Russell Reiner (SBN: 084461)
**REINER, SLAUGHTER, MAINZER & FRANKEL**
2851 Park Marina Drive., Suite 200
Redding, California 96001
Telephone: (530) 241-1905
Facsimile: (530) 241-0622

William Kershaw (SBN: 057486)
Stuart C. Talley (SBN: 180374)
**KERSHAW, COOK & TALLEY PC**
401 Watt Avenue
Sacramento, California 95864
Telephone: (916) 779-7000
Facsimile: (916) 244-4829

Wendy C. York (SBN: 166864)
Daniel Jay (SBN: 215860)
**YORK LAW CORPORATION**
1111 Exposition Blvd., Building 500
Sacramento, California 95815
Telephone: (916) 643-2200
Facsimile: (916) 643-4680

*Attorneys for Plaintiffs*



SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SHASTA

NANCY HEARDEN; individually and as successor in interest to ARTHUR TRENERRY (Decedent); JOHANNA TRENERRY; individually and as successor in interest to ARTHUR TRENERRY (Decedent); IRENE KELLEY, individually and as successor in interest to ARTHUR TRENERRY (Decedent); SALLY KELLEY, individually and as successor in interest to ARTHUR TRENERRY (Decedent); MATTHEW TRENERRY, individually and as successor in interest to ARTHUR TRENERRY (Decedent); WILLIAM TRENERRY; individually and as successor in interest to ARTHUR TRENERRY (Decedent); BEVERLY FULLER, individually and as successor in interest to ARTHUR TRENERRY (Decedent); ANTHONY TRENERRY, individually and as successor in interest to ARTHUR TRENERRY (Decedent);

CASE NO.: 198083

**COMPLAINT FOR (1) ABUSE/NEGLECT OF AN ELDER; (2) NEGLIGENCE PER SE; (3) VIOLATION OF PATIENT'S BILL OF RIGHTS [HEALTH AND SAFETY CODE § 1430]; (4) UNFAIR BUSINESS PRACTICES [BUSINESS AND PROFESSIONS CODE § 17200]; (5) WRONGFUL DEATH; and (6) FRAUD/MISREPRESENTATION**

**DEMAND FOR JURY TRIAL**

SHARON MCMAINES, individually and as successor in interest to WAYNE MCMAINES (Decedent); JANIS BODINE, individually and as successor in interest to WAYNE MCMAINES (Decedent); DENNIS MCMAINES, individually and as successor in interest to WAYNE MCMAINES (Decedent); DARLYN DULANEY, individually and as successor in interest to GENE WALLACE (Decedent); KARLENE WALLACE, individually and as successor in interest to GENE WALLACE (Decedent); JEREMIAH BOENINGER, individually and as successor in interest to REINHILD BOENINGER (Decedent); SANDRA BRYANT, individually and as successor in interest to REINHILD BOENINGER (Decedent); TAMARA DUKES, individually and as successor in interest to CHERIE SCOTT (Decedent); ROBERT RATHER, individually and as successor in interest to CHERIE SCOTT (Decedent); LARRY RIGGS, individually and as successor in interest to ADA RIGGS (Decedent); ROBERT RIGGS, individually and as successor in interest to ADA RIGGS (Decedent); SALLY SORENSON, individually and as successor in interest to ESTHER SHAFER (Decedent); TERRIE CALLAWAY, individually and as successor in interest to LARRY JOHNSON (Decedent); ROBERT GUTIERRES, individually and as successor in interest to CHRISTINE GUTIERRES (Decedent); DELORES GUTIERRES, individually and as successor in interest to CHRISTINE GUTIERRES (Decedent); CARYL ENDICOTT, individually and as successor in interest to EMMA HART (Decedent); DAMON WHITE, individually and as successor in interest to DANNY WHITE (Decedent); CAROLYN SILVA, individually and as successor in interest to RICHARD MATTOS (Decedent); PAMELA SANTOS, individually and as successor in interest to RICHARD MATTOS (Decedent); GARY MATTOS, individually and as successor in interest to RICHARD MATTOS (Decedent); GORDON FARMER, individually and as successor in interest to NICHOLAS

FARMER (Decedent); SCOTT FARMER, individually and as successor in interest to NICHOLAS FARMER (Decedent); CHARLES BALDING, individually and as successor in interest to CHARMAINE TAPPEN (Decedent); and LEONARD BALDING, individually and as successor in interest to CHARMAINE TAPPEN (Decedent),

Plaintiffs,

v.

WINDSOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ , BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, an individual; S&F MANAGEMENT COMPANY; and DOES 1 through 50, inclusive,

Defendants.

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Plaintiffs, NANCY HEARDEN, JOHANNA TRENERRY, IRENE KELLEY, SALLY KELLEY, MATTHEW TRENERRY, WILLIAM TRENERRY, BEVERLY FULLER, ANTHONY TRENERRY, SHARON MCMAINES, JANIS BODINE, DENNIS MCMAINES, DARLYN DULANEY, KARLENE WALLACE, JEREMIAH BOENINGER, SANDRA BRYANT, TAMARA DUKES, ROBERT RATHER, LARRY RIGGS, ROBERT RIGGS, SALLY SORENSON, TERRIE CALLAWAY, ROBERT GUTIERRES, DELORES GUTIERRES, CARYL ENDICOTT, DAMON WHITE, CAROLYN SILVA, PAMELA SANTOS, GARY MATTOS, GORDON FARMER, SCOTT FARMER, CHARLES BALDING, and LEONARD BALDING, individually and as successors in interest to the Decedents identified herein ("DECEDENTS"), hereby complain of Defendants, and each of them, for causes of action and allege as follows:

## PRELIMINARY ALLEGATIONS

1. This is an elder neglect/abuse case brought against an unlicensed owner-operator of a skilled nursing facility, Defendant SHLOMO RECHNITZ and his management companies,

by Plaintiffs both as individuals and as successors in interest to the DECEDENTS identified herein, for elder neglect, negligence, misrepresentation, unfair business practices, and wrongful death.

2. At all relevant times, Defendant SHLOMO RECHNITZ and his management/operating companies were an unlicensed owner-operator of the subject facility who had been denied a license by California Department of Public Health (hereinafter "CDPH") under Health & Safety Code Section 1265(f), citing Defendant RECHNITZ and BRIUS' non-compliance history with multiple other facilities Defendants owned, managed, or operated, either directly or indirectly. For a three-year period, CDPH's review revealed 265 federal regulatory violations (not including multiple federal and state regulatory violations) at a severity level of F or higher in other facilities Defendant SHLOMO RECHNITZ owned, managed, or operated for a three-year period. Many of the regulatory violations and deficiencies included a failure to ensure an Infection Control Program was in place and a failure to prevent neglect, mistreatment or abuse. The table below shows the number of deficiencies by deficiency level of F or greater that CDPH cited to, in part, for its denial of a license to own, operate or manage the subject facility located at 2490 Court Street, Redding, CA 96001:

Three-Year Federal Regulatory Violation History

| Deficiency Level | Scope & Severity Level Descprition | Number of Deficiencies |
|---|---|---|
| F | No actual harm with potential for more than minimal harm that is not immediate jeopardy but is widespread | 172 |
| G | Actual harm that is not immediate jeopardy and is isolated | 45 |
| H | Scope is pattern present, severity level of actual harm that is not immediate jeopardy. | 9 |
| J | Immediate jeopardy to resident health or safety and is isolated | 11 |
| K | Immediate jeopardy to resident health or safety and is a pattern | 16 |
| L | Immediate jeopardy to resident health and safety and is widespread. | 12 |

3. Defendant SHLOMO RECHNITZ and his management operating companies, to circumvent CDPH's rejection of his license application to operate the subject facility, now named WINDSOR REDDING CARE CENTER, created a joint venture or contractual

arrangement with Defendant LEE SAMSON and his "WINDSOR" brand to enable Defendant SHLOMO RECHNITZ to own and operate and profit from the subject facility operations, despite CDPH's denial of a license to the RECHNITZ/BRIUS Defendants to own, operate or manage the subject skilled nursing facility now named "WINDSOR REDDING CARE CENTER." A further description of the Defendant is alleged below.

4. DECEDENTS, all of whom are over the age of 65 or were dependent adults, were residents at Windsor Redding Care Center located in Redding, California ("Windsor"). In September 2020, in violation of California law, Windsor forced employees to report to work even though those employees had reported Symptoms of COVID-19. As a result of this action, along with its failure to comply with its own infection prevention protocols, a large outbreak of COVID-19 occurred within the facility and caused more than 60 patients to contract the virus. To make matters worse, once patients contracted COVID-19, Windsor quarantined them in a separate wing of the facility and completely failed to care for them while they were struggling to survive their illness. In fact, Windsor only had one nurse assigned to care for more than 25 sick patients, leaving these patients to be neglected and alone. As a direct result of Windsor's neglect, approximately 24 of its patients, including all the DECEDENTS named herein, died.

5. As described more fully herein, this elder neglect/abuse case arises from the reckless and chronic failures of Defendants WINDOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 ("Defendants") to adequately staff Windsor; failures to properly train staff; failures to treat residents, including DECEDENTS, with dignity; failure to provide care and services to DECEDENTS, neglecting DECEDENTS after they contracted COVID-19 by leaving them in a unit that had only one RN to 25 patients thus their care needs could not be met, and failures to properly create and implement infection control procedures, even though Defendants knew that its residents were at high risk and vulnerable should they be exposed to COVID-19.

## JURISDICTION AND VENUE

6. At all times mentioned herein, Defendants WINDSOR REDDING CARE

CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 ("Defendants") were and are in the business of providing continuous skilled nursing care as a twenty-four hour facility as defined in section 72103 of Title 22 of the California Code of Regulations and in § 125(c) of the California Health and Safety Code, and subject to the requirements of State and Federal law. At all times mentioned, Defendants were doing business at 2490 Court Street, Redding California, as a skilled nursing facility and "care custodian" (Welfare and Institutions Code § 15610.17). Defendants are located in, and do business in, the city of Redding, Shasta County, California. The Windsor facility operated by Defendants is licensed by the Department of Public Health to operate a skilled nursing facility. Under the provisions of Welfare and Institutions Code sections 15610.23 and 15610.27, the DECEDENTS mentioned herein were "elders" and "dependent adults".

7. Venue is proper in this Court because Defendants reside and/or do business within the jurisdictional boundaries of the County of Shasta and Defendants' tortious acts took place in the County of Shasta.

**PARTIES**

8. Defendants WINDSOR REDDING CARE CENTER, LLC; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; DOES 1 through 50; and Defendants' officers, directors, and/or managing agents, including but not limited to Defendant SHLOMO RECHNITZ, had the responsibility and ability to implement and enforce policies, to budget for sufficient staff and PPE equipment, to prevent the reckless, malicious, oppressive, and fraudulent conduct described in this Complaint. Therefore, Defendants are directly liable for failing to implement and/or enforce such policies, and failing to budget to provide sufficient staff and sufficient staff training to meet their residents' high acuity needs, in conscious disregard for the rights and safety of Decedents and other residents. It was Defendants' conscious choice to understaff, to undertrain the staff, and to fail to enforce policies at its facilities to maximize profits that caused Decedents' neglect, illnesses and eventual death, as detailed in this Complaint.

9. Defendants WINDSOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 are alter egos of each other. There exists, and at all times herein mentioned there existed, a unity of interest and ownership between, by and among Defendants WINDSOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 such that any individuality and separateness between these individuals and entities has ceased to exist. Defendants WINDSOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 have used and continue to use corporate or other entity funds and assets belonging to each other as if they were the same entities. Defendants failed to adequately capitalize their corporations, instead siphoning off profits and diverting assets from the Windsor facility to Defendants SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 to wrongfully protect the facility's assets from exposure to liability. Since the profits have been wrongfully transferred to these management entities, leaving the Windsor facility underfunded, an injustice would occur to injured victims if all Defendants were not parties to this suit.

10. Defendants WINDSOR REDDING CARE CENTER, LLC; SHLOMO RECHNITZ; BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC; and DOES 1 through 50 have also historically undercapitalized the Windsor facility, disregarded corporate formalities, failed to keep minutes and adequate corporate records, failed to segregate funds of separate entities, and compiled assets and liabilities of its other skilled nursing facilities. Thus, Defendants, and each of them, are alter egos of each other. Further, Defendants created a joint venture with Defendant LEE SAMSON and S&F MANAGEMENT COMPANY, LLC to circumvent DPH's refusal to grant Defendant RECHNITZ a license to operate or manage the subject facility.

11. Defendant SHLOMO RECHNITZ exerts total and consistent ownership and

operational control over each of the other Defendants and, in turn, Defendants BRIUS MANAGEMENT CO.; BRIUS, LLC; LEE SAMSON, S&F MANAGEMENT COMPANY, LLC exert total and consistent operational control over each of Defendants' skilled nursing facilities in California, including Defendant WINDSOR REDDING CARE CENTER, LLC's facility.

12. The true names and capacities of the Defendants named herein as DOES 1 through 50, inclusive, whether individual, corporate, associate, or otherwise, are unknown to Plaintiff, who therefore sues such Defendants by fictitious names pursuant to Code of Civil Procedure section 474. Plaintiffs are informed and believe that said DOE defendants are California residents, and Plaintiffs will amend this Complaint to show such true names and capacities when they have been determined.

13. At all times mentioned herein, each and every Defendant was the agent and employee of each and every other Defendant; and, in doing the things alleged, was acting within the course and scope of such agency and employment; and, in doing the acts herein alleged, was acting with the consent, permission and authorization of each of the remaining defendants. All actions of each Defendant herein alleged were ratified and approved by the officers or managing agents of every other Defendant.

14. Plaintiffs are informed and believe, and thereby allege, that each of the Defendants herein were at all times relevant hereto the agent, managing agent, employee or representative of the remaining defendants and was acting at least in part within the course and scope of such relationship.

15. Plaintiff ARTHUR TRENERRY was at all times material hereto a resident of Shasta County. At all relevant times, ARTHUR TRENERRY was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, ARTHUR TRENERRY was a resident at Windsor and contracted COVID-19 during his stay the facility. ARTHUR TRENERRY suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

16. Plaintiff NANCY HEARDEN is the daughter and successor-in-interest to

ARTHUR TRENERRY. Plaintiff NANCY HEARDEN will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, NANCY HEARDEN was and is a resident of Shasta County.

17. Plaintiff JOHANNA TRENERRY is the wife and successor-in-interest to ARTHUR TRENERRY. Plaintiff JOHANNA TRENERRY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, JOHANNA TRENERRY was and is a resident of Shasta County.

18. Plaintiff IRENE KELLEY is the daughter and successor-in-interest to ARTHUR TRENERRY. Plaintiff IRENE KELLEY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, IRENE KELLEY was and is a resident of Chester County, Tennessee.

19. Plaintiff SALLY KELLEY is the daughter and successor-in-interest to ARTHUR TRENERRY. Plaintiff SALLY KELLEY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, SALLY KELLEY was and is a resident of Chester County, Tennessee.

20. Plaintiff MATTHEW TRENERRY is the son and successor-in-interest to ARTHUR TRENERRY. Plaintiff MATTHEW TRENERRY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, MATTHEW TRENERRY was and is a resident of Shasta County.

21. Plaintiff WILLIAM TRENERRY is the son and successor-in-interest to ARTHUR TRENERRY. Plaintiff WILLIAM TRENERRY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, WILLIAM TRENERRY

was and is a resident of Shasta County.

22. Plaintiff BEVERLY FULLER is the daughter and successor-in-interest to ARTHUR TRENERRY. Plaintiff BEVERLY FULLER will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, BEVERLY FULLER was and is a resident of Shasta County.

23. Plaintiff ANTHONY TRENERRY is the son and successor-in-interest to ARTHUR TRENERRY. Plaintiff ANTHONY TRENERRY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, ANTHONY TRENERRY was and is a resident of Chester County, Tennessee.

24. Plaintiff WAYNE MCMAINES was at all times material hereto a resident of Shasta County. At all relevant times, WAYNE MCMAINES was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, WAYNE MCMAINES was a resident at Windsor and contracted COVID-19 during his stay at the facility. WAYNE MCMAINES suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

25. Plaintiff SHARON MCMAINES is the wife and successor-in-interest to WAYNE MCMAINES. Plaintiff SHARON MCMAINES will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, SHARON MCMAINES was and is a resident of Shasta County.

26. Plaintiff JANIS BODINE is the daughter and successor-in-interest to WAYNE MCMAINES. Plaintiff JANIS BODINE will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, JANIS BODINE was and is a resident of Shasta County.

27. Plaintiff DENNIS MCMAINES is the son and successor-in-interest to WAYNE

MCMAINES. Plaintiff DENNIS MCMAINES will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, DENNIS MCMAINES was and is a resident of Shasta County.

28. Plaintiff GENE WALLACE was at all times material hereto a resident of Shasta County. At all relevant times, GENE WALLACE was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, GENE WALLACE was a resident at Windsor and contracted COVID-19 during his stay at the facility. GENE WALLACE suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

29. Plaintiff DARLYN DULANEY is the daughter and successor-in-interest to GENE WALLACE. Plaintiff DARLYN DULANEY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, DARLYN DULANEY was and is a resident of Shasta County.

30. Plaintiff KARLENE WALLACE is the wife and successor-in-interest to GENE WALLACE. Plaintiff KARLENE WALLACE will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, KARLENE WALLACE was and is a resident of Shasta County.

31. Plaintiff REINHILD BOENINGER was at all times material hereto a resident of Shasta County. At all relevant times, REINHILD BOENINGER was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of her death, REINHILD BOENINGER was a resident at Windsor and contracted COVID-19 during his stay at the facility. REINHILD BOENINGER suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

32. Plaintiff JEREMIAH BOENINGER is the son and successor-in-interest to

REINHILD BOENINGER. Plaintiff JEREMIAH BOENINGER will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, JEREMIAH BOENINGER was and is a resident of Tehama County.

33. Plaintiff SANDRA BRYANT is the daughter and successor-in-interest to REINHILD BOENINGER. Plaintiff SANDRA BRYANT will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, SANDRA BRYANT was and is a resident of Multnomah County, Oregon.

34. Plaintiff CHERIE SCOTT was at all times material hereto a resident of Tehama County. At all relevant times, CHERIE SCOTT was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of her death, CHERIE SCOTT was a resident at Windsor and contracted COVID-19 during her stay at the facility. CHERIE SCOTT suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

35. Plaintiff TAMARA DUKES is the daughter and successor-in-interest to CHERIE SCOTT. Plaintiff TAMARA DUKES will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, TAMARA DUKES was and is a resident of Butte County.

36. Plaintiff ROBERT RATHER is the son and successor-in-interest to CHERIE SCOTT. Plaintiff ROBERT RATHER will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, ROBERT RATHER was and is a resident of Casey County, Kentucky.

37. Plaintiff ADA RIGGS was at all times material hereto a resident of Shasta County. At all relevant times, ADA RIGGS was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020

until the date of her death, ADA RIGGS was a resident at Windsor and contracted COVID-19 during her stay at the facility. ADA RIGGS suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

38. Plaintiff LARRY RIGGS is the son and successor-in-interest to ADA RIGGS. Plaintiff LARRY RIGGS will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, LARRY RIGGS was and is a resident of Shasta County.

39. Plaintiff ROBERT RIGGS is the son and successor-in-interest to ADA RIGGS. Plaintiff ROBERT RIGGS will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, ROBERT RIGGS was and is a resident of Lassen County.

40. Plaintiff ESTHER SHAFER was at all times material hereto a resident of Shasta County. At all relevant times, ESTHER SHAFER was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of her death, ESTHER SHAFER was a resident at Windsor and contracted COVID-19 during her stay at the facility. ESTHER SHAFER suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

41. Plaintiff SALLY SORENSON is the daughter and successor-in-interest to ESTHER SHAFER. Plaintiff SALLY SORENSON will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, SALLY SORENSON was and is a resident of Sonoma County.

42. Plaintiff LARRY JOHNSON was at all times material hereto a resident of Shasta County. At all relevant times, LARRY JOHNSON was a dependent adult within the meaning of Welfare and Institutions Code section 15600, et seq. From August 2020 until the date of his death, LARRY JOHNSON was a resident at Windsor and contracted COVID-19 during his stay at the facility. LARRY JOHNSON suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

43. Plaintiff TERRIE CALLAWAY is the sister and successor-in-interest to LARRY JOHNSON. Plaintiff TERRIE CALLAWAY will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, TERRIE CALLAWAY was and is a resident of Shasta County.

44. Plaintiff CHRISTINE GUTIERRES was at all times material hereto a resident of Shasta County. At all relevant times, CHRISTINE GUTIERRES was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of her death, CHRISTINE GUTIERRES was a resident at Windsor and contracted COVID-19 during her stay at the facility. CHRISTINE GUTIERRES suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

45. Plaintiff ROBERT GUTIERRES is the grandson and successor-in-interest to CHRISTINE GUTIERRES. Plaintiff ROBERT GUTIERRES will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, ROBERT GUTIERRES was and is a resident of Shasta County.

46. Plaintiff DELORES GUTIERRES is the daughter and successor-in-interest to CHRISTINE GUTIERRES. Plaintiff DELORES GUTIERRES will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, DELORES GUTIERRES was and is a resident of Shasta County.

47. Plaintiff EMMA HART was at all times material hereto a resident of Shasta County. At all relevant times, EMMA HART was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of her death, EMMA HART was a resident at Windsor and contracted COVID-19 during her stay at the facility. EMMA HART suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

48. Plaintiff CARYL ENDICOTT is the daughter and successor-in-interest to EMMA HART. Plaintiff CARYL ENDICOTT will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, CARYL ENDICOTT was and is a resident of Shasta County.

49. Plaintiff DANNY WHITE was at all times material hereto a resident of Shasta County. At all relevant times, DANNY WHITE was a dependent adult within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, DANNY WHITE was a resident at Windsor and contracted COVID-19 during his stay at the facility. DANNY WHITE suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

50. Plaintiff DAMON WHITE is the son and successor-in-interest to DANNY WHITE. Plaintiff DAMON WHITE will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, DAMON WHITE was and is a resident of Tehama County.

51. Plaintiff RICHARD MATTOS was at all times material hereto a resident of Shasta County. At all relevant times, RICHARD MATTOS was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, RICHARD MATTOS was a resident at Windsor and contracted COVID-19 during his stay at the facility. RICHARD MATTOS suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

52. Plaintiff CAROLYN SILVA is the daughter and successor-in-interest to RICHARD MATTOS. Plaintiff Carolyn Silva will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, CAROLYN SILVA was and is a resident of Sweetwater County, Wyoming.

53. Plaintiff PAMELA SANTOS is the daughter and successor-in-interest to

RICHARD MATTOS. Plaintiff PAMELA SANTOS will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, PAMELA SANTOS was and is a resident of Santa Clara County.

54. Plaintiff GARY MATTOS is the son and successor-in-interest to RICHARD MATTOS. Plaintiff GARY MATTOS will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, GARY MATTOS was and is a resident of Santa Clara County.

55. Plaintiff NICHOLAS FARMER was at all times material hereto a resident of Tehama County. At all relevant times, NICHOLAS FARMER was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.* From August 2020 until the date of his death, NICHOLAS FARMER was a resident at Windsor and contracted COVID-19 during his stay at the facility. NICHOLAS FARMER suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

56. Plaintiff GORDON FARMER is the son and successor-in-interest to NICHOLAS FARMER. Plaintiff GORDON FARMER will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, GORDON FARMER was and is a resident of Tulare County.

57. Plaintiff SCOTT FARMER is the son and successor-in-interest to NICHOLAS FARMER. Plaintiff SCOTT FARMER will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, SCOTT FARMER was and is a resident of Sacramento County.

58. Plaintiff CHARMAINE TAPPEN was at all times material hereto a resident of Shasta County. At all relevant times, CHARMAINE TAPPEN was over the age of 65 years old and thus an "elder" within the meaning of Welfare and Institutions Code section 15600, *et seq.*

From August 2020 until the date of her death, CHARMAIN TAPPEN was a resident at Windsor and contracted COVID-19 during her stay at the facility. CHARMAINE TAPPEN suffered untold pain, suffering, injury, and death as a result of all named defendants' reckless neglect and abuse.

59. Plaintiff CHARLES BALDING is the son and successor-in-interest to CHARMAINE TAPPEN. Plaintiff CHARLES BALDING will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, CHARLES BALDING was and is a resident of Contra Costa County.

60. Plaintiff LEONARD BALDING is the son and successor-in-interest to CHARMAINE TAPPEN. Plaintiff LEONARD BALDING will comply with Welfare & Institutions Code section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32. At all times relevant to this action, LEONARD BALDING was and is a resident of Shasta County.

61. Throughout this complaint Plaintiffs, ARTHUR TRENERRY, WAYNE MCMAINES, GENE WALLACE, REINHILD BOENINGER, CHERIE SCOTT, ADA RIGGS, ESTHER SHAFER, LARRY JOHNSON, CHRISTINE GUTIERRES, EMMA HART, RICHARD MATTOS, NICHOLAS FARMER, and CHARMAINE TAPPEN, are collectively referred to as "DECEDENTS."

62. Throughout this complaint Plaintiffs, NANCY HEARDEN, JOHANNA TRENERRY, IRENE KELLEY, SALLY KELLEY, MATTHEW TRENERRY, WILLIAM TRENERRY, BEVERLY FULLER, ANTHONY TRENERRY, SHARON MCMAINES, JANIS BODINE, DENNIS MCMAINES, DARLYN DULANEY, KARLENE WALLACE, JEREMIAH BOENINGER, SANDRA BRYANT, TAMARA DUKES, ROBERT RATHER, LARRY RIGGS, ROBERT RIGGS, SALLY SORENSON, TERRIE CALLAWAY, ROBERT GUTIERRES, DELORES GUTIERRES, CARYL ENDICOTT, DAMON WHITE, CAROLYN SILVA, PAMELA SANTOS, GARY MATTOS, GORDON FARMER, SCOTT FARMER, CHARLES BALDING, and LEONARD BALDING, are collectively referred to as "HEIRS."

## FACTUAL ALLEGATIONS

63. The now BRIUS facility that is the subject of this action has a history of resident care violations, well before the COVID pandemic that included but is not limited to the following:

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| 1/8/2018 | Quality of Care/Treatment | | Substantiated |
| 1/31/2018 | Infection Control | | Substantiated |
| 1/31/2018 | Quality of Care/Treatment | | Substantiated |
| 2/7/2018 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 3/1/2018 | Quality of Care/Treatment | | Substantiated |
| 3/13/2018 | Infection Control | | Substantiated |
| 3/19/2018 | Pharmaceutical Services | | Substantiated |
| 3/30/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 4/19/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 4/23/2018 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 5/4/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident | Substantiated |
| 5/7/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident | Substantiated |
| 5/14/2018 | Quality of Care/Treatment | | Substantiated |
| 5/14/2018` | Resident/Patient/Client Rights | | Substantiated |
| 5/18/2018 | Infection Control | | Substantiated |
| 5/18/2018 | Quality of Care/Treatment | | Substantiated |
| 5/29/2018 | Resident/Patient/Client Rights | | Substantiated |
| 6/14/2018 | Resident/Patient/Client Rights | Failure to Prevent Resident Neglect/ | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| | | Abuse | |
| 6/15/2018 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 6/15/2018 | Resident/Patient/Client Neglect | Assess/Monitor | Substantiated |
| 6/18/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 7/9/2018 | Resident/Patient/Client Abuse | Sexual | Substantiated |
| 7/20/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/8/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/20/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/22/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/24/2018 | Quality of Care/Treatment | | Substantiated |
| 8/27/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 9/11/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 9/19/2018 | Resident/Patient/Client Rights | | Substantiated |
| 9/28/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 10/1/2018 | Quality of Care/Treatment | | Substantiated |
| 10/2/2018 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 10/2/2018 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 10/2/2018 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 10/9/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| | | Neglect/Abuse | |
| 10/10/2018 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 10/15/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 10/16/2018 | Quality of Care/Treatment | | Substantiated |
| 10/22/2018 | Resident/Patient/Client Rights | | Substantiated |
| 10/22/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 10/25/2018 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 10/25/2018 | Resident/Patient/Client Rights | | Substantiated |
| 11/9/2018 | Resident/Patient/Client Abuse | Sexual | Substantiated |
| 11/9/2018 | Resident/Patient/Client Abuse | | Substantiated |
| 11/9/2018 | Resident/Patient/Client Abuse | | Substantiated |
| 11/9/2018 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 11/13/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 11/16/2018 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 11/26/2018 | Quality of Care/Treatment | | Substantiated |
| 12/3/2018 | Quality of Care/Treatment | | Substantiated |
| 12/6/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/17/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/19/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/27/2018 | Quality of Care/Treatment | | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| 12/28/2018 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/2/2019 | Nursing Services | | Substantiated |
| 1/2/2019 | Quality of Care/Treatment | | Substantiated |
| 1/2/2019 | Resident/Patient/Client Neglect | Other | Substantiated |
| 1/7/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/9/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/28/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 2/8/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 2/14/2019 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 2/15/2019 | Resident/Patient/Client Abuse | Sexual | Substantiated |
| 3/18/2019 | Quality of Care/Treatment | | Substantiated |
| 4/11/2019 | Quality of Care/Treatment | | Substantiated |
| 4/15/2019 | Nursing Services | | Substantiated |
| 4/15/2019 | Quality of Care/Treatment | | Substantiated |
| 5/16/2019 | Infection Control | | Substantiated |
| 5/16/2019 | Quality of Care/Treatment | | Substantiated |
| 5/16/2019 | Nursing Services | | Substantiated |
| 5/17/2019 | Quality of Care/Treatment | | Substantiated |
| 6/25/2019 | Quality of Care/Treatment | | Substantiated |
| 7/8/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| 7/8/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 7/9/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 7/15/2019 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 9/3/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 9/25/2019 | Quality of Care/Treatment | | Substantiated |
| 10/1/2019 | Quality of Care/Treatment | | Substantiated |
| 10/7/2019 | Resident/Patient/Client Rights | Resident Not Treated with Dignity/Respect | Substantiated |
| 10/7/2019 | Quality of Care/Treatment | Facility Staffing | Substantiated |
| 11/25/2019 | Administration/Personnel | | Substantiated |
| 11/25/2019 | Resident/Patient/Client Rights | | Substantiated |
| 11/27/2019 | Quality of Care/Treatment | | Substantiated |
| 12/2/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/10/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/13/2019 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 12/14/2019 | Quality of Care/Treatment | | Substantiated |
| 12/17/2019 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 12/18/2019 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 12/18/2019 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 12/26/2019 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| 1/8/2020 | Death – General | | Substantiated |
| 1/8/2020 | Resident/Patient/Client Neglect | Assess/Monitor | Substantiated |
| 1/13/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/14/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/15/2020 | Quality of Care/Treatment | | Substantiated |
| 1/15/2020 | Pharmaceutical Services | Other | Substantiated |
| 1/21/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/23/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 1/30/2020 | Quality of Care/Treatment | | Substantiated |
| 2/24/2020 | Quality of Care/Treatment | Facility Staffing | Substantiated |
| 3/23/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 3/27/2020 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 3/31/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 4/1/2020 | Infection Control | | Substantiated |
| 4/6/2020 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 4/6/2020 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 5/15/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 5/27/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 5/28/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 6/5/2020 | Death – General | | Substantiated |
| 6/15/2020 | Resident/Patient/Client | Failure to Prevent | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| | Abuse | Resident Neglect/Abuse | |
| 6/17/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 7/2/2020 | Quality of Care/Treatment | Improper Incontinent Care For Resident | Substantiated |
| 7/27/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 8/6/2020 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 8/6/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/6/2020 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 8/6/2020 | Resident/Patient/Client Abuse | Verbal | Substantiated |
| 8/6/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 8/13/2020 | Resident/Patient/Client Abuse | Resident's Privacy Not Protected | Substantiated |
| 8/13/2020 | State Monitoring | Intentional breach by person other than HC worker | Substantiated |
| 8/20/2020 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 8/20/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 9/18/2020 | Infection Control | | Substantiated |
| 9/18/2020 | Quality of Care/Treatment | Improper Infection Control Practiced By Facility | Substantiated |
| 10/5/2020 | Infection Control | COVID-19 Noncompliance | Substantiated |
| 10/5/2020 | Quality of Care/Treatment | Resident Safety/Falls | Substantiated |
| 10/8/2020 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 10/12/2020 | Quality of Care/Treatment | Facility Staffing | Substantiated |

| DATE | ALLEGATION CATEGORY | ALLEGATION SUB CATEGORY | INVESTIGATION FINDINGS |
|---|---|---|---|
| 10/12/2020 | Death – General | | Substantiated |
| 10/12/2020 | Quality of Care/Treatment | Resident Not Assessed After Change In Cond Timely | Substantiated |
| 10/19/2020 | Resident/Patient/Client Abuse | Failure to Prevent Resident Neglect/Abuse | Substantiated |
| 3/22/2021 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 4/20/2021 | Quality of Care/Treatment | Resident Not Groomed Adequately | Substantiated |
| 4/23/2021 | Resident/Patient/Client Neglect | Assess/Monitor | Substantiated |
| 4/23/2021 | Quality of Care/Treatment | Resident Safety | Substantiated |
| 5/11/2021 | Resident/Patient/Client Abuse | Employee to Resident | Substantiated |
| 6/16/2021 | Quality of Care/Treatment | Resident Safety | Substantiated |

64. As demonstrated above, the Defendants were in repeated non-compliance with multiple state and federal regulations related to patient safety, including failure to have adequate staffing and infection control, well before COVID-19. Thus, when COVID-19 occurred, it was foreseeable that Defendants would continue to neglect and harm more residents during the pandemic.

65. Beginning in March 2020, COVID-19 had been declared a global pandemic with many infections reaching the United States. By September 2020, the pandemic had spread throughout the Untied States with more than 6.1 million cases and 186,000 deaths. According to records from the CDC, nearly 1/3 of the U.S. deaths occurred in patients who were residents at long term care facilities. The problems caused by COVID-19 and the risk of death this virus posed to residents of long-term care facilities was widely known to the public and the defendants.

66. On July 8, 2020, the California Department of Public Health ("CDPH") conducted an inspection of the Windsor facility to ensure that it was implementing appropriate

policies and procedures to prevent the spread of COVID-19 throughout the facility. During the inspection the CPDH noted numerous deficiencies including;

- The failure to test residents who were potentially exposed to COVID-19 for the virus;
- Allowing residents with unknown COVID-19 status to share rooms with those who were established as "COVID-19 negative."
- Using the same staff to care for patients whose COVID-19 status was unknown with patients who were known "COVID-19 negative."

67. On August 10 and 11, 2020, the CDPH performed another inspection of the Windsor facility. During the inspection, the CDPH again cited Windsor for failing to follow appropriate infection control procedures to prevent the spread of COVID-19 throughout the facility. Specifically, the inspector found the following:

- Windsor admitted a COVID-19 negative patient into a room with two residents who were COVID-19 positive.
- Windsor was admitting new residents into rooms being occupied by residents who it knew had been exposed to COVID-19.

68. Despite receiving two citations from the CDPH, Windsor failed to change its policies and failed to bring in additional staff to help ensure that additional COVID-19 cases did not come into the facility. Instead, it continued its custom and practice of ignoring regulatory requirements and infection control procedures. By September 2020, the Windsor facility had a massive outbreak of COVID-19 that ran throughout the facility and by October virtually all of Windsor's residents had contracted the virus. Specifically, 60 of Windsor's 83 residents contracted the virus and, of those, approximately 24 passed away from complications related to COVID-19.

69. On September 25, 2020 the CDPH had conducted an inspection of the facility and discovered why Windsor had such a large outbreak. Specifically, it discovered the following:

- On two separate occasions in early September Windsor employees called in and reported experiencing symptoms of COVID-19. Despite these symptoms, the

employees were told they had to report to work. Both later tested positive for COVID-19 but only after exposing countless residents to the virus. The inspector noted that one of the reasons the employees may have felt compelled to report to work was that Windsor had adopted a punitive sick leave policy in violation of California law.

- Due to chronic understaffing that required management to care for patients, Windsor management did not have time to train its employees in the proper use of personal protective equipment ("PPE") and other infection control procedures to prevent the spread of COVID-19 throughout the facility. In fact, when the inspector asked one nurse who was wearing a mask on her chin whether the mask should be covering her nose and mouth she responded by stating "I don't know."
- Windsor failed to have sufficient PPE on hand and, as a result, staff routinely reused gowns, masks, and other PPE.
- Staff that had tested positive for COVID-19 reported that before testing positive, they routinely cared for patients without wearing masks.
- In violation of its own policies and procedures, Windsor routinely failed to test staff for COVID-19 and permitted untested staff members to report to work.

70. At the conclusion of the September inspection, the CDPH concluded that the failures noted above "resulted in a significant amount of residents and staff contracting and spreading illness throughout the building which placed everyone at significant risk."

71. To make matters worse, once residents contracted COVID-19, Windsor completely neglected these residents. Specifically, on October 21, 2020 the CDPH conducted another inspection of the Windsor facility and focused on examining the charts of patients who had died from COVID-19. During this inspection, the inspector noted the following:

- On multiple occasions nurses reported significant changes in the condition of COVID-19 positive patients but failed to contact a doctor or treat the resident to help improve the change in their conditions.

- Of the 16 medical charts reviewed by the inspector, there were multiple instances where patients were not being monitored by staff. In fact, the inspector discovered 47 days where no progress notes were reported in the resident's chart and there were 84 shifts where no COVID-19 specific assessments were done.
- When nurses working with COVID-19 patients were interviewed, they reported that the reason no assessments were done was due to extreme understaffing. In fact, one LVN reported that she, alone was responsible for 27 COVID-19 positive residents.

72. At the conclusion of this October inspection the CDPH noted that Windsor's utter neglect of residents who had contracted COVID-19 "had the potential to put these high risk residents of becoming increasingly ill without it being recognized and treated in an appropriate and timely manner by a physician."

73. As a direct result of defendants' reckless neglect described herein, all of the DECEDENTS identified herein contracted COVID-19 during their stay at Windsor and eventually died a lonely death, without the ability to see their family.

**FIRST CAUSE OF ACTION**

**(Abuse/Neglect of an Elder)**

**(As against all Defendants)**

74. Plaintiffs refer to and reallege paragraphs 1 through 73, inclusive as set though set forth fully herein.

75. Defendants, by and through their management, agents and employees, were charged with the care and custody of DECEDENTS, all of whom were elder, dependent adult who required assistance with basic care needs.

76. Defendants owed a duty to DECEDENTS to ensure that they received necessary care, supervision, nutrition, and a safe, clean and hazard free environment that was free from physical and mental abuse and neglect.

77. When DECEDENTS entered Defendants' facility, they were dependent upon Defendants and its employees and management for assistance with care needs. They were also

completely dependent upon Defendants to ensure that appropriate policies and procedures were in place and that the facility was adequately staffed to prevent harm, injury or death and to prevent them from contracting COVID-19. Because DECEDENTS were completely dependent on Defendants to provide assistance with daily living needs, to assess their condition, and to provide supervision they were among the most vulnerable persons in our society and literally placed their lives in Defendants' hands.

78. Because DECEDENTS were residents of Defendants' facility, Defendants, and each of them, had duties under state laws, designed for the protection and benefit of elders and dependent adults like DECEDENTS, to provide them with twenty-four-hour care and supervision, nourishment, and a safe, comfortable, healthful environment. Specifically, Defendants had a duty to:

a. Follow, implement, and adhere to all physicians' orders pursuant to 22 C.C.R. § 72301;

b. Develop and implement an individual patient care plan pursuant to 22 C.C. R. § 72311;

c. Treat DECEDENTS with dignity and respect and not subject them to physical abuse of any kind pursuant to 22 C.C.R. § 72315;

d. Provide nursing personnel in sufficient numbers pursuant to 22 C.C.R. §§ 72329, and 72329.1;

e. Provide an adequate number of qualified personnel to carry out all the functions of the facility pursuant to 22 C.C.R. § 72501;

f. Only accept patients for whom it can provide adequate care pursuant to 22 C.C.R. § 72515;

g. Ensure that DECEDENTS were free from mental and physical abuse pursuant to 22 C.C.R § 72527;

h. Treat DECEDENTS with dignity and respect pursuant to 22 C.C.R. § 72527;

i. Employ an adequate number of qualified personnel to carry out all of the functions of the facility pursuant to California Health and Safety Code § 15 99 .1;

j. Ensure that DECEDENTS were free from abuse and neglect pursuant to 42 C.F.R. § 483.12;

k. Conduct a comprehensive assessment of DECEDENTS pursuant to 42 C.F.R. §483.20;

l. Develop a care plan for DECEDENTS pursuant to 42 C.F.R. § 483.21;

n. Ensure that the facility has sufficient nursing staff to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident pursuant to 42 C.F.R. 483.35;

o. Administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident pursuant to 42 C.F.R. § 483. 70; and

p. Maintain accurate records regarding DECEDENTS pursuant to 42 C.F.R. § 483.70.

79. During the DECEDENTS' residence at Defendants' facility, Defendants acted negligently and recklessly and with conscious disregard with respect to DECEDENTS, as detailed above. In particular, and without limiting the generality of the foregoing, Defendants, and each of them, neglected to exercise reasonable care in caring for DECEDENTS and acted with conscious disregard of their rights, health, and safety, and caused severe injuries, including loss of their lives, when they: (1) neglected to adequately staff their building with sufficient staffing of quality caregivers to provide adequate care, services and supervision for pure profit reasons; (2) willfully and repeatedly neglected to provide basic care to DECEDENTS; (3) willfully and repeatedly failed to properly monitor DECEDENTS; (4) willfully and repeatedly failed to provide sufficient equipment that would allow their staff to prevent the spread of COVID-19 throughout their facility; (5) willfully and repeatedly failed to provide sufficient training to their staff to prevent the spread of COVID-19 throughout their facility; (6) willfully and repeatedly forced employees to report to work with symptoms of COVID-19 and failure to have adequate PPE for staff and patients to wear to prevent spread of infections; (7) willfully and repeatedly failed to comply with its own policies and procedures or enact the appropriate

policies and procedures to prevent the spread of COVID-19 throughout the Windsor facility

80. As a proximate result of being neglected, DECEDENTS contracted COVID-19, then left unattended, neglected and suffered changes in condition, which ultimately led to their lonely deaths.

81. As a further direct and proximate result of the Defendants actions, DECEDENTS sustained special damages in an amount according to proof at trial.

82. Defendants' conduct, as herein alleged, was and is a part of a general business practice of the Defendants. The business practice exists in part because Defendants made a conscious, calculated choice to reduce staff to save money on personnel costs, thus understaffing the facility based upon the residents' acuity levels in effort to maximize profit directly and indirectly, despite knowing that they had legal obligations under regulations to staff the facility to meet the residents' needs/acuity levels. Defendants knew that the only way to provide a safe environment and to provide care to its residents, was with adequate numbers of trained, competent caregiver personnel, but Defendants instead took shortcuts at the cost and risk of their residents' health and well-being. Defendants knew that adverse consequences would flow from their understaffing, mistreatment, and neglect of their elderly and vulnerable residents. Thus, Defendants made a conscious, motivated decision to promote their financial condition at the expense of their legal obligations of care to their elderly residents, including the DECEDENTS.

83. By and through their management, employees, medical director, administration, director of nursing, agents and/or staff, Defendants breached their duties of care to DECEDENTS by failing to provide adequate numbers of staff to meet the needs of its residents and to keep them safe, by failing to comply with state and federal regulations to have a clean environment and implement infection control programs to prevent the spread of disease, and by further failing to take appropriate steps to prevent the spread of COVID-19 in their facility, thereby subjecting all DECEDENTS to neglect as described herein.

84. As a proximate cause of Defendants failure to provide basic custodial care which was a part of their basic, core services, DECEDENTS suffered physical injuries, pain and suffering, and death.

85. As a result of Defendant'' acts and omissions, Plaintiffs are entitled to reasonable attorneys' fees and costs of said suit as provided by California Welfare & Institutions Code Section 15657.

86. Because the aforementioned conduct of the Defendants and DOES 1 through 50 were carried out in a deliberate, profit driven, reckless, cold, callous, and intentional manner in order to injure and damage DECEDENTS or, in the alternative, was despicable conduct carried out with a willful, reckless, profit driven and conscious disregard for the rights and safety of others and subjected DECEDENTS to cruel and unjust hardship in conscious disregard of their rights, Plaintiffs request the assessment of punitive damages against Defendants and DOES 1 through 50 in an amount according to proof.

WHEREFORE, Plaintiffs pray for damages as set forth below.

**SECOND CAUSE OF ACTION**

**(Negligence/Negligence Per Se)**

**(As against all Defendants)**

87. Plaintiffs refer to and reallege paragraphs 1 through 86, inclusive as though set forth fully herein.

88. Defendants, and each of them, by and through their management, agents and employees, were charged with the care and custody of DECEDENTS, who were elderly, dependent adults suffering from physical and mentally limitations, and completely dependent on Defendants for all activities of daily living.

89. During the period of their residence at the Windsor facility, each Defendant continually, willfully, and recklessly breached their duties to DECEDENTS as set forth above. These negligent acts and omissions by the Defendants resulted in DECEDENTS being abandoned and suffering resulting in severe injuries and their death.

90. In particular, and without limiting the generality of the foregoing, Defendants, and each of them, acted with conscious disregard for Plaintiffs; rights, health, safety, and violated the state and federal regulations, including but not limited to 22 C. C.R. § 72301; 22 C.C.R. § 72311; 22 C.C.R. § 72315; 22 C.C.R. §§ 72329, and 72329.1; 22 C.C.R. § 72501; 22

C.C.R. § 72515; 22 C.C.R § 72527; 22 C.C.R. § 72527; Health and Safety Code§ 1599.1; 42 C.F.R. § 483.10; 42 C.F.R. § 483.12; 42 C.F.R. § 483.15; 42 C.F.R. §483.20; 42 C.F.R. § 483.21; 42 C.F.R. § 483.25; 42 C.F.R. 483.35; 42 C.F.R. § 483.70; and 42 C.F.R. § 483.70; 42 C.F.R. § 483.80 all of which caused injury and emotional distress to Plaintiffs when they:

a. Failed to treat DECEDENTS with dignity, kindness, and respect to fully honor their civil liberties;

b. Failed to provide a safe, comfortable, and homelike environment for DECEDENTS and protect them from physical or mental abuse, neglect, exploitation, or endangerment;

c. Failed to provide service personnel in sufficient numbers and with adequate skill to meet the needs of DECEDENTS

d. Failed to provide 'basic services' such as adequate care and supervision; assistance with instrumental activities of daily living; ensuring residents' general health, safety, and well-being;

f. Neglected DECEDENTS pursuant to Welfare & Institutions Code § 15610.57 by failing to exercise a degree of care that a reasonable person in a like position would have exercised; failed to provide care for physical and mental health needs; and failed to protect DECDENTS from health and safety hazards;

g. Failed to provide training to staff that was appropriate for the job assigned so as to provide safe and effective job performance;

h. Failed to adequately train staff in recognizing dangers posed to those who are at risk;

i. Failed to provide an adequate number of direct care staff to support each resident's physical, social, emotional, safety, and health care needs; and

j. Failed to establish and implement an adequate infection control program.

91. As a result of Defendants' actions, failures, and deficiencies, DECEDENTS all contracted COVID-19 causing their deaths.

92. Defendants' breaches were intentional and in reckless disregard of the severe

injury which would foreseeably result from Defendants' neglect, abuse, and refusal to adhere to their duties. Defendants and their employees knew there was a probability that injury would result from their neglect and their failure to adhere to their duties. Defendants, and each of them, acted with deliberate indifference to DECEDENTS' health and safety as set forth herein.

93. As a legal result of Defendants' conduct and subsequent breach of their duties, DECEDENTS endured pain and suffering and died.

94. As a result of Defendants' acts and omissions, Plaintiffs are entitled to reasonable attorneys' fees and costs of said suit as provided by California Welfare & Institutions Code Section 15657.

95. Because the aforementioned conduct of the Defendants and DOES 1 through 50 was carried out in a deliberate, profit driven, reckless, cold, callous, and intentional manner in order to injure and damage DECEDENTS or, in the alternative, was despicable conduct carried out with a willful, reckless, profit driven and conscious disregard for the rights and safety of others and subjected DECEDENTS to cruel and unjust hardship in conscious disregard of their rights, Plaintiffs request the assessment of punitive damages against Defendants and DOES 1 through 50 in an amount according to proof.

WHEREFORE, Plaintiffs pray for damages as set forth below.

## THIRD CAUSE OF ACTION

**(Violation of Patient's Bill of Rights-Health and Safety Code§ 1430)**

**(As Against Defendants)**

96. Plaintiffs refer to and reallege paragraphs 1 through 95, inclusive as though set forth fully herein.

97. Defendants, and each of them, by and through their management, agents and employees, were charged with the care and custody of DECEDENTS, who were elderly, dependent adults suffering from physical and mentally limitations, and completely dependent on Defendants for all activities of daily living.

98. Defendants, and each of them, owed a duty to DECEDENTS to ensure that their patient rights were not violated. (California Health and Safety Code § 1430.) DECEDENTS'

patient rights are established in the Patient Bill of Rights in section 72527 of Title 22 of the California Code of Regulations and Health and Safety Code section 123110 and 1599, et al. These resident rights include, but are not limited to the right,

a. To be accorded safe, healthful, and comfortable accommodations, furnishings, and equipment (Health & Safety Code§ 15991(e));

b. To receive care, supervision, and services that meet the resident's individual needs and are delivered by staff that are sufficient in numbers, qualifications, and competency to meet those needs (Health and Safety Code § 15 99 .1 (a));

c. To be free from neglect, financial exploitation, involuntary seclusion, punishment, humiliation, intimidation, and verbal, mental, physical, or sexual abuse (Title 22, CCR 72527(a)(10)); and

d. To be encouraged to maintain and develop the resident's fullest potential for independent living through participation in activities that are designed and implemented for this purpose (Health & Safety Code § 1569.269 (a)(26).

99. Defendants violated the above-referenced rights when Defendants failed to provide appropriate services to prevent serious health and safety hazards to DECDENTS and failed to provide adequate care to meet their needs. In particular, and without limiting the generality of the forgoing, Defendants, and each of them, violated DECEDENT'S rights when they:

a. Failed to ensure that DECEDENTS were free from physical abuse and neglect;

b. Failed to treat DECEDENTS with dignity, kindness, and respect;

c. Failed to provide DECEDENTS with a safe environment free from physical and/or mental abuse, neglect, exploitation, and/or danger;

d. Failed to provide adequate supervision/staffing, care, and services which met DECEDENTS needs.

100. As a direct and proximate result of the foregoing, DECEDENTS sustained injuries and painful physical and emotional suffering which caused their death.

101. As an actual and proximate result of the acts and omissions of Defendants, and

each of them, Plaintiffs incurred significant general and special damages.

102. As an actual and proximate result of the acts and omissions of Defendants, and each of them, Plaintiffs are entitled to compensation as provided by California Health and Safety Code§ 1430, et seq.

103. As an actual and proximate result of the acts and omissions of Defendants, and each of them, Plaintiffs are entitled to reasonable attorneys' fees and costs of said suit as provided by the California Health and Safety Code§ 1430, et seq.

104. In addition, California Health and Safety Code § 1430 (b) provides that Defendants "may be enjoined from permitting the violation to continue." Defendants have acted and continue to act in violation of the aforementioned basic rights of their residents. Defendants' residents will continue to suffer injuries as a result of these violations and/or practices unless the Court takes injunctive action. Therefore, Plaintiffs request injunctive relief against Defendants as follows:

a. To provide new hire and bi-annual in-service training of staff regarding (1) safe resident environments; (2) the implementation of appropriate infection control procedures; (3) provide adequate staffing levels to meet the residents' needs; and

b. To provide new orientation and bi-annual in-service training to staff regarding resident rights including: following physician orders, reporting changes in condition to the resident's physician and family, treating residents with dignity and respect, the release of resident facility records to resident/responsible party, and the implementation of devices and means for protecting the health and safety of the residents;

c. To ensure that the Defendant's facility is staffed based upon acuity levels of the residents (meeting the residents' needs); and

d. Annual audit of training and staff by a third-party at Defendants' expense including auditing and reporting on the above matters and staffing levels.

WHEREFORE, Plaintiffs pray for damages as set forth below.

## FOURTH CAUSE OF ACTION

**(Unfair Business Practices [Business and Professions Code § 17200])**

**(As Against Defendants)**

105. Plaintiffs refer to and reallege paragraphs 1 through 104, inclusive, as set though set forth fully herein.

106. Defendants' conduct, as herein alleged, was and is a part of a general business practice of Defendants. The business practice exists in part because Defendants expected that few adverse consequences would flow from their violations of state and federal law and the resulting mistreatment and neglect of their elderly, dependent and vulnerable residents, and thus Defendants made a considered decision to protect and promote their financial condition at the expense of its legal obligations to resident patients, including the DECEDENTS.

107. Plaintiffs are informed and thereon allege that Defendants, and each of them, made a practice of generally not advising new residents of their legal rights and Defendants' prior regulatory violations and/or complaints against the facility. Plaintiffs are also informed and thereon allege that Defendants made a practice of misrepresenting to potential residents and their families, and particularly to DECEDENTS, the type, level and extent of care that would be provided to residents upon admission.

108. Plaintiffs are further informed and thereon allege that Defendants, and each of them, made a conscious and considered decision to omit and/or misrepresent material facts related to the type, level and extent of care, failed to provide follow up investigation into whether Plaintiffs needs were being met, Defendants' unfair and fraudulent practices also include, but are not limited to: Defendants also breached their duty to Plaintiffs and their family to disclose all material facts that might influence DECEDENTS and their families on whether Defendants could properly care for DECEDENTS, including the duty to disclose whether Defendants had a history of neglect, abuse, violation of patient rights or prior citations issued for regulation violations involving patient care.

109. These practices set forth above constitute unfair, unlawful, and/or fraudulent business practices within the meaning of Business and Professions Code § 17200 and is violative

of public policy, and is unethical, fraudulent and injurious to consumers, particularly the elderly and to dependent adults. Plaintiffs directly fall within the category of individuals that Business and Professions Code § 17200 was designed to protect.

110. As a result, Plaintiffs are entitled to restitution of all funds paid by DECEDENTS or on their behalf.

111. As a result of Defendants' conduct, Plaintiffs have incurred and will incur attorneys' fees and related expenses in an amount to be proven at trial.

WHEREFORE, Plaintiffs pray for damages as set forth below.

**FIFTH CAUSE OF ACTION**

**(Wrongful Death)**

**(As against all Defendants)**

112. Plaintiffs refer to and reallege paragraphs 1 through 111, inclusive, as set though set forth fully herein.

113. The HEIRS are the surviving relatives of DECEDENTS.

114. As detailed in this Complaint, as a proximate result of Defendants' neglect of DECEDENTS they all contracted COVID-19 and eventually died from this virus.

115. As a further result of Defendants' neglect of Decedent, the HEIRS of DECEDENTS have been deprived of the society, comfort, companionship, attention, services, support, and friendship, and are therefore entitled to damages in an amount to be proven at trial.

WHEREFORE, Plaintiffs pray for damages as set forth below.

**SIXTH CAUSE OF ACTION**

**(Fraud/Misrepresentation)**

**(As Against All Defendants)**

116. Plaintiffs refer to and reallege paragraphs 1 through 115, inclusive as set forth fully herein.

117. Both before and after the admissions process, Defendants knowingly made false representations with intent to deceive and/or induce reliance by DECEDENTS and others and which resulted in a justifiable reliance by DECEDENTS which ultimately resulted in damages as

described herein.

118. As set forth previously, Defendants' Windsor facility has an extensive history of governmental citations relating to deficient care practices. Further, in response to these citations and deficiencies, Defendants made representations to the California Department of Public Health that it would comply with applicable regulatory standards and correct the deficiencies when it submitted plans of correction and also when it sought annual renewals of its license to operate.

119. Defendants' representations to the California Department of Public Health were false and were intended to retain licensure status and further intended to induce elderly consumers such as DECEDENTS to reside at Defendants' facility. Yet, the promised corrections were not made despite an unreasonable risk of harm to elderly residents such as DECEDENTS.

120. Without Defendants' representations, Defendants' facility would not have been licensed and DECEDENTS would not have entered the facility as residents or remained there. DECEDENTS were in a class of persons that were foreseeably injured by Defendants' representations to the California Department of Public Health and, as a result, suffered damages as set forth below.

121. All of these representations were intentionally made to deceive and/or induce reliance by DECEDENTS and their families. Such representations did cause DECEDENTS and their families to rely on Defendants' representations and DECEDENTS suffered monetary damages and physical and mental injuries as a result of their reliance on the statements of Defendants.

122. Defendants failed to disclose important facts, that were unknown and inaccessible to DECEDENTS and their families, that would have impacted DECEDENTS and their families' decision of whether to have them admitted to Defendants' nursing home and whether to have DECEDENTS remain at the facility after they were admitted. Specifically, Defendants did not disclose the facility's lengthy complaint and deficiency history with regulatory agencies which was unknown to DECEDENTS and their families. The failure to provide the information became even more relevant once Plaintiffs were at the facility and experienced many of the problems that were previously complained of.

123. As a corporate-owned skilled nursing facility, Defendants were charged and entrusted with providing total care for DECEDENTS, who were elders in a significant position of vulnerability because of their age and medical condition(s), who relied on Defendants for their most basic needs. DECEDENTS and their families placed their trust, confidence, and DECEDENTS well-being in Defendants. As such, when Defendants admitted DECEDENTS and thereafter during their residency at Defendants' facility, Defendants were in a position of power over DECEDENTS (i.e. they could decide whether or not to provide necessary goods and services) and were fiduciaries to DECEDENTS and, therefore, owed them and their families a fiduciary duty, which includes a duty to disclose material facts without concealment, misrepresentations, or half-truths and a duty to not allow financial conflicts of interest to adversely impact the care provided to DECEDENTS.

124. In breach of their fiduciary duty, Defendants consciously concealed important facts that would have impacted DECEDENTS and their families' decision of whether to have admitted them to Defendants' facility and their decision of whether to have them remain at Defendants' facility. Defendants failed to disclose their facility's complaint and deficiency history. These deficiencies include failures to provide necessary care and services to residents; failures to meet standards of quality; failures to provide adequate supervision; failures to notify residents and their family of significant changes in condition; and misusing medications. Defendants did so with the intent to induce DECEDENTS and their families to admit and retain them at the facility and to maintain an additional source of profit for the facility. Had DECEDENTS and their families known of this history, which they did not, they would not have chosen to admit and retain DECEDENTS at Defendants' facility. The failure to provide this information became even more relevant once DECEDENTS were at the facility.

125. Defendants further engaged in constructive fraud when they breached their fiduciary duty to DECEDENTS by understaffing their facility, with the knowledge that by doing so, they were placing their residents at risk of abuse, neglect, serious injury, and death and by failing to provide necessary, basic care to DECEDENTS. DECEDENTS and their families did not know that Defendants chronically understaffed their facility at the time of admission and

thereafter when they remained at Defendants' facility in part because of Defendants' representations that Defendants would provide DECEDENTS with total care from a professional care staff that would provide all of the assistance with activities of daily living that they required, medication monitoring and management, a 24-hour response system to respond to emergencies and staffing based on resident acuity.

126. By choosing to provide insufficient nursing service hours to meet the need of each of their residents and the appropriate equipment to prevent the spread of infection in order to maximize profits, Defendants breached their fiduciary duty owed to DECEDENTS to not allow a financial conflict of interest to affect their healthcare decision making and the level of care provided to DECEDENTS and others. Therefore, Defendants committed constructive fraud.

127. Said representations and omissions of material, harmful facts were made with the intent and purpose of retaining DECEDENTS as residents of Defendants' nursing home and also made with the intent of deceiving the DECEDENTS so as to avoid complaints regarding the quality of care and the threat of losing a potential income source.

128. DECEDENTS reasonably relied upon said representations to their detriment by deciding that the Defendants' facility was qualified and capable of providing custodial care for DECEDENTS. DECEDENTS further reasonably relied upon said representations when they chose to remain at Defendants' facility.

129. As a direct and proximate result of the foregoing, DECEDENTS sustained injuries, pain, suffering, and emotional distress through physical abuse and neglect in an amount to be determined according to proof at trial.

130. As a further direct and proximate result of the representation DECEDENTS sustained special damages in an amount to be determined according to proof at trial.

131. By virtue of the foregoing, Defendants acted fraudulently, recklessly and in conscious disregard for the rights and safety of its patients and residents, including DECEDENTS, and consequently realized a financial benefit. Accordingly, Defendants are required to disgorge those financial benefits.

WHEREFORE, Plaintiffs pray for damages as set forth below.

## PRAYER

1. For special damages according to proof;

2. For general damages according to proof;

3. For punitive damages according to proof;

4. For costs of suit and attorneys' fees herein incurred pursuant to Welfare and Institutions Code section 15657 et seq., Code of Civil Procedure Section 1021.5 or any other applicable statute;

5. For pre-judgment of economic damages and post-judgment interests pursuant to Civil Code Section 3287 and/or 3288 or any applicable provision of law;

6 For reimbursement of medical expenses and skilled nursing facility expenses;

7 Restitution pursuant to Business and Professions code § 17200;

8 For injunctive relief and third-party audits and monitoring as at Defendants' expense against Defendants as follows:

a. To provide new hire and bi-annual in-service training of staff regarding (1) safe resident environments; (2) the implementation of appropriate infection control procedures; (3) provide adequate staffing levels to meet the residents' needs; and

b. To provide new orientation and bi-annual in-service training to staff regarding resident rights including: following physician orders, reporting changes in condition to the resident's physician and family, treating residents with dignity and respect, the release of resident facility records to resident/responsible party, and the implementation of devices and means for protecting the health and safety of the residents;

c. To ensure that the Defendant's facility is staffed based upon acuity levels of the residents (meeting the residents' needs); and

d. Annual audit of training and staff by a third-party at Defendants' expense including auditing and reporting on the above matters and staffing levels.

9. For damages allowed under Health & Safety Code § 1430;

10. For such other and further relief as the Court may deem proper.

**JURY DEMAND**

Plaintiffs demand a trial by jury on all issues so triable.

Dated: August 26, 2021

REINER, SLAUGHTER, MAINZER & FRANKEL

By: _____

Russell Reiner
2851 Park Marina Drive., Suite 200
Redding, California 96001
Telephone: (530) 241-1905
Facsimile: (530) 241-0622

Stuart C. Talley, Esq.
KERSHAW, COOK & TALLEY, PC
401 Watt Avenue
Sacramento, California 95864
Telephone: (916) 779-7000
Facsimile: (916) 244-4829

Wendy C. York
YORK LAW CORPORATION
1111 Exposition Blvd., Building 500
Sacramento, California 95815
Telephone: (916) 643-2200
Facsimile: (916) 643-4680

*Counsel for Plaintiffs*