 x 10.0 x UTD cm with odor and exudates. In addition to the deterioration of her sacral decubitus ulcer, Ms. Pennington's right big toe also developed necrotic tissue by May 7, 2012. The deterioration of decubitus ulcers is avoidable if a resident is provided with adequate and timely pressure relief, wound care, daily hygiene and nutrition and hydration. V.H.R.C.'s staff knew that Ms. Pennington's underlying conditions made her completely reliant for assistance with all activities of daily living; however, despite this knowledge, V.H.R.C.'s staff failed to provide Ms. Pennington with assistance with all activities of daily living, left her lying in the same position for prolonged periods of time, failed to provide her with pressure relief and wound care, failed to provide her with daily hygiene and failed to failed to place her on a specialty or low air loss mattress. As a result of V.H.R.C.'s staff's neglectful acts and omissions, Ms. Pennington's sacral decubitus ulcer became necrotic, deteriorated in stage and more than trebled in size and her right big toe developed necrotic tissue and she had to undergo painful surgical debridement of her sacral decubitus ulcer when she was readmitted to KAISER on May 7, 2012.

25. In addition to the deterioration of Ms. Pennington's skin integrity, Ms. Pennington also became severely malnourished and dehydrated while under V.H.R.C.'s staff's primary care, causing her to loose an unhealthy amount of weight and become anemic. When Ms. Pennington was admitted to V.H.R.C., V.H.R.C.'s staff knew that her reduced ability to feed herself, her swallowing problem and her cognitive decline, as well as having just suffered a stroke, made her completely reliant on staff for assistance with eating, daily nutrition and daily hydration.

However, despite this knowledge, V.H.R.C.'s staff failed to provide Ms. Pennington with assistance with eating, failed to provide her with the necessary nutrition and failed to provide her with the necessary hydration. As a direct result of these acts and omissions, Ms. Pennington, who at 5'2" weighed a mere 131.1 lbs upon her admission to V.H.R.C., lost 6.6 lbs in just 9 days shortly after her admission to V.H.R.C. On May 7, 2012, when Ms. Pennington was rushed from V.H.R.C. to KAISER's emergency room, she was diagnosed with anemia, a direct result of having become malnourished and dehydrated and having lost a significant and unhealthy amount of weight while under V.H.R.C.'s primary care.

26. Additionally, Ms. Pennington developed sepsis while under V.H.R.C.'s primary care. When Ms. Pennington was admitted to V.H.R.C. on April 21, 2012, she was free from any infections. However, when Ms. Pennington was readmitted to KAISER from V.H.R.C. on May 7, 2012, lab collected upon her admission confirmed that she had contracted sepsis while she was under V.H.R.C.'s primary care. This nosocomial infection was not only avoidable had V.H.R.C. staff provided Ms. Pennington with daily hygiene, kept her clean and dry, and followed basic infection control policies and procedures but the infection placed additional stress to Ms. Pennington's fragile health and wellbeing. In addition to sepsis, Ms. Pennington also developed pneumonia while under V.H.R.C.'s primary care. Both the development of sepsis and pneumonia caused Ms. Pennington to be rushed to KAISER on May 7, 2012 with a diagnosis of leuocytosis, a result of infection.

27. As a result of V.H.R.C.'s staff's inability to provide adequate custodial care to Ms. Pennington as described herein, she was not turned and repositioned regularly, received inadequate pressure relief, received inadequate skin assessments, did not receive adequate daily hygiene, nutrition and hydration or wound care.

28. As a further proximate result of V.H.R.C.'s staff's repeated failures to provide adequate care, Ms. Pennington continues to suffer from the development of a sacral decubitus ulcer which significantly deteriorated while she was under V.H.R.C.'s primary care and which significantly contributed to her pain and suffering. All of the above noted injuries developed

while Ms. Pennington was a resident at V.H.R.C., highly contributed to her pain and suffering and permanently increased Ms. Pennington's morbidity.

29. At all times material, Defendant V.H.R.C.'s staff's was under a duty to use such skill, prudence, and diligence as other employees of similar institutions commonly possess and exercise in the assessment, care and treatment of patients. Between the above dates, V.H.R.C.'s staff's and DOES 51 through 98 failed to exercise such skill, prudence and diligence in the assessment, care, and treatment of Mrs. Pennington. As a direct and proximate result of said acts and omissions, Mrs. Pennington suffered from the deterioration of her sacral decubitus ulcer from a Stage II ulcer measuring 2.8 x 2.0 cm to a necrotic unstageable ulcer measuring 9.0 x 10.0 x UTD cm with odor and exudates, development of necrotic tissue to her right big toe, the contraction of sepsis and pneumonia, and the development of malnutrition and dehydration, resulting in unhealthy weight loss.

30. As a further direct and proximate result of said V.H.R.C.'s staff's acts and omissions, Ms. Pennington incurred economic damages in a sum to be determined according to proof, and Ms. Pennington's physical condition continued to decline to such a degree that today, she remains in constant pain.

31. Defendant V.H.R.C.'s staff's acts and omissions in failing to provide care planning, turning and repositioning, wound care, pressure relief and daily hygiene and failure to hire adequately trained professionals to provide necessary services and goods to Ms. Pennington fell far below the applicable standard of care for the community. Furthermore, V.H.R.C.'s staff's failed to adequately document and treat Ms. Pennington's injuries described above by allowing her to develop avoidable skin breakdowns, develop pneumonia and sepsis and become severely malnourished and dehydrated.

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THIRD CAUSE OF ACTION

(Elder and Dependent Adult Abuse, Welfare & Institutions Code sections 15600 et seq., Against Defendants VALLEY HOUSE REHABILITATION CENTER and DOES 51 through 98, Inclusive)

32. Plaintiffs re-allege and incorporate by reference the allegations in paragraphs 1 through 31 above as though fully set forth herein.

33. At all times material, Ms. Pennington was an elder and Defendant V.H.R.C. was a "care custodian" as defined by the Welfare & Institutions Code.

34. At all times material, in owning, operating, managing, and/or supervising an acute care facility, Defendant V.H.R.C. were required to provide appropriate health care, room and board, 24-hour supervision, and personal care and assistance to its patients. The care and supervision required of said Defendants includes, but is not limited to: assistance with personal care and hygienic health needs, as more specifically described in Health & Safety Code §1569.20(d); assistance with instrumental activities of daily life, as defined in Health & Safety Code §1569.20(f); and monitoring of its patients' activities, so as to ensure its patients' health, safety and welfare.

35. While she was under V.H.R.C.' primary care, Ms. Pennington was a 80 year old elder resident with diabetes and gangrene to her left foot and to her right big toe who had recently suffered a stroke (causing the right side of her face to droop). All of these conditions rendered Ms. Pennington completely dependent on staff from Defendant V.H.R.C. for all Activities of Daily Living ("ADLs") including bathing, grooming, hygiene, turning and repositioning, nutrition, hydration and wound care.

36. Although Defendant V.H.R.C.' staff knew that Ms. Pennington was a maximum assist resident who was completely dependent on staff for total assistance with all ADLs, Defendant V.H.R.C. staff, willfully and with conscious disregard to Ms. Pennington's rights and safety, abandoned and neglected Ms. Pennington by leaving her unattended for prolonged periods of time, causing her skin to avoidably breakdown and her decubitus ulcers to deteriorate,

deprived her of goods and services to avoid physical harm and mental suffering by failing to turn and reposition her and failing to provide her with pressure relief and wound care; physically abused her by depriving her of necessary food and water, causing her to become malnourished and dehydrated and to lose an unhealthy amount of weight; and deprived her of daily hygiene to avoid the contraction of critical infections. Each of these avoidable injuries occurred as a direct result of V.H.R.C.'s staff's neglectful and malicious acts and omissions towards Ms. Pennington.

37. As a result of V.H.R.C.'s staff's neglect and deprivation of necessary goods and services, Ms. Pennington's sacral decubitus ulcer deteriorated significantly from a Stage II ulcer measuring 2.8 x 2.0 cm to a necrotic unstageable ulcer measuring 9.0 x 10.0 x UTD cm with odor and exudates, developed of necrotic tissue to her right big toe, developed sepsis and pneumonia, and became malnourished and dehydrated, resulting in unhealthy weight loss and development of anemia.

38. V.H.R.C. knew that its neglectful and malicious acts and omissions would create a substantial risk of injury to Ms. Pennington, yet failed to take any action to correct or rectify those failures. V.H.R.C.'s acts of putting profits over the health and safety of its patients, its failure to provide necessary nursing staff, its failure to provide trained staff (in both number and quality) and its failure to provide daily hygiene, turning and repositioning, nourishment and hydration, wound care and pressure relief, was a significant cause in increasing Ms. Pennington's morbidity. All of the above noted injuries developed as a result of V.H.R.C. and its staff's neglectful acts and omissions and highly contributed to her pain and suffering, and permanently increased her morbidity.

39. All the injuries sustained by Ms. Pennington while under V.H.R.C.'s primary care were entirely preventable had V.H.R.C. provided enough sufficiently trained staff to provide Ms. Pennington with the amount of care that State and Federal regulations required. Defendant V.H.R.C. owed a duty to provide a sufficient budget and sufficient staff to meet the care needs of their residents, including Ms. Pennington. Additionally, all of the above severe injuries

exacerbated her pre-existing medical conditions, and caused her to suffer physical harm and mental suffering, all to Plaintiff's general damage in a sum to be determined.

40. In undertaking to care for Ms. Pennington, Defendant V.H.R.C. and DOES 6 through 45 and each of them, acknowledged and promised to protect Ms. Pennington from primary health and safety risks associated with the care of dependent residents, and acknowledged, in fact, that such protection was a specific, if not the primary, purpose for admission.

41. It is Plaintiff's contention that at all times relevant herein, Defendant V.H.R.C. conceived of and implemented a plan to wrongfully increase its business profits, at the expense of residents such as Ms. Pennington. Integral to this plan was the custom and practice of Defendant staffing its facility with an insufficient number of care personnel, many of whom were not properly trained nor qualified to care for the dependent adults whose lives were entrusted to them. The understaffing and lack of training was designed so as to reduce labor costs and to increase profits, and resulted in the physical abuse and neglect of many residents of the facility, and most specifically, Ms. Pennington.

42. The acts and occurrences as alleged herein on the part of Defendant V.H.R.C. were directed by, authorized by, and/or ratified by various officers, directors, administrators and managing agents of Defendant V.H.R.C. and by others whose names are presently unknown to Plaintiffs and are therefore named herein as DOES 80 through 89.

43. Defendants, by and through corporate officers, directors, administrators and managing agents of Defendant V.H.R.C. and by others whose names are presently unknown to Plaintiff and therefore named herein as DOES 80 through 89, directed, authorized and/or ratified the conduct of all Defendant V.H.R.C., in that they were aware of the under-staffing at V.H.R.C., in both number and training, the relationship between the under-staffing and the neglectful, abusive or deprived care to patients of V.H.R.C., including Ms. Pennington. Furthermore, Defendant V.H.R.C. by and through its corporate officers and directors, and by other whose names are presently unknown to the Plaintiff and, therefore, named herein as DOES 80 through

89, directed, authorized and/or ratified the conduct of their co-defendants in that they were aware that such under-staffing and deficiencies would lead to injury to residents of the facility, including Ms. Pennington, and the insufficiency of financial budgets to lawfully operate V.H.R.C..

44. Based on information and belief, Defendant V.H.R.C. acted or failed to act by and through its administrator, who is/was a managing agent pursuant to Health and Safety Code Section 1569, et seq., and other managing personnel, including but not limited to the Director of Nursing, the 'Regional Vice President of Operations,' the 'Regional Clinical Nurses,' and the 'Regional Care Plan Specialists,' and other individuals currently not known to the Plaintiffs, who oversaw the day-to-day operations of V.H.R.C..

45. During Ms. Pennington's residency at V.H.R.C., V.H.R.C. additionally had duties under federal and state laws, which were designated for the benefit of dependent residents, such as Ms. Pennington, to provide for and to protect patients' health and welfare. V.H.R.C. also had a common law duty to provide for Ms. Pennington's health and welfare. Without limiting the generality of the foregoing, said Defendants had a duty with respect to Ms. Pennington health and welfare to:

a. Accurately monitor and provide for Ms. Pennington's health, comfort, and safety;

b. Carry out physician's orders with respect to prescribed medication;

b. Attend to and maintain Ms. Pennington's personal hygiene;

c. Ensure that Ms. Pennington received appropriate nutrition, liquids, therapy, medications and acceptable supplements, to maintain and improve her health; and

d. Maintain trained, qualified, and licensed nursing and other staffing at levels adequate to meet Ms. Pennington's needs.

46. Moreover, Defendant V.H.R.C. had a duty, under applicable federal and state laws, to provide for and to protect Ms. Pennington's health and welfare. Said Defendant also had a common law duty to provide for the health and welfare of Ms. Pennington. Without limiting the

generality of the foregoing, said Defendant had the specific duties itemized in the incorporated paragraphs herein above and including, but not limited to the following:

a. The facility must provide each resident with sufficient fluid intake to maintain proper nutrition, hydration and health.

b. Care plans shall address the comprehensive needs of the resident. Care plans shall be followed. Care plans shall be revised quarterly as resident needs dictate and shall take into consideration the fact that medications must be administered and timely given.

c. Facility staff shall be knowledgeable in caring for the aged, frail and disabled. Staff shall demonstrate competency in skills and techniques necessary to care for the residents' needs, as identified through the residents' assessments, and described in the plan of care.

47. During Ms. Pennington's residency at V.H.R.C., V.H.R.C. engaged in a continuing pattern of tortious misconduct, which resulted in multiple breaches of the above-noted duties owed to patients such as Ms. Pennington. This continuing pattern of tortious misconduct included, but was not limited to, V.H.R.C. and its staff's failure in providing Ms. Pennington with necessary goods and services, such as turning and repositioning, pressure relief and wound care; failure in ensuring that Ms. Pennington remained hydrated and nourished; failure in leaving Ms. Pennington unattended for extended periods of time and allowing her to lie in the same position for prolonged periods of time; and failure to provide Ms. Pennington with daily hygiene. These continuing breaches of performing these duties were intentional and/or in conscious disregard of the probability that severe harm would result to Ms. Pennington, particularly as V.H.R.C. staff were aware that Ms. Pennington was a maximum assist resident. As a consequence of the course of conduct described above, Ms. Pennington developed horrific decubitus ulcers, developed critical infections including sepsis and pneumonia, developed significant malnutrition and dehydration, resulting in unhealthy weight loss and anemia.

48. The above-described conduct of said Defendants, and each of them, constitutes multiple violations of Penal Code §368(a)-(b), and further amounts to a continuing pattern of dependent abuse.

49. The personnel at V.H.R.C. intentionally acted to cover up the existence and cause of the injuries and conditions described in the proceeding subparagraphs, by failing or refusing to investigate and document such patient care issues, and by failing or refusing to notify Ms. Pennington's daughter, Teresa Pennington, who held her power of attorney.

50. At all times herein mentioned, as more specifically delineated above, Defendant V.H.R.C. knew of the need to comply with the laws applicable to the ownership, operation, management, and/or supervision of care facilities, and further knew that non-compliance with such laws would put the health and welfare of the residents unreasonably at risk. V.H.R.C. staff knew that the continual failure or refusal to discharge their duties to Ms. Pennington would likely result in her injury and harm.

51. The conduct of V.H.R.C. staff, as alleged above, constitute "physical abuse," "neglect," and "deprivation of necessary goods and services" as those terms are defined in Welfare & Institutions Code §§15610.63 and 15610.57, in that Defendant V.H.R.C. failed to exercise the degree of care that a reasonable person having the custody of Ms. Pennington would exercise.

52. Unknown to Plaintiffs, at the time of Ms. Pennington admission, V.H.R.C. was engaged in implementing a plan of under-staffing. Defendants additionally compounded the harm and damage resulting from their "under-staffing" plan through the following misconduct:

a. By intentionally, willfully, and/or recklessly staffing the facilities with employees who were known, or should have been known, to be unqualified or unfit to perform many of the tasks required of them, including tasks associated with the care of and nursing of the dependent and/or infirm residents; and

b. By designing, developing, implementing, and enforcing staffing policies

and procedures which were known, or should have been known, to likely result in the widespread and frequent violations of federal and state laws and the chronic abuse and neglect of the resident

53. Defendants V.H.R.C. and DOES 51 to 98, without limitation to that to be more fully proven at time of trial, failed to properly assess Ms. Pennington's conditions in a timely manner and failed to implement appropriate care plans to respond to Ms. Pennington's emergent conditions. Defendant V.H.R.C. owed a duty to Ms. Pennington, and others similarly situated, yet failed to provide custodial services with a sufficient budget and sufficient staffing to meet the custodial needs of its residents, including Ms. Pennington, as required by law.

54. Defendant V.H.R.C. owed a duty to Ms. Pennington, and others similarly situated, yet failed to operate, own, manage, control and/or administer the facility in a manner that enabled it to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each patient, including Ms. Pennington, as required by law.

55. Defendant V.H.R.C. owed a duty to Ms. Pennington, and others similarly situated, yet failed to inform Ms. Pennington's primary care physician and family when there was a significant change in Ms. Pennington's physical, mental, or psycho-social status as required by law.

56. Defendant V.H.R.C. was engaged in a deliberate plan to under-staff and under resource the level of custodial and/or nursing care needed. Defendant also consciously under-trained its employees in the appropriate care and treatment of dependent residents such as Ms. Pennington. Defendant additionally compounded the harm and damage resulting from their "under-staffing" plan through the following misconduct:

a. By intentionally, willfully, and/or recklessly staffing the facilities with employees who were known, or should have been known, to be unqualified or unfit to perform many of the tasks required of them, including tasks associated with the care of and nursing of the dependent and/or infirm residents.

57. Notwithstanding their knowledge, Defendant V.H.R.C. grossly disregarded its duty to adequately staff, and properly train and sensitize it workers, in order that gross neglect of residents would neither occur nor be tolerated. In breaching its duties to residents, such as Ms. Pennington, Defendant V.H.R.C. acted intentionally and in conscious disregard of the health and safety of their residents, all according to the plan of maintaining neglectful resident care, thereby unlawfully increasing the profitability and/or achieving the goal of remaining within the budgetary constraints of Defendant's business operation to satisfy the personal and professional objectives of the Defendant.

58. In doing the acts alleged herein, Defendant V.H.R.C. willfully disregarded multiple duties, regulations, administrative policies and laws which would require them to devote resources to the care and treatment of residents like Ms. Pennington, and not divert those resources solely to the attainment of profit goals.

59. The conduct of Defendant V.H.R.C. was a direct consequence of the motive and plans set forth herein, and Defendant V.H.R.C. is guilty of malice, fraud, recklessness and oppression.

DEMAND FOR JURY TRIAL

Plaintiff demands trial by jury as to all causes of action.

WHEREFORE, Plaintiff prays for judgment against Defendants as follows:

On Plaintiff's First and Second Causes of Action for Negligence against KAISER PERMANENTE- SANTA CLARA, KAISER FOUNDATION HEALTH PLAN, INC., VALLEY HOUSE REHABILITATION CENTER, and DOES 1 to 100:

1. For special damages according to proof;
2. For general damages according to proof;
3. For prejudgment interest as allowed by law;
4. For costs of suit; and
5. For such other and further relief as to the Court may seem just and proper.

On Plaintiff's Third Cause of Action for Elder Abuse against VALLEY HOUSE REHABILITATION CENTER and DOES 51 to 100 only:

1. For general damages according to proof;
2. For special damages according to proof;
3. For attorney's fees pursuant to Welfare & Institutions Code section 15657(a);
4. For punitive damages as to defendants who are found by clear and convincing evidence to be guilty of fraud, malice and/or conscious disregard for the safety and well-being of Ms. Pennington and others similarly situated;
5. For prejudgment interest as allowed by law;
6. For costs of suit; and
7. For such other and further relief as to the Court may seem just and proper.

DATED: February 6, 2013

McNULTY LAW FIRM

By: _____
Peter J. McNulty
Sarvnaz Mackin
Attorneys for Plaintiff