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Superior Court of California, County of San Francisco
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BY: JEFFREY FLORES
Deputy Clerk

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN FRANCISCO

VICTORIA SANCHEZ, Individually and as Successor-in-Interest to the Estate of EDWARD SANCHEZ; TSAN VONG, ANH VONG, and KEVIN LIEU, Individually and as Successors-in-Interest to the Estate of NGO VI LIEU; and LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA, HENRY PHAM, and LINDA PHAM, Individually and as Successors-in-Interest to the Estate of QUY PHAM,

Plaintiffs,

vs.

CITY AND COUNTY OF SAN FRANCISCO; SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH; LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER; SAN FRANCISCO MEDICAL RESPITE & SOBERING CENTER; COUNTY OF SAN MATEO dba BURLINGAME SKILLED NURSING d/p SNF; BRIUS, LLC; BOARDWALK WEST FINANCIAL SERVICES, LLC; ROCKPORT ADMINISTRATIVE SERVICES, LLC; SHLOMO RECHNITZ; CHESTER KUNNAPPILLY; AHMC SETON MEDICAL CENTER, LLC dba AHMC SETON MEDICAL CENTER COASTSIDE d/p SNF; AHMC HEALTHCARE INC.; AHMC HEALTHCARE, LP; MOCHI GROUP, LP; OLIVIA JOY INVESTMENT CORP; AHMC, INC.; ANTHONY ARMADA; KERIANNE

Case No. CGC-23-606373

COMPLAINT FOR DAMAGES

(1) Elder/Dependent Adult Abuse/Neglect;
(2) Violation of Patient's Rights;
(3) Negligence; and
(4) Wrongful Death.

JURY TRIAL DEMANDED

CALIGUIRE; KENNETH LIEU, KIN KINH LIEU, LOI LIEU, PHONG PHAM, AND HOA PHAMLY as nominal defendants; and DOES 1–100, inclusive,

Defendants.

Plaintiffs VICTORIA SANCHEZ, Individually and as Successor-in-Interest to the Estate of EDWARD SANCHEZ; TSAN VONG, ANH VONG, and KEVIN LIEU, Individually and as Successors-in-Interest to the Estate of NGO VI LIEU; and LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA, HENRY PHAM, and LINDA PHAM, Individually and as Successors-in-Interest to the Estate of QUY PHAM (hereinafter collectively referred to as "Plaintiffs"), complain as follows:

PARTIES

Plaintiff VICTORIA SANCHEZ, Individually and as Successor-in-Interest to the Estate of EDWARD SANCHEZ ("Plaintiff SANCHEZ")

1. Plaintiff SANCHEZ is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California.

2. Decedent EDWARD SANCHEZ ("Decedent SANCHEZ") was at all times herein mentioned a resident of the City and County of San Francisco, State of California. At all times herein mentioned, Decedent SANCHEZ was a dependent adult within the meaning of Welfare & Institutions Code §15610, et seq. At all times relevant, Decedent SANCHEZ was a dependent adult who was substantially more vulnerable than other members of the public because of his disabilities. As set forth herein, Decedent SANCHEZ suffered from physical injuries and emotional distress and ultimately died due to the failures of Defendants (1) CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH, LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER, and DOES 1-10 (collectively referred to herein as the "Laguna Honda Defendants"), (2) SAN FRANCISCO MEDICAL RESPITE & SOBERING CENTER, and DOES 11-20, and (3) DOES 51-70 (all collectively referred to herein as the "SANCHEZ Defendants").

3. Plaintiff SANCHEZ is Decedent SANCHEZ's mother and sole heir to the Estate of

EDWARD SANCHEZ.

4. At all times relevant to this action, Decedent SANCHEZ was an dependent adult within the meaning of Welfare & Institutions Code §15610, et seq. Decedent SANCHEZ, who was 63-years-old at the time of his transfer and discharge from LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER (hereinafter "LAGUNA HONDA") and admission to SAN FRANCISCO MEDICAL RESPITE & SOBERING CENTER (hereinafter "MEDICAL RESPITE"), had physical and/or mental limitations that restricted his ability to carry out normal activities or to protect his rights, and was at all times relevant substantially more vulnerable than other members of the public to the conduct of the SANCHEZ Defendants because of his disability, and Decedent SANCHEZ actually suffered substantial physical, emotional, and/or economic damage resulting from the conduct of the SANCHEZ Defendants, as described below.

5. On or about December 16, 2022, Plaintiff SANCHEZ timely presented a claim to the CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH, LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER, and SAN FRANCISCO MEDICAL RESPITE & SOBERING CENTER for the damages suffered and incurred by Plaintiff SANCHEZ by reason of the occurrences described herein, all in compliance with the requirements of Government Code § 905. Said claims were rejected on or about March 23, 2023. Accordingly, this Complaint was timely filed per Government Code § 945.6.

TSAN VONG, ANH VONG, and KEVIN LIEU, Individually and as Successors-in-Interest to the Estate of NGO VI LIEU (collectively the "LIEU Plaintiffs")

6. Plaintiff TSAN VONG is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California. Plaintiff ANH VONG is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California. Plaintiff KEVIN LIEU is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California. Plaintiff TSAN VONG is Decedent's living spouse. Plaintiffs ANH VONG, KEVIN LIEU, Nominal Defendant KENNETH LIEU, Nominal Defendant KIN KINH LIEU, and Nominal Defendant LOI LIEU are the living children of Decedent NGO VI LEIU

1 (“Decedent LIEU”).

2 7. Decedent LIEU was at all times herein mentioned a resident of the City and County
3 of San Francisco and/or County of San Mateo, State of California. At all times herein mentioned,
4 Decedent LEIU was an elder within the meaning of Welfare & Institutions Code § 15610, et seq. At
5 all times relevant, Decedent LEIU was a senior citizen who was substantially more vulnerable than
6 other members of the public because of his disabilities and his age of 84 years. As set forth herein,
7 Decedent LEIU suffered from physical injuries and emotional distress and ultimately died due to the
8 failures of (1) the Laguna Honda Defendants and DOES 51-60, (2) the COUNTY OF SAN MATEO
9 dba BURLINGAME SKILLED NURSING d/p SNF, BRIUS, LLC, BOARDWALK WEST
10 FINANCIAL SERVICES, LLC, ROCKPORT ADMINISTRATIVE SERVICES, LLC, SHLOMO
11 RECHNITZ, CHESTER KUNNAPPILLY, and DOES 21-35 (collectively the “Burlingame Skilled
12 Defendants”), and (3) DOES 71-80 (all collectively referred to herein as the “LIEU Defendants”).

13 8. At all times relevant to this action, Decedent LIEU was an elder within the meaning
14 of Welfare & Institutions Code § 15610, et seq. Decedent LIEU, who was 84-years-old at the time
15 of his transfer and discharge from LAGUNA HONDA and admission to BURLINGAME SKILLED
16 NURSING d/p SNF (hereinafter “BURLINGAME SKILLED”), had physical and/or mental
17 limitations that restricted his ability to carry out normal activities or to protect his rights, and was at
18 all times relevant substantially more vulnerable than other members of the public to the conduct of
19 the LIEU Defendants because of his age and disability, and Decedent LIEU actually suffered
20 substantial physical, emotional, and/or economic damage resulting from the conduct of the LIEU
21 Defendants, as described below.

22 9. On or about December 16, 2022, the LIEU Plaintiffs timely presented a claim to the
23 CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO DEPARTMENT OF PUBLIC
24 HEALTH, LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER, and the
25 COUNTY OF SAN MATEO dba BURLINGAME SKILLED NURSING d/p SNF for the damages
26 they suffered and incurred by the LIEU Plaintiffs by reason of the occurrences described herein, all
27 in compliance with the requirements of Government Code § 905. Said claims were rejected on or

about March 16, 2023 by the CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH, LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER, and on or about January 26, 2023 by the COUNTY OF SAN MATEO dba BURLINGAME SKILLED NURSING d/p SNF. Accordingly, this Complaint was timely filed per Government Code § 945.6.

LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA, HENRY PHAM, and LINDA PHAM, Individually and as Successors-in-Interest to the Estate of QUY PHAM (collectively the "PHAM Plaintiffs")

10. Plaintiff LAN PHAM is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California. Plaintiff QUYEN JENNIFER PHAM is and was at all times herein mentioned a resident of the County of San Mateo, State of California. Plaintiff MAI PHAM is and was at all times herein mentioned a resident of the County of Sacramento, State of California. Plaintiff LY PHAM RIVERA is and was at all times herein mentioned a resident of the County of Marin, State of California. Plaintiff HENRY PHAM is and was at all times herein mentioned a resident of the County of Marin, State of California. Plaintiff LINDA PHAM is and was at all times herein mentioned a resident of the City and County of San Francisco, State of California. Plaintiffs LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA, HENRY PHAM, LINDA PHAM, and Nominal Defendant PHONG PHAM are the living children of Decedent QUY PHAM ("Decedent PHAM"). Nominal Defendant HOA PHAMLY is Decedent PHAM's living spouse.

11. Decedent PHAM was at all times herein mentioned a resident of the City and County of San Francisco and/or County of San Mateo, State of California. At all times herein mentioned, Decedent PHAM was an elder within the meaning of Welfare & Institutions Code §15610, et seq. At all times relevant, Decedent PHAM was a senior citizen who was substantially more vulnerable than other members of the public because of his disabilities and his age of 80 years. As set forth herein, Decedent PHAM suffered from physical injuries and emotional distress and ultimately died due to the failures of (1) the Laguna Honda Defendants and DOES 51-60, (2) AHMC SETON

MEDICAL CENTER, LLC dba AHMC SETON MEDICAL CENTER COASTSIDE d/p SNF; AHMC HEALTHCARE INC.; AHMC HEALTHCARE, LP; MOCHI GROUP, LP; OLIVIA JOY INVESTMENT CORP; AHMC, INC.; ANTHONY ARMADA; KERIANNE CALIGUIRE and DOES 36-50 (collectively the "Seton Defendants"), and (3) DOES 81-90 (all collectively referred to herein as the "PHAM Defendants").

12. At all times relevant to this action, Decedent PHAM was an elder within the meaning of Welfare & Institutions Code §15610, et seq. Decedent PHAM, who was 80-years-old at the time of his transfer and discharge from LAGUNA HONDA and admission to AHMC SETON MEDICAL CENTER COASTSIDE d/p SNF (hereinafter "SETON"), had physical and/or mental limitations that restricted his ability to carry out normal activities or to protect his rights, and was at all times relevant substantially more vulnerable than other members of the public to the conduct of the PHAM Defendants and because of his disability, and Decedent PHAM actually suffered substantial physical, emotional, and/or economic damage resulting from the conduct of the PHAM Defendants, as described below.

13. On or about December 14, 2022, the PHAM Plaintiffs timely presented a claim to the CITY AND COUNTY OF SAN FRANCISCO and LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER for the damages suffered and incurred by the PHAM Plaintiffs by reason of the occurrences described herein, all in compliance with the requirements of Government Code § 905. Said claims were rejected on or about March 17, 2023. Accordingly, this lawsuit was timely filed per Government Code § 945.6.

DEFENDANTS

14. The Laguna Honda Defendants own and operate, and/or are in the business of providing care at LAGUNA HONDA, located at 375 Laguna Honda Boulevard, San Francisco, CA 94116, which is real property owned or controlled by the Laguna Honda Defendants. The Laguna Honda Defendants are located and doing business in the City and County of San Francisco, State of California. The Laguna Honda Defendants, and each of them, owned, leased, licensed, operated, administered, managed, directed, and/or controlled and are "managing agents" of LAGUNA

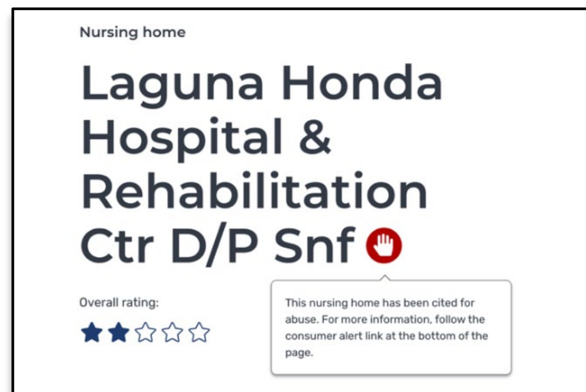
HONDA at all relevant times herein and actively participated in and controlled the business of LAGUNA HONDA.

15. The Laguna Honda Defendants, by and through their corporate officers and directors, and others presently unknown to Plaintiffs, acted recklessly and later ratified the conduct of their co-defendants, in that they were aware that there was an insufficient number of staff, that the staff present at LAGUNA HONDA was not adequately trained, and that the staff present at LAGUNA HONDA was not adequately supervised, and were aware of the relationship between these shortcomings and the lack of provision of care to patients of LAGUNA HONDA, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, which resulted in numerous poor outcomes, multiple Statements of Deficiencies and/or Citations being issued by the California Department of Public Health, and multiple claims and/or lawsuits being filed against the Laguna Honda Defendants. This knowing flouting of staffing regulations was part of the Laguna Honda Defendants' knowing pattern and practice to cut costs at LAGUNA HONDA, thereby endangering LAGUNA HONDA's dependent elderly and/or dependent adult patients, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM.

16. Plaintiffs are informed and believe and on that basis allege that Roland Pickens and/or Michael Phillips was an Administrator of LAGUNA HONDA, and that at all times relevant to this action, in their capacity as Administrator, Roland Pickens and/or Michael Phillips is and was responsible for all operational activities of LAGUNA HONDA, including the duty to ensure LAGUNA HONDA is adequately staffed to meet the needs of the patients and the duty to make sure the persons working in LAGUNA HONDA were adequately trained to meet the needs of the patients. Plaintiffs are informed and believe and on that basis allege that LAGUNA HONDA Administrator and Director of San Francisco Health Network, Roland Pickens, Administrator Michael Philips, Chief Integrity Officer and Director of the Office of Compliance and Privacy Affairs, Margaret A. Rykowski, Director of Health, Grant Colfax, Chief Medical Officer, Medical Director, Director of Quality, San Francisco Department of Public Health Office of Compliance and Privacy Affairs, Garrett Chatfield, Director of Nursing, Theresa Dentoni and/or Monica Biley,

Director of Regulatory Affairs, Geraldine Mariano, LAGUNA HONDA's social workers, including social worker Cindia Lok, and others each made and approved key decisions concerning LAGUNA HONDA's day-to-day operations, such as setting staffing levels, employee hiring and firing, budgets, resident transfers/discharges, and related issues and were managing agents of the Laguna Honda Defendants. Plaintiffs are further informed and believe and on that basis allege that each of the individuals named herein were at all times herein mentioned citizens of the State of California.

17. Prior to and during the admissions to LAGUNA HONDA of Decedent SANCHEZ, Decedent LIEU, and DECEDENT PHAM, the Laguna Honda Defendants had a pattern of substandard care, lack of supervision, and purposeful understaffing, which was well known to the Laguna Honda Defendants and their managing agents. For example, Plaintiffs are informed and believe and accordingly allege that during the admissions to LAGUNA HONDA of Decedent SANCHEZ, Decedent LIEU, and DECEDENT PHAM, LAGUNA HONDA was given an overall rating of two out of five stars (i.e., "Below Average") by the official Centers for Medicare & Medicaid Services ("CMS") Nursing Home Compare, a one out of five stars, or "much below average," for health inspections, and a red hand icon given to facilities cited for abuse (see image below).[1] The managing agents of the Laguna Honda Defendants knew or should have known of the



lack of basic assistance, supervision, and care to its patients at LAGUNA HONDA, as well as the lack of training provided to LAGUNA HONDA's staff. The Laguna Honda Defendants and their

[1] CMS Nursing Home Compare, Nursing Home Profile for LAGUNA HONDA available at: https://www.medicare.gov/care-compare/details/nursing-home/555020?id=1eb8cb96-e0bc-4994-be75-b3ec700c4878&city=San%20Francisco&state=CA&zipcode=94102 (last accessed December 12, 2022.)

managing agents had a duty to direct their nurses and staff yet did not make any changes at LAGUNA HONDA, even with knowledge of substandard care, failures to supervise and monitor residents, inadequate staffing, and failures to protect residents from health and safety hazards there.

18. In approximately April 2022, the U.S. Department of Health and Human Services (HHS) ended LAGUNA HONDA's participation in its Medicare/Medicaid programs after LAGUNA HONDA was found out of compliance on multiple safety inspections. On approximately May 13, 2022, the Laguna Honda Defendants submitted the "Laguna Honda Hospital and Rehabilitation Center Notification of Closure and Patient Transfer and Relocation Plan" (referred to herein as the "Closure Plan") to the Centers for Medicare & Medicaid Services (CMS) and California Department of Public Health (CDPH), which stated an anticipated closure date for LAGUNA HONDA as September 13, 2022. The Closure Plan states, "The intent of this Closure Plan is to ensure the safe, orderly, and clinically appropriate transfer or discharge of each patient with a minimum amount of stress for patients, families, guardians, and legal representatives…"[2]

19. Plaintiffs informed and believe, and accordingly allege, that the Laguna Honda Defendants knew or should have known of the risk of transfer trauma to Decedent SANCHEZ, Decedent LIEU, Decedent PHAM and other residents at LAGUNA HONDA, yet they consciously disregarded this risk. Studies from as early as 2018 have found that there is a substantial likelihood of negative effects for long-term patients and/or residents of hospitals and/or skilled nursing facilities, often resulting in increased rate of morbidity and mortality, which is often referred to as "transfer trauma." For example, the following contains the results from a 2018 study from the Gerontological Society of America:

> The effects of relocation were discussed in terms of mortality and morbidity. In most studies, the health effects of the relocation of older adults suffering from dementia were negative. A decline in physical, mental, behavioral, and functional well-being was reported. The most recurring effect was a higher level of stress, which is more problematic for patients with dementia. In general, unless it is carefully planned, it is best to avoid changing lives of people with dementia and it is

[2] See "Laguna Honda Hospital and Rehabilitation Center Notification of Closure and Patient Transfer and Relocation Plan," available at https://sf.gov/sites/default/files/2022-05/Laguna%20Honda%20Hospital%20and%20Rehabilitation%20Center%20Notification%20of%20Closure%20and%20Patient%20Transfer%20and%20Relocation%20Plan.pdf (last accessed December 12, 2022.)

recommended to actively work to reduce their exposure to stress.

20. Plaintiffs are informed and believe, and accordingly allege, that the Laguna Honda Defendants and their managing agents forced Decedent SANCHEZ, Decedent LIEU, Decedent PHAM and other residents to transfer from LAGUNA HONDA to other facilities without following recommendations for the transfer process as outlined by medical professionals and by regulation, despite knowing the high probability of these elder and/or dependent adults, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, would suffer transfer trauma and resulting complications, including a decline in condition and death.

21. Plaintiffs are informed and believe, and accordingly allege, that the mistreatment of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM by the Laguna Honda Defendants and their managing agents/employees, including their transfer trauma and subsequent death, happened to multiple other previous patients of LAGUNA HONDA who were also pressured and/or coerced into being discharged from LAGUNA HONDA.[3] These failures by the Laguna Honda Defendants are the result of a systemic lack of communication, oversight, and follow up by the Laguna Honda Defendants' managing agents, who have allowed to exist for a period of several years a culture of secrecy, wrongful conduct, and abuse of the Laguna Honda Defendants' patients at LAGUNA HONDA, including Decedent SANCHEZ, Decedent LIEU and Decedent PHAM. Each of these acts and omissions by the Laguna Honda Defendants' managing agents/employees regarding the care and treatment of Decedent SANCHEZ, Decedent LIEU and Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA.

22. Plaintiffs are informed and believe and, on that basis allege, that as a result of the lack of care provided at LAGUNA HONDA, reportable incidents have occurred in the months leading up to the forced discharge of Decedent SANCHEZ, Decedent LIEU and Decedent PHAM, including multiple falls, missing residents, and other dangerous situations. Plaintiffs are informed and believe and, on that basis allege, that the Laguna Honda Defendants, and/or their

[3] See, e.g., SF Examiner, "Laguna Honda halts discharges after deaths; future of the hospital still unclear," available at https://www.sfexaminer.com/news/laguna-honda-halts-discharges-after-deaths-future-of-the-hospital-still-unclear/article_f5563e42-0ec2-11ed-8a35-bf7fec064aad.html (last accessed December 12, 2022).

1 employees/managing agents per Government Code §815.2 and §820(a), were aware that factors
2 contributing to these and other injuries and safety risks included, but were not limited to,
3 inconsistent practices and an overall failure to promote a safe environment and reduce potential risks
4 at LAGUNA HONDA. However, these corporate managing agents did nothing, even with
5 knowledge of the neglect and risk of injury and death. As a result, multiple claims and/or lawsuits
6 have been filed against the Laguna Honda Defendants.

7 23. Defendants CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO
8 DEPARTMENT OF PUBLIC HEALTH, SAN FRANCISCO MEDICAL RESPITE & SOBERING
9 CENTER and DOES 11-20 (collectively referred to herein as "Medical Respite Defendants") own
10 and operate, and/or are in the business of providing care at MEDICAL RESPITE, located at 1171
11 Mission St, San Francisco, CA 94103, which is real property owned or controlled by the Medical
12 Respite Defendants. The Medical Respite Defendants are located and doing business in the City and
13 County of San Francisco, State of California. The Medical Respite Defendants, owned, leased,
14 licensed, operated, administered, managed, directed, and/or controlled and are "managing agents" of
15 MEDICAL RESPITE and actively participated in and controlled the business of MEDICAL
16 RESPITE. The Medical Respite Defendants, by and through their corporate officers and directors,
17 and others presently unknown to Plaintiff SANCHEZ, acted recklessly and later ratified the conduct
18 of their co-defendants in that they were aware that there was an insufficient number of staff, that the
19 staff present at MEDICAL RESPITE was not trained, and that the staff present at MEDICAL
20 RESPITE was not supervised, and were aware of the relationship between these shortcomings and the
21 sub-standard provision of care to patients of MEDICAL RESPITE, including Decedent SANCHEZ,
22 which resulted in numerous poor outcomes. This knowing flouting of staffing regulations was part of
23 the Medical Respite Defendants' pattern and practice to cut costs, thereby endangering MEDICAL
24 RESPITE's elderly and/or dependent adult patients, including Decedent SANCHEZ.

25 24. Plaintiff SANCHEZ is informed and believes that the Medical Respite Respondents'
26 Medical Director, Nurse Manager, social workers, and others each made and approved key decisions
27 concerning MEDICAL RESPITE's day-to-day operations, such as setting staffing levels, employee

hiring and firing, budgets, resident admissions, and related issues and were managing agents of the Medical Respite Defendants. Plaintiff SANCHEZ is further informed and believes that each of the individuals named herein were at all times herein mentioned citizens of the State of California.

25. The Burlingame Skilled Defendants own and operate, and/or are in the business of providing care at BURLINGAME SKILLED, a skilled nursing facility located at 1100 Trousdale Dr, Burlingame, CA 94010, which is real property owned or controlled by the Burlingame Skilled Defendants. The Burlingame Skilled Defendants are located and doing business in the County of San Mateo, State of California. The Burlingame Skilled Defendants, and each of them, owned, leased, licensed, operated, administered, managed, directed, and/or controlled and are "managing agents" of BURLINGAME SKILLED and actively participated in and controlled the business of BURLINGAME SKILLED. The COUNTY OF SAN MATEO is identified as the licensee of BURLINGAME SKILLED on the CDPH website, which also identifies defendant BRIUS, LLC as the management company for BURLINGAME SKILLED. The LIEU Plaintiffs are informed and believe that defendants BOARDWALK WEST FINANCIAL SERVICES, LLC, ROCKPORT ADMINISTRATIVE SERVICES, LLC and DOES 21-25 provides "professional services" to BURLINGAME SKILLED, and were at all times relevant effectively the day-to-day operators of BURLINGAME SKILLED. BOARDWALK WEST FINANCIAL SERVICES, LLC reports its principal place of business as 5900 Wilshire Blvd., Suite 2600, Los Angeles, California 90036. The managing member of BOARDWALK WEST FINANCIAL SERVICES, LLC, as reported to the Secretary of State of California, is SHLOMO RECHNITZ, who reports his address to the Secretary of State of California as 7223 Beverly Blvd., Suite 205, Los Angeles, California, 90036, the same mailing address as BOARDWALK WEST FINANCIAL SERVICES, LLC. The LIEU Plaintiffs are informed and believe that ROCKPORT ADMINISTRATIVE SERVICES, LLC is a company which was created by Steven Stroll, who is the Certified Public Accountant for SHLOMO RECHNITZ, that reports its principal place of business to the Secretary of State of California as 5900 Wilshire Blvd., Suite 1600, Los Angeles, California. The LIEU Plaintiffs are informed and believe that the control of BURLINGAME SKILLED by BOARDWALK WEST FINANCIAL SERVICES, LLC is

achieved via a "Professional Services Agreement" between the BURLINGAME SKILLED and BOARDWALK WEST FINANCIAL SERVICES, LLC, which sets forth the services BOARDWALK WEST FINANCIAL SERVICES, LLC is to provide to the BURLINGAME SKILLED, which in sum is the functional equivalent of operational control over the BURLINGAME SKILLED and includes, but is not limited to: (1) providing for nursing services that relate to the direct care of the patients of the BURLINGAME SKILLED; (2) providing nursing personnel to fill in for temporarily vacant positions at the BURLINGAME SKILLED; (3) providing nursing compliance services to the BURLINGAME SKILLED required to ensure that nursing services were in compliance with the requirements of the BURLINGAME SKILLED; (4) providing nursing personnel to assess patients and make clinical coverage decisions at the FACILITY; and (5) providing nursing personnel to the FACILITY to ensure residents at the facility are provided with the skilled services they require based on their acuity levels to ensure proper staffing. Moreover, the LIEU Plaintiffs are informed and believe that BOARDWALK WEST FINANCIAL SERVICES, LLC directs the operations of BURLINGAME SKILLED as a mere instrumentality by way of total control through "State of the Division" directives, Annual Administrator Incentive Plans, directives of Organization Changes, directive of how and when "Business Performance Reviews" as to staffing issues will be performed, and many other mechanisms, including hiring of Administrators of the facilities with directives that the Administrator report directly to BOARDWALK WEST FINANCIAL SERVICES, LLC, among other things.

26. The LIEU Plaintiffs are informed and believe, and based thereon allege, that at all times mentioned herein defendant SHLOMO RECHNITZ was, and is, a citizen of the State of California, with his principal residence in Los Angeles, California. According to a motion filed by former California Attorney General Kamala Harris in the US Bankruptcy Court for the Central District of California to disqualify entities owned and controlled by SHLOMO RECHNITZ from (1) interim management of debtor facilities and (2) purchasing debtors' facilities or assets: (a) SHLOMO RECHNITZ and his companies owned 57 skilled nursing facilities ("SNFs") as of August 28, 2014 and was in the process of obtaining 19 additional SNFs; (b) in 2014,

reimbursements were withheld to SHLOMO RECHNITZ's facilities from both Medi-Cal and Medicare as a result of "continued and repeated refusals to comply with industry laws and regulations"; (c) on August 22, 2014, California Department of Health Care Services ("DHCS") sent a letter to SHLOMO RECHNITZ's attorney for the failure of SHLOMO RECHNITZ to submit a home office cost report for related entities including defendant BOARDWALK WEST FINANCIAL SERVICES, LLC (formerly known as Boardwalk Financial Services, LLC); and (d) "RECHNITZ and his companies have a history of failing to comply with laws and regulations enforced by the DHCS and the Federal Centers for Medicare and Medicaid." Steven Stroll, SHLOMO RECHNITZ's CPA, who has a principal place of business as 5900 Wilshire Blvd., Suite 1600, Los Angeles, California, signed a declaration in bankruptcy court stating that SHLOMO RECHNITZ "through affiliated entities that he controls, is one of the largest if not the largest, owners and operators of skilled nursing facilities." SHLOMO RECHNITZ has admitted that he is the owner of various skilled nursing facilities and entities, and that he does not "know the actual legal names of all my companies." SHLOMO RECHNITZ has repeatedly confused pronouns when referring to his various companies, using the term "me" when it should be the corporation. Based on the Operating Agreements in place for the majority of SHLOMO RECHNITZ' entities, he is or was the manager and had the "capacity to lend money, and I was the lender, but the nursing home that we were putting it into was the borrower, and I was a member of that as well." When one of his facilities wants to make a draw from the line of credit, they have to submit in writing to him personally for his approval. The language from at least one Operating Agreement states that "[t]he manager shall have the general supervision, direction and control of the business of the company and the general powers and duties of management typically vested in the president of the corporation…" SHLOMO RECHNITZ has testified under oath that he gets a monthly financial report from each of his facilities, that "they were supposed to inform me of any surveys that we would fail, any citations we would receive and any lawsuits for care or even a bad outcome that resulted in someone asking for information or a patient file. You know, if you got to that level, they were to notify me." The LIEU Plaintiffs are informed and believe that defendant SHLOMO

RECHNITZ is the managing agent and/or controlling owner of BOARDWALK WEST FINANCIAL SERVICES, LLC, and uses this entity as a to unjustly enrich himself.

27. The Burlingame Skilled Defendants, by and through their corporate officers and directors, and others presently unknown to the LIEU Plaintiffs, acted recklessly and later ratified the conduct of their co-defendants in that they were aware that there was an insufficient number of staff, that the staff present at BURLINGAME SKILLED was not trained, and that the staff present at BURLINGAME SKILLED was not supervised, and were aware of the relationship between these shortcomings and the sub-standard provision of care to patients of BURLINGAME SKILLED, including Decedent LIEU, which resulted in numerous poor outcomes. This knowing flouting of staffing regulations was part of the Burlingame Skilled Defendants' pattern and practice to cut costs, thereby endangering BURLINGAME SKILLED's elderly and/or dependent adult patients, including Decedent LIEU.

28. The LIEU Plaintiffs are informed and believe that CHESTER KUNNAPPILLY was an Administrator of BURLINGAME SKILLED, and that at all times relevant to this action, in his capacity as Administrator, CHESTER KUNNAPPILLY is and was responsible for all operational activities of BURLINGAME SKILLED, including the duty to ensure BURLINGAME SKILLED is adequately staffed to meet the needs of the patients and the duty to make sure the persons working in BURLINGAME SKILLED were trained to meet the needs of the patients. The LIEU Plaintiffs are informed and believe that BURLINGAME SKILLED's Administrator CHESTER KUNNAPPILLY, Director of Nursing Shirley Faller, Board Member/Officer Susan Ehrlich, and others each made and approved key decisions concerning BURLINGAME SKILLED's day-to-day operations, such as setting staffing levels, employee hiring and firing, budgets, resident admissions/discharges, and related issues and were managing agents of the Burlingame Skilled Defendants. The LIEU Plaintiffs are further informed and believe that each of the individuals named herein were at all times herein mentioned citizens of the State of California.

29. The Seton Defendants own and operate, and/or are in the business of providing care at SETON, a skilled nursing facility located at 600 Marine Blvd., Moss Beach, CA 94038, which is

real property owned or controlled by the Seton Defendants. The Seton Defendants are located and doing business in the County of San Mateo, State of California. The Seton Defendants, and each of them, owned, leased, licensed, operated, administered, managed, directed, and/or controlled and are "managing agents" of SETON and actively participated in and controlled the business of SETON. AHMC SETON MEDICAL CENTER LLC is identified as the licensee of SETON on the CDPH website, which also identifies defendants AHMC HEALTHCARE INC.; AHMC HEALTHCARE, LP; MOCHI GROUP, LP; OLIVIA JOY INVESTMENT CORP; AHMC, INC. as being partial owners of SETON. The Seton Defendants, by and through their corporate officers and directors, and others presently unknown to the PHAM Plaintiffs, acted recklessly and later ratified the conduct of their co-defendants in that they were aware that there was an insufficient number of staff, that the staff present at SETON was not trained, and that the staff present at SETON was not supervised, and were aware of the relationship between these shortcomings and the sub-standard provision of care to patients of SETON, including Decedent PHAM, which resulted in numerous poor outcomes. This knowing flouting of staffing regulations was part of the Seton Defendants' pattern and practice to cut costs, thereby endangering SETON's elderly and/or dependent adult patients, including Decedent PHAM.

30. The PHAM Plaintiffs are informed and believe and on that basis allege that ANTHONY ARMADA was an Administrator of SETON, and that at all times relevant to this action, in his capacity as Administrator, ANTHONY ARMADA is and was responsible for all operational activities of SETON, including the duty to ensure SETON is adequately staffed to meet the needs of the patients and the duty to make sure the persons working in SETON were trained to meet the needs of the patients. The PHAM Plaintiffs are informed and believe and on that basis allege that SETON's Administrator ANTHONY ARMADA, Director of Nursing KERIANNE CALIGUIRE, Board Member/Officers Bin Fen Cheng, Jonathan Wu, Joy Lin, Matthew Yuan Ching Lin, and others each made and approved key decisions concerning SETON's day-to-day operations, such as setting staffing levels, employee hiring and firing, budgets, resident admissions/discharges, and related issues and are managing agents of the Seton Defendants. The LIEU Plaintiffs are further

informed and believe and, on that basis, allege that each of the individuals named herein were at all times herein mentioned citizens of the State of California.

31. DOES 51-60 are the unaffiliated staffing agencies, registries and/or employers of "travelling nurses" and/or temporary or registry nurses, CNAs or other staff who worked at LAGUNA HONDA during the admissions of Decedent SANCHEZ, Decedent LIEU, and/or Decedent PHAM. Plaintiffs are further informed and believe and, on that basis, allege that DOES 51-60 are health care providers, including licensed nurses and certified nursing assistants, who were at all times relevant employees of Laguna Honda Defendants.

32. DOES 61-70 are the unaffiliated staffing agencies, registries and/or employers of "travelling nurses" and/or temporary or registry nurses, CNAs or other staff who worked at MEDICAL RESPITE during the admission of Decedent SANCHEZ at MEDICAL RESPITE. Plaintiff SANCHEZ is further informed and believes and, on that basis, alleges that DOES 61-70 are health care providers, including licensed nurses and certified nursing assistants, who were at all times relevant employees of the Medical Respite Defendants.

33. DOES 71-80 are the unaffiliated staffing agencies, registries and/or employers of "travelling nurses" and/or temporary or registry nurses, CNAs or other staff who worked at BURLINGAME SKILLED during the admission of Decedent LIEU at BURLINGAME SKILLED. The LIEU Plaintiffs are further informed and believe and, on that basis, allege that DOES 71-80 are health care providers, including licensed nurses and certified nursing assistants, who were at all times relevant employees of the Burlingame Skilled Defendants.

34. DOES 81-90 are the unaffiliated staffing agencies, registries and/or employers of "travelling nurses" and/or temporary or registry nurses, CNAs or other staff who worked at SETON during the admission of Decedent PHAM at SETON. The PHAM Plaintiffs are further informed and believe and, on that basis, allege that DOES 81-90 are health care providers, including licensed nurses and certified nursing assistants, who were at all times relevant employees of the Seton Defendants.

35. Plaintiffs are ignorant of the true names and capacities of those defendants named

and sued herein as Does 1 through 100, and for that reason has identified said defendants by such fictitious names. Plaintiffs will seek leave to amend this claim to reflect their true names when ascertained. Plaintiffs are informed and believe, and accordingly allege, that each of the defendants sued herein as Does 1 through 100 is responsible in some manner for the occurrences alleged in this complaint and that these respondents proximately caused the harms suffered by Plaintiffs.

36. Plaintiffs are informed and believe, and accordingly allege, that at all relevant times each of the Laguna Honda Defendants was the employer, employee, agent, servant, alter ego, principal, or subsidiary of the other Laguna Honda Defendants and at all times acted within the course and scope of such employment or agency and with the knowledge and approval of said co-defendants. In particular, at all times material hereto, the Laguna Honda Defendants individually and through their officers, directors, and/or managing agents, (i) had advance knowledge of the unfitness of their employees and employed said employees with a conscious disregard of the rights and safety of others, (ii) authorized the wrongful conduct alleged in this complaint, and/or (iii) were personally guilty of oppression, fraud, malice and/or recklessness.

37. Plaintiff SANCHEZ is informed and believes, and accordingly alleges, that at all relevant times each of the Medical Respite Defendants was the employer, employee, agent, servant, alter ego, principal, or subsidiary of the other Medical Respite Defendants and at all times acted within the course and scope of such employment or agency and with the knowledge and approval of said co-defendants. In particular, at all times material hereto, the Medical Respite Defendants individually and through their officers, directors, and/or managing agents, (i) had advance knowledge of the unfitness of their employees and employed said employees with a conscious disregard of the rights and safety of others, (ii) authorized the wrongful conduct alleged in this complaint, and/or (iii) were personally guilty of oppression, fraud, malice and/or recklessness.

38. The LIEU Plaintiffs are informed and believe, and accordingly allege, that at all relevant times each of the Burlingame Skilled Defendants was the employer, employee, agent, servant, alter ego, principal, or subsidiary of the other Burlingame Skilled Defendants and at all times acted within the course and scope of such employment or agency and with the knowledge and

approval of said co-defendants. In particular, at all times material hereto, the Burlingame Skilled Defendants individually and through their officers, directors, and/or managing agents, (i) had advance knowledge of the unfitness of their employees and employed said employees with a conscious disregard of the rights and safety of others, (ii) authorized the wrongful conduct alleged in this complaint, and/or (iii) were personally guilty of oppression, fraud, malice and/or recklessness.

39. The PHAM Plaintiffs are informed and believe, and accordingly allege, that at all relevant times each of the Seton Defendants was the employer, employee, agent, servant, alter ego, principal, or subsidiary of the other Seton Defendants and at all times acted within the course and scope of such employment or agency and with the knowledge and approval of said co-defendants. In particular, at all times material hereto, the Seton Defendants individually and through their officers, directors, and/or managing agents, (i) had advance knowledge of the unfitness of their employees and employed said employees with a conscious disregard of the rights and safety of others, (ii) authorized the wrongful conduct alleged in this complaint, and/or (iii) were personally guilty of oppression, fraud, malice and/or recklessness.

40. The SANCHEZ Defendants, the LIEU Defendants, the PHAM Defendants, and DOES 91-100 (collectively "DEFENDANTS") are vicariously liable for the acts of their employees committed in the course and scope of their employment. (*See* Government Code §815.2.) All claims, causes of action and allegations asserted herein are brought pursuant to DEFENDANTS direct liability, where applicable, and/or pursuant to DEFENDANTS' vicarious liability for acts and omissions of DEFENDANTS' managing agents/employees undertaken in the course and scope of their employment.

41. Each patient of LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED, and SETON is an elder and/or a dependent adult as defined by Welfare & Institutions Code §15610, et seq. DEFENDANTS, and/or their employees/managing agents, knew or should have known that their conduct, as described below, was directed to one or more elder and/or dependent adults. (*See* Government Code §§815.2 and 820(a).)

42. At all times mentioned herein, the Laguna Honda Defendants, and/or their

employees/managing agents pursuant to Government Code §815.2 and §820(a), were providing for the care and custody of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, were "care custodians" within the meaning of Welfare & Institutions Code §15610.17, and as to the Laguna Honda Defendants' employees/managing agents, were acting in the course and scope of their employment with the Laguna Honda Defendants. The Laguna Honda Defendants, and each of them, had a substantial caretaking relationship with Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM involving continuous and ongoing care, management, oversight and provision of their basic needs over an extended period of time during their admissions to LAGUNA HONDA.

43. At all times mentioned herein, the Medical Respite Defendants, and/or their employees/managing agents pursuant to Government Code §815.2 and §820(a), were providing for the care and custody of Decedent SANCHEZ, were "care custodians" within the meaning of Welfare & Institutions Code §15610.17, and as to the Medical Respite Defendants' employees/managing agents, were acting in the course and scope of their employment with the Medical Respite Defendants. The Medical Respite Defendants, and each of them, had a substantial caretaking relationship with Decedent SANCHEZ involving continuous and ongoing care, management, oversight and provision of his basic needs over an extended period of time during his admission to MEDICAL RESPITE.

44. At all times mentioned herein, the Burlingame Skilled Defendants, and/or their employees/managing agents pursuant to Government Code §815.2 and §820(a), were providing for the care and custody of Decedent LIEU, were "care custodians" within the meaning of Welfare & Institutions Code §15610.17, and as to the Burlingame Skilled Defendants' employees/managing agents, were acting in the course and scope of their employment with the Burlingame Skilled Defendants. The Burlingame Skilled Defendants, and each of them, had a substantial caretaking relationship with Decedent LIEU involving continuous and ongoing care, management, oversight and provision of his basic needs over an extended period of time during his admission to BURLINGAME SKILLED.

45. At all times mentioned herein, the Seton Defendants, and/or their

employees/managing agents, were providing for the care and custody of Decedent PHAM, were "care custodians" within the meaning of Welfare & Institutions Code §15610.17, and as to the Seton Defendants' employees/managing agents, were acting in the course and scope of their employment with the Seton Defendants. The Seton Defendants, and each of them, had a substantial caretaking relationship with Decedent PHAM involving continuous and ongoing care, management, oversight and provision of his basic needs over an extended period of time during his admission to SETON.

FACTUAL BACKGROUND

Plaintiff SANCHEZ

46. Decedent SANCHEZ was admitted to LAGUNA HONDA on approximately April 13, 2021. Decedent SANCHEZ was admitted to LAGUNA HONDA with diagnoses including, but not limited to, laryngeal cancer, chronic anemia, cirrhosis of liver, human immunodeficiency virus infection (HIV), impulse control disorder in adult, malignant neoplasm of larynx, nicotine dependence, toxic metabolic encephalopathy, and viral hepatitis C without hepatic coma. Plaintiff SANCHEZ is also informed and believes that Decedent SANCHEZ was on narcotic replacement therapy during his admission to LAGUNA HONDA. Prior to his admission to LAGUNA HONDA, Decedent SANCHEZ experienced chronic homelessness and was hospitalized in approximately November 2020 for suicidality and hepatic encephalopathy. Plaintiff SANCHEZ is informed and believes that Decedent SANCHEZ underwent a laryngectomy in approximately January or February 2021, causing him to have difficulty communicating. At all times while at LAGUNA HONDA, Decedent SANCHEZ was dependent on the Laguna Honda Defendants' staff for assistance with his physical and mental needs due to his multiple medical and mental conditions.

47. On June 23, 2022, the Laguna Honda Defendants issued a "Notice of Proposed Transfer/Discharge" to Decedent SANCHEZ, which stated, "The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility." Said Discharge Notice stated that Decedent SANCHEZ would be transferred to MEDICAL RESPITE and was signed by a LAGUNA HONDA Facility Representative on June 23, 2022. Decedent SANCHEZ declined to sign said Discharge Notice. Said Discharge Notice also

listed the effective date of transfer/discharge as June 23, 2023, the same date of the notification of the proposed transfer/discharge for Decedent SANCHEZ. Plaintiff SANCHEZ is informed and believes and accordingly alleges that Decedent SANCHEZ's health had not "improved sufficiently" such that he was not an appropriate transfer/discharge candidate. Plaintiff SANCHEZ is further informed and believes, and accordingly alleges, that Decedent SANCHEZ did not consent to being transferred from LAGUNA HONDA to MEDICAL RESPITE and was coerced, threatened, and/or pressured into being discharged from LAGUNA HONDA and transferred to MEDICAL RESPITE by the SANCHEZ Defendants.

48. Decedent SANCHEZ was discharged from LAGUNA HONDA and admitted to MEDICAL RESPITE on June 23, 2022. Plaintiff SANCHEZ is informed and believes that the Laguna Honda Defendants recklessly failed to arrange any transportation to transfer Decedent SANCHEZ from LAGUNA HONDA to MEDICAL RESPITE, and Decedent SANCHEZ had to walk the approximately four miles from LAGUNA HONDA to MEDICAL RESPITE. Plaintiff SANCHEZ is further informed and believes that MEDICAL RESPITE was not an appropriate facility for Decedent SANCHEZ and was not equipped to meet Decedent SANCHEZ's care needs. For example, the Medical Respite Defendants and their staff recklessly failed to ensure Decedent SANCHEZ was taking his medications, and Decedent SANCHEZ missed doses for several of his medications. Plaintiff SANCHEZ is further informed and believes and accordingly alleges that the Medical Respite Defendants' staff recklessly failed to monitor, supervise, and assist Decedent SANCHEZ while he was a resident at MEDICAL RESPITE. At all times while at MEDICAL RESPITE, Decedent SANCHEZ was dependent on the Medical Respite Defendants' staff for assistance with his physical and mental needs due to his multiple medical and mental conditions.

49. On July 17, 2022, Decedent SANCHEZ was found unresponsive sitting on the bathroom toilet in the "back dorm area" of MEDICAL RESPITE. The Medical Respite Defendants' staff called 911 and initiated CPR. Paramedics declared Decedent SANCHEZ dead soon after they arrived. Plaintiff SANCHEZ is informed and believes that Decedent SANCHEZ died as a result of the transfer trauma, neglect, and resulting decline in condition caused by the SANCHEZ

Defendants' reckless and egregious acts and omissions.

50. The SANCHEZ Defendants, and/or their employees/managing agents, owed certain duties to Decedent SANCHEZ while he was under their care and custody at LAGUNA HONDA and/or MEDICAL RESPITE pursuant to various state and federal statutes. (*See* Government Code §§815.2 and 820(a).) Said duties include, but are not limited to, those established and defined by Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq*., 22 C.C.R. §72311(a)(3)(B), 22 C.C.R. §72547, 22 C.C.R. § 2527(a), 22 C.C.R. §72501(e), 22 C.C.R §72509, Health & Safety Code §1599.1(a), Health and Safety Code §1336.2, and 42 C.F.R. §483.70(m). The SANCHEZ Defendants, and/or their employees/managing agents, breached said duties to Decedent SANCHEZ as set forth herein. (*See* Government Code §§815.2 and 820(a).) Each of these acts and omissions by the SANCHEZ Defendants managing agents/employees regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)

51. The SANCHEZ Defendants, and/or their employees/managing agents, had responsibility for meeting the basic needs of Decedent SANCHEZ, including his safety, medical care, and protecting him from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) Although the SANCHEZ Defendants knew of conditions that made Decedent SANCHEZ unable to provide for his own basic needs as described herein, the SANCHEZ Defendants recklessly and egregiously denied and withheld goods or services necessary to meet Decedent SANCHEZ's basic needs. The SANCHEZ Defendants denied and withheld this basic care to him despite the knowledge that by doing so, injury was substantially certain to befall him or with conscious disregard of the high probability of such injury. The SANCHEZ Defendants' reckless and egregious denial and withholding of basic care to Decedent SANCHEZ and the Laguna Honda Defendants' forced transfer of Decedent SANCHEZ to MEDICAL RESPITE caused his injuries.

52. Each of the acts and omissions described above by the SANCHEZ Defendants' managing agents/employees regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA HONDA and/or MEDICAL

RESPITE. (*See* Government Code §§815.2 and 820(a).)

53. Specifically, as described above, the SANCHEZ Defendants, and/or their employees/managing agents, recklessly and egregiously failed to take the necessary precautions to protect Decedent SANCHEZ from neglect, from violations of his patients' rights, and from transfer trauma, and these failures caused him injury. (*See* Government Code §§815.2 and 820(a).) The SANCHEZ Defendants failed to supervise the staff at LAGUNA HONDA and/or MEDICAL RESPITE, which caused Decedent SANCHEZ injury. The SANCHEZ Defendants failed to provide Decedent SANCHEZ with supervision and assistance that he required and failed to protect him from health and safety hazards which caused him injury. The SANCHEZ Defendants also failed to train staff to prevent physical abuse, neglect, transfer trauma, and failed to investigate to ensure that physical abuse, neglect, transfer trauma was being considered and properly avoided, which caused Decedent SANCHEZ injury. The SANCHEZ Defendants also failed to implement interventions, which caused Decedent SANCHEZ injury. The SANCHEZ Defendants, and/or their employees/managing agents, also failed to ensure that LAGUNA HONDA and/or MEDICAL RESPITE was adequately staffed as required by law, which caused Decedent SANCHEZ injury. Each of these acts and omissions by the SANCHEZ Defendants' managing agents/employees regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)

54. At all times relevant, the SANCHEZ Defendants, and/or their employees/managing agents, knew of Decedent SANCHEZ's declining condition and the critical need to monitor and treat his condition properly and to provide adequate custodial care to him at all times. (*See* Government Code §§815.2 and 820(a).) However, the SANCHEZ Defendants recklessly and egregiously failed to provide custodial care, supervision and protection to Decedent SANCHEZ despite his vulnerable and worsening condition. The SANCHEZ Defendants' conduct, as detailed herein, was reckless and in conscious disregard of Decedent SANCHEZ's rights and safety. Each of these acts and omissions by the SANCHEZ Defendants and/or their managing agents/employees

regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)

55. These acts and omissions by the SANCHEZ Defendants, and/or their employees/managing agents, were not only to Decedent SANCHEZ, but, instead, were part of a continual pattern at LAGUNA HONDA and/or MEDICAL RESPITE. The pattern of substandard care, insufficient supervision and understaffing was well known to the SANCHEZ's Defendants' managing agents. Specifically, the nurses and other care providers at LAGUNA HONDA and/or MEDICAL RESPITE who provided care to Decedent SANCHEZ were under the direction of supervisors who were managing agents of the SANCHEZ Defendants. In addition, the supervisors' direct supervisors were managing agents of the SANCHEZ Defendants, such as LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing and/or Monica Biley, and others. The managing agents of the SANCHEZ Defendants knew or should have known of the continuing lack of proper custodial care and protection to its residents, as well as understaffing and poor training regarding basic custodial care needs, including the prevention of abuse and/or neglect.

56. This neglect was known to the SANCHEZ Defendants' managing agents, including, but not limited to, LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing Theresa Dentoni and/or Monica Biley, the MEDICAL RESPITE Administrator and Director of Nursing, and their supervisors, or should have been known to them. Specifically, the SANCHEZ Defendants' staff supervisors and their supervisor knew or should have known of the poor care, inadequate staffing, and insufficient supervision of staff and insufficient monitoring of residents, as well as the fact that LAGUNA HONDA and/or MEDICAL RESPITE does not employ an adequate number of nursing staff to meet the needs of its patients and protect them from abuse, neglect, and violations of their rights. Despite the SANCHEZ Defendants' knowledge of the understaffing of nursing staff at LAGUNA HONDA and/or MEDICAL RESPITE, the SANCHEZ Defendants' managing agents did not inform residents, their families or the floor

1 nurses of these shortages, although this understaffing necessarily affected the care provided and
2 LAGUNA HONDA's and/or MEDICAL RESPITE's response to the care and treatment of patients
3 at LAGUNA HONDA and/or MEDICAL RESPITE. The SANCHEZ Defendants' own managing
4 agents, including the supervisors who are responsible for training staff in how to properly
5 implement these policies and procedures are not adequately familiar with the policies and
6 procedures in LAGUNA HONDA and/or MEDICAL RESPITE. Additionally, the SANCHEZ
7 Defendants' protocols, as created by the SANCHEZ Defendants' managing agents, are inadequate.
8 These inadequate policies were ratified by an administrative group employed by the SANCHEZ
9 Defendants at LAGUNA HONDA and/or MEDICAL RESPITE and resulted in the forced transfer
10 and subsequent neglect of Decedent SANCHEZ due to LAGUNA HONDA losing its CMS
11 certification.
12 57. The SANCHEZ Defendants' managing agents knew or should have known of the
13 lack of care, supervision, assessment, monitoring and basic assistance to their patients, and of the
14 lack of training provided to LAGUNA HONDA and/or MEDICAL RESPITE staff. Despite the
15 SANCHEZ Defendants' conscious knowledge of these conditions, the managing agents did not take
16 appropriate and adequate steps to prevent and correct them, and they did not inform Decedent
17 SANCHEZ or his family of what they knew about these dangerous conditions. Each of these acts
18 and omissions by the SANCHEZ Defendants' managing agents/employees regarding the care and
19 treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at
20 LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)
21 58. The SANCHEZ Defendants, and/or their employees/managing agents, had a duty to
22 protect Decedent SANCHEZ from mental and physical abuse and neglect and a duty to protect him
23 from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) The SANCHEZ
24 Defendants had a duty to treat Decedent SANCHEZ and other residents with dignity and respect,
25 and to provide adequate numbers of nursing and other similar staff to assist them. The SANCHEZ
26 Defendants had a duty to employ adequately trained staff. Yet the SANCHEZ Defendants failed to
27 provide medical care and custodial care to meet Decedent SANCHEZ's physical and mental health

needs and failed to protect him from health and safety hazards, as described in detail herein. The SANCHEZ Defendants knew Decedent SANCHEZ was a dependent adult who required assistance to meet his basic needs and was substantially more vulnerable than the general population, yet transferred him to an unsafe and hazardous environment, even with knowledge of Decedent SANCHEZ's high risk for injury, his fragile mental state, his need for assistance, and the substantial certainty that Decedent SANCHEZ would be injured if these needs were not provided for. The SANCHEZ Defendants' reckless and egregious failure to provide Decedent SANCHEZ with the care, assistance, and monitoring that they knew he required caused him injury. Each of these acts and omissions by the SANCHEZ Defendants' managing agents/employees regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)

The LIEU PLAINTIFFS

59. Decedent LIEU was admitted to LAGUNA HONDA on approximately February 8, 2021. Decedent LIEU was admitted to LAGUNA HONDA with diagnoses including, but not limited to, right temporal parietal intracerebral brain hemorrhage (ICH), history of prior left middle cerebral artery stroke, aphasia, dysphagia, hemiparesis affecting his dominant side as late effect of cerebrovascular accident, hypercholesteremia, hypertension, systolic heart failure, and vascular dementia. Before his admission to LAGUNA HONDA, Decedent LIEU suffered a stroke, which caused him to be unable to communicate. During his admission to LAGUNA HONDA, Decedent LIEU was also had a gastrostomy, i.e., a feeding tube, and Decedent LIEU was dependent on the Laguna Honda Defendants' staff to monitor Decedent LIEU for complications related to his feeding tube. During his admission to LAGUNA HONDA, Decedent LIEU was able to remember his family members, who visited often, and was able to non-verbally respond to questions. At all times while at LAGUNA HONDA, Decedent LIEU was dependent on the Laguna Honda Defendants' staff for assistance with his activities of daily living due to his age, dementia, and medical conditions as set forth herein.

60. On May 17, 2022, the Laguna Honda Defendants' staff, a social worker, conducted a

discharge assessment for Decedent LIEU, in which she documented that Decedent LIEU was "Not Discharge Ready" due to "Palliative Care," "Chronic Progressive Disease," and "Cognitive Impairment." Despite the determination that Decedent LIEU was "Not Discharge Ready the Laguna Honda Defendants continuously contacted Plaintiff ANH VONG regarding discharging Decedent LIEU from LAGUNA HONDA and transferring him to another skilled nursing facility.

61. On approximately June 8, 2022, the Laguna Honda Defendants' staff provided Plaintiff ANH VONG with a Notice of Proposed Transfer/Discharge, which stated that Decedent LIEU was to be discharged from LAGUNA HONDA and transferred to BURLINGAME SKILLED on June 10, 2022. Plaintiff ANH VONG asked the Laguna Honda Defendants' staff for additional time to talk with her family and tour BURLINGAME SKILLED before her father was transferred there and requested that the Laguna Honda Defendants postpone Decedent LIEU's discharge and transfer for at least a week. The LIEU Plaintiffs are informed and believe, and accordingly allege, that the Laguna Honda Defendants ignored Plaintiff ANH VONG's request to postpone Decedent LIEU's discharge and transfer. The LIEU Plaintiffs are further informed and believe, and accordingly allege, that the Laguna Honda Defendants coerced and/or pressured Decedent LIEU and his family to transferring him to BURLINGAME SKILLED.

62. On approximately June 10, 2022, Decedent LIEU was discharged from LAGUNA HONDA and admitted to BURLINGAME SKILLED. Decedent LIEU's family members, including the LIEU Plaintiffs, soon noticed that BURLINGAME SKILLED was not told about Decedent LIEU's care needs, did not understand Decedent LIEU's care needs, and/or was not adequately staffed to handle Decedent LIEU's care needs and failed to communicate with them regarding Decedent LIEU's condition. For example, by the time Plaintiff ANH VONG was able to travel to BURLINGAME SKILLED to visit her father within the first few days of his admission, Decedent LIEU was already in the process of being transferred to the hospital due to his feeding tube being obstructed. During Decedent LIEU's hospitalization after Decedent LIEU was admitted to BURLINGAME SKILLED, an intensive care unit (ICU) nurse informed Plaintiff ANH VONG that Decedent LIEU had multiple health issues due to BURLINGAME SKILLED not adequately taking

care of him. During Decedent LIEU's admission to BURLINGAME SKILLED, Decedent LIEU was sent to the ICU approximately every week. Decedent LIEU also had several hospitalizations during his approximately five-week admission to BURLINGAME SKILLED. The LIEU Plaintiffs are informed and believe, and accordingly allege, that Decedent LIEU's hospitalizations and decline in condition were caused by the Burlingame Defendants' failure to care and maintain his feeding tube, causing his feeding tube to become obstructed multiple times and causing the worsening of his malnourishment and weakness, among other failures. Additionally, when the LIEU Plaintiffs visited Decedent LIEU at BURLINGAME SKILLED for approximately two to three hours, the Burlingame Defendants' staff did not come into Decedent LIEU's room to check on Decedent LIEU and/or provide care to him. The LIEU Plaintiffs are informed and believe, and accordingly allege, that Decedent LIEU's hospitalizations and subsequent decline were caused in part by the Burlingame Defendants' reckless and egregious neglect, including, but not limited to, their failure to monitor his feeding tube, maintain his feeding tube to prevent blockage, provide him with needed assistance, monitoring, and supervision, and protect him from health and safety hazards at BURLINGAME SKILLED. At all times while at BURLINGAME SKILLED, Decedent LIEU was dependent on the Burlingame Defendants' staff for assistance with his activities of daily living due to his age, dementia, and medical conditions as set forth herein.

63. On July 16, 2022, Decedent LIEU died as a result of the LIEU Defendants' reckless and egregious failures, including, but not limited to, the transfer trauma caused by the Laguna Honda Defendants' acts and omissions at LAGUNA HONDA and the Burlingame Defendants' subsequent reckless and egregious neglect of Decedent LIEU at BURLINGAME SKILLED.

64. The LIEU Defendants, and/or their employees/managing agents, owed certain duties to Decedent LIEU while he was under their care and custody at LAGUNA HONDA and/or BURLINGAME SKILLED pursuant to various state and federal statutes. (*See* Government Code §§815.2 and 820(a).) Said duties include, but are not limited to, those established and defined by Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq*., 22 C.C.R. §72311(a)(3)(B), 22 C.C.R. §72547, 22 C.C.R. § 2527(a), 22 C.C.R. §72501(e), 22 C.C.R §72509, Health & Safety

Code §1599.1(a), Health and Safety Code §1336.2, and 42 C.F.R. §483.70(m). The LIEU Defendants, and/or their employees/managing agents, breached said duties to Decedent LIEU as set forth herein. Each of these acts and omissions by the LIEU Defendants managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

65. The LIEU Defendants, and/or their employees/managing agents, had responsibility for meeting the basic needs of Decedent LIEU, including his safety, medical care, and protecting him from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) Although the LIEU Defendants knew of conditions that made Decedent LIEU unable to provide for his own basic needs as described herein, the LIEU Defendants recklessly and egregiously denied and withheld goods or services necessary to meet Decedent LIEU's basic needs. The LIEU Defendants denied and withheld this basic care to Decedent LIEU despite the knowledge that by doing so, injury was substantially certain to befall Decedent LIEU or with conscious disregard of the high probability of such injury. The LIEU Defendants' reckless and egregious denial and withholding of basic care to Decedent LIEU and the Laguna Honda Defendants' forced transfer of Decedent LIEU to BURLINGAME SKILLED caused his injuries.

66. Each of the acts and omissions described above by the LIEU Defendants' managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

67. Specifically, as described above, the LIEU Defendants, and/or their employees/managing agents, recklessly and egregiously failed to take precautions to protect Decedent LIEU from neglect, from violations of his patients' rights, and from transfer trauma, and these failures caused him injury. (*See* Government Code §§815.2 and 820(a).) The LIEU Defendants failed to supervise the staff at LAGUNA HONDA and/or BURLINGAME SKILLED, which caused Decedent LIEU injury. The LIEU Defendants also failed to provide Decedent LIEU with

supervision and assistance that he required and failed to protect him from health and safety hazards which caused him injury. The LIEU Defendants also failed to train staff to prevent physical abuse, neglect, transfer trauma, and failed to investigate to ensure that physical abuse, neglect, transfer trauma was being considered and properly avoided, which caused Decedent LIEU injury. The LIEU Defendants also failed to implement interventions, which caused Decedent LIEU injury. The LIEU Defendants, and/or their employees/managing agents, failed to ensure that LAGUNA HONDA and/or BURLINGAME SKILLED was adequately staffed, which caused Decedent LIEU injury. Each of these acts and omissions by the LIEU Defendants' managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

68. At all times relevant, the LIEU Defendants, and/or their employees/managing agents, knew of Decedent LIEU's declining condition and the critical need to monitor and treat his condition properly and to provide adequate custodial care to him at all times. (*See* Government Code §§815.2 and 820(a).) However, the LIEU Defendants failed to provide custodial care, supervision and protection to Decedent LIEU despite his vulnerable and worsening condition. The LIEU Defendants' conduct, as detailed herein, was reckless and in conscious disregard of Decedent LIEU's rights and safety. Each of these acts and omissions by the LIEU Defendants and/or their managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

69. These acts and omissions by the LIEU Defendants, and/or their employees/managing agents, were not only to Decedent LIEU, but, instead, were part of a continual pattern at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).) The pattern of substandard care, insufficient supervision and understaffing was well known to the LIEU's Defendants' managing agents. Specifically, the nurses and other care providers at LAGUNA HONDA and/or BURLINGAME SKILLED who provided care to Decedent LIEU were under the

direction of supervisors who were managing agents of the LIEU Defendants. In addition, the supervisors' direct supervisors were managing agents of the LIEU Defendants, such as LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing and/or Monica Biley, and others. The managing agents of the LIEU Defendants knew or should have known of the continuing lack of proper custodial care and protection to its residents, as well as understaffing and poor training regarding basic custodial care needs, including the prevention of abuse and/or neglect.

70. This neglect was known to the LIEU Defendants' managing agents, including, but not limited to, LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing Theresa Dentoni and/or Monica Biley, the BURLINGAME SKILLED Administrator, CHESTER KUNNAPPILLY, and Director of Nursing, and their supervisors, or should have been known to them. Specifically, the LIEU Defendants' staff supervisors and their supervisor knew or should have known of the poor care, inadequate staffing, and insufficient supervision of staff and insufficient monitoring of residents, as well as the fact that LAGUNA HONDA and/or BURLINGAME SKILLED does not employ an adequate number of nursing staff to meet the needs of its patients and protect them from abuse, neglect, and violations of their rights. Despite the LIEU Defendants' knowledge of the understaffing of nursing staff at LAGUNA HONDA and/or BURLINGAME SKILLED, the LIEU Defendants' managing agents did not inform residents, their families or the floor nurses of these shortages, although this understaffing necessarily affected the care provided and LAGUNA HONDA's and/or BURLINGAME SKILLED's response to the care and treatment of patients at LAGUNA HONDA and/or BURLINGAME SKILLED. The LIEU Defendants' own managing agents, including the supervisors who are responsible for training staff in how to properly implement these policies and procedures are not adequately familiar with the policies and procedures in LAGUNA HONDA and/or BURLINGAME SKILLED. Additionally, the LIEU Defendants' protocols, as created by the LIEU Defendants' managing agents, are inadequate. These inadequate policies were ratified by an administrative group employed by the LIEU Defendants at LAGUNA HONDA and/or

BURLINGAME SKILLED and resulted in the forced transfer and subsequent neglect of Decedent LIEU due to LAGUNA HONDA losing its CMS certification.

71. The LIEU Defendants' managing agents knew or should have known of the lack of care, supervision, assessment, monitoring and basic assistance to their patients, and of the lack of training provided to LAGUNA HONDA and/or BURLINGAME SKILLED staff. Despite the LIEU Defendants' conscious knowledge of these conditions, the managing agents did not take appropriate and adequate steps to prevent and correct them, and they did not inform Decedent LIEU or his family of what they knew about these dangerous conditions. Each of these acts and omissions by the LIEU Defendants' managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

72. The LIEU Defendants, and/or their employees/managing agents, had a duty to protect Decedent LIEU from mental and physical abuse and neglect and a duty to protect him from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) The LIEU Defendants had a duty to treat Decedent LIEU and other residents with dignity and respect, and to provide adequate numbers of nursing and other similar staff to assist them. The LIEU Defendants had a duty to employ adequately trained staff. Yet the LIEU Defendants failed to provide medical care and custodial care sufficient to meet Decedent LIEU's physical and mental health needs and failed to protect him from health and safety hazards, as described in detail herein. The LIEU Defendants knew that Decedent LIEU was an elder who required assistance to meet his basic needs and was substantially more vulnerable than the general population, yet transferred him to an unsafe and hazardous environment, even with knowledge of Decedent LIEU's high risk for injury, his fragile mental state, his need for assistance, and the substantial certainty that Decedent LIEU would be injured if these needs were not provided for. The LIEU Defendants' reckless and egregious failure to provide Decedent LIEU with the care, assistance, and monitoring that he required caused him injury. Each of these acts and omissions by the LIEU Defendants' managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in the course and scope of their

employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code §§815.2 and 820(a).)

The PHAM Plaintiffs

73. Decedent PHAM was admitted to LAGUNA HONDA on approximately July 8, 2021. Decedent PHAM was admitted to the LAGUNA HONDA with diagnoses including, but not limited to, Alzheimer's dementia, anemia, dizziness and giddiness, enlarged prostate without lower urinary tract symptoms, hearing loss, hyperlipidemia, repeated falls, incontinence of bowel, and urinary incontinence. Prior to being admitted to LAGUNA HONDA, Decedent PHAM was living at home with the assistance of a caregiver. However, by July 2021, Decedent PHAM's dementia worsened, and his care needs increased. At all times while at the LAGUNA HONDA, Decedent PHAM was dependent on the Laguna Honda Defendants' staff for assistance with activities of daily living, including assistance with feeding, transfers, incontinence care, and bathing, and required monitoring and supervision due to his dementia and history of falls.

74. On approximately June 8, 2022, Decedent PHAM's daughter, Plaintiff LAN PHAM, attended a regular monthly care meeting to get updates from the Laguna Honda Defendants regarding Decedent PHAM's condition and care at the LAGUNA HONDA. The Laguna Honda Defendants' staff started the care meeting similar to the other monthly care meetings that Plaintiff LAN PHAM had attended regarding Decedent PHAM and the Laguna Honda Defendants' staff informed Plaintiff LAN PHAM that her father's condition was stable. However, the Laguna Honda Defendants' staff then began to discuss a "Pre-Discharge Assessment" and the discharge planning process. The Laguna Honda Defendants' staff informed Plaintiff LAN PHAM they were working with consultants to find beds in other facilities where LAGUNA HONDA patients could be transferred to, including Decedent PHAM. The Laguna Honda Defendants' staff informed Plaintiff LAN PHAM she could appeal the discharge and transfer from LAGUNA HONDA but threatened that if she were to appeal, Decedent PHAM would be forced to go to another facility farther away from Decedent PHAM's family, who all live in and around the San Francisco Bay Area.

75. On approximately June 22, 2022, the Laguna Honda Defendants' staff left

approximately five voicemails for Plaintiff LAN PHAM and stated that Decedent PHAM was accepted to be transferred to SETON, a general acute care hospital and skilled nursing facility located at 600 Marine Boulevard in Moss Beach, California. The Laguna Honda Defendants' staff stated that if Plaintiff LAN PHAM did not accept the placement for her father at SETON by July 15, 2022, Decedent PHAM would be billed $40,000-50,000 per month. Accordingly, the PHAM Plaintiffs felt that they had no choice but to accept the placement for Decedent PHAM at SETON, and on approximately July 7, 2022, Plaintiff LAN PHAM reluctantly agreed to transfer Decedent PHAM to SETON.

76. On July 8, 2022, Decedent PHAM was discharged from LAGUNA HONDA and admitted to SETON. Decedent PHAM's family members, including the PHAM Plaintiffs, soon noticed that SETON was not told about and/or did not understand Decedent PHAM's care needs and failed to adequately communicate with them regarding Decedent PHAM's condition. For example, Decedent PHAM's daughter would see a water pitcher on a table in her father's room, but Decedent PHAM needed assistance for drinking and could not drink the water from the pitcher on his own. When family members, including the PHAM Plaintiffs, visited, they had to assist Decedent PHAM so that he could drink water, and he would drink the water with a great sense of relief, as if he had not had water for days. The PHAM Plaintiffs soon witnessed a dramatic decline in Decedent PHAM at SETON, including, but not limited to, his inability to swallow and dehydration. Decedent PHAM's change in condition, including his dehydration and subsequent decline, was not reported by the Seton Defendants' staff to Decedent PHAM's family and/or responsible party, including the PHAM Plaintiffs. At all times while at the SETON, Decedent PHAM was dependent on the Seton Defendants' staff for assistance with activities of daily living, including assistance with feeding, drinking, transfers, incontinence care, and bathing, and required monitoring and supervision due to his dementia and history of falls.

77. On July 25, 2022, Decedent PHAM died as a result of the PHAM Defendants' reckless and egregious failures, including, but not limited to, the transfer trauma caused by the Laguna Honda Defendants' acts and omissions at LAGUNA HONDA and the Seton Defendants'

subsequent neglect of Decedent PHAM at SETON.

78. The PHAM Defendants, and/or their employees/managing agents, owed certain duties to Decedent PHAM while he was under their care and custody at LAGUNA HONDA and/or SETON pursuant to various state and federal statutes. (*See* Government Code §§815.2 and 820(a).) Said duties include, but are not limited to, those established and defined by Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq*., 22 C.C.R. §72311(a)(3)(B), 22 C.C.R. §72547, 22 C.C.R. § 2527(a), 22 C.C.R. §72501(e), 22 C.C.R §72509, Health & Safety Code §1599.1(a), Health and Safety Code §1336.2, and 42 C.F.R. §483.70(m). The PHAM Defendants, and/or their employees/managing agents, breached said duties to Decedent PHAM as set forth herein. Each of these acts and omissions by the PHAM Defendants managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

79. The PHAM Defendants, and/or their employees/managing agents, had responsibility for meeting the basic needs of Decedent PHAM, including his safety, medical care, and protecting him from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) Although the PHAM Defendants knew of conditions that made Decedent PHAM unable to provide for his own basic needs as described herein, the PHAM Defendants recklessly and egregiously denied and withheld goods or services necessary to meet Decedent PHAM's basic needs. The PHAM Defendants denied and withheld this basic care to Decedent PHAM despite the knowledge that by doing so, injury was substantially certain to befall Decedent PHAM or with conscious disregard of the high probability of such injury. The PHAM Defendants' reckless and egregious denial and withholding of basic care to Decedent PHAM and the Laguna Honda Defendants' forced transfer of Decedent PHAM to SETON caused his injuries.

80. Each of the acts and omissions described above by the PHAM Defendants' managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

81. Specifically, as described above, the PHAM Defendants, and/or their employees/managing agents, recklessly and egregious failed to take precautions to protect Decedent PHAM from neglect, from violations of his patients' rights, and from transfer trauma, and these failures caused him injury. (*See* Government Code §§815.2 and 820(a).) The PHAM Defendants failed to supervise the staff at LAGUNA HONDA and/or SETON, which caused Decedent PHAM injury. The PHAM Defendants also failed to provide Decedent PHAM with supervision and assistance that he required and failed to protect him from health and safety hazards which caused him injury. The PHAM Defendants also failed to train staff to prevent physical abuse, neglect, transfer trauma, and failed to investigate to ensure that physical abuse, neglect, transfer trauma was being considered and properly avoided, which caused Decedent PHAM injury. The PHAM Defendants also failed to implement interventions, which caused Decedent PHAM injury. The PHAM Defendants, and/or their employees/managing agents, also failed to ensure that LAGUNA HONDA and/or SETON was adequately staffed, which caused Decedent PHAM injury. Each of these acts and omissions by the PHAM Defendants' managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

82. At all times relevant, the PHAM Defendants, and/or their employees/managing agents, knew of Decedent PHAM's declining condition and the critical need to monitor and treat his condition properly and to provide adequate custodial care to him at all times. (*See* Government Code §§815.2 and 820(a).) However, the PHAM Defendants recklessly and egregiously failed to provide proper custodial care, supervision and protection to Decedent PHAM despite his vulnerable and worsening condition. The PHAM Defendants' conduct, as detailed herein, was reckless and in conscious disregard of Decedent PHAM's rights and safety. Each of these acts and omissions by the PHAM Defendants and/or their managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

83. These acts and omissions by the PHAM Defendants, and/or their

employees/managing agents, were not only to Decedent PHAM, but, instead, were part of a continual pattern at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).) The pattern of substandard care, insufficient supervision and understaffing was well known to the PHAM's Defendants' managing agents. Specifically, the nurses and other care providers at LAGUNA HONDA and/or SETON who provided care to Decedent PHAM were under the direction of supervisors who were managing agents of the PHAM Defendants. In addition, the supervisors' direct supervisors were managing agents of the PHAM Defendants, such as LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing and/or Monica Biley, and others. The managing agents of the PHAM Defendants knew or should have known of the continuing lack of proper custodial care and protection to its residents, as well as understaffing and poor training regarding basic custodial care needs, including the prevention of abuse and/or neglect.

84. This neglect was known to the PHAM Defendants' managing agents, including, but not limited to, LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing Theresa Dentoni and/or Monica Biley, the SETON Administrator, ANTHONY ARMADA, and Director of Nursing, KERIANNE CALIGUIRE, and their supervisors, or should have been known to them. Specifically, the PHAM Defendants' staff supervisors and their supervisor knew or should have known of the poor care, inadequate staffing, and insufficient supervision of staff and insufficient monitoring of residents, as well as the fact that LAGUNA HONDA and/or SETON does not employ an adequate number of nursing staff to meet the needs of its patients and protect them from abuse, neglect, and violations of their rights. Despite the PHAM Defendants' knowledge of the understaffing of nursing staff at LAGUNA HONDA and/or SETON, the PHAM Defendants' managing agents did not inform residents, their families or the floor nurses of these shortages, although this understaffing necessarily affected the care provided and LAGUNA HONDA's and/or SETON's response to the care and treatment of patients at LAGUNA HONDA and/or SETON. The PHAM Defendants' own managing agents, including the supervisors who are responsible for training staff in how to properly implement these policies and

procedures are not adequately familiar with the policies and procedures in LAGUNA HONDA and/or SETON. Additionally, the PHAM Defendants' protocols, as created by the PHAM Defendants' managing agents, are inadequate. These inadequate policies were ratified by an administrative group employed by the PHAM Defendants at LAGUNA HONDA and/or SETON and resulted in the forced transfer and subsequent neglect of Decedent PHAM due to LAGUNA HONDA losing its CMS certification.

85. The PHAM Defendants' managing agents knew or should have known of the lack of care, supervision, assessment, monitoring and basic assistance to their patients, and of the lack of training provided to LAGUNA HONDA and/or SETON staff. Despite the PHAM Defendants' conscious knowledge of these conditions, the managing agents did not take appropriate and adequate steps to prevent and correct them, and they did not inform Decedent PHAM or his family of what they knew about these dangerous conditions. Each of these acts and omissions by the PHAM Defendants' managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

86. The PHAM Defendants, and/or their employees/managing agents, had a duty to protect Decedent PHAM from mental and physical abuse and neglect and a duty to protect him from health and safety hazards. (*See* Government Code §§815.2 and 820(a).) The PHAM Defendants had a duty to treat Decedent PHAM and other residents with dignity and respect, and to provide adequate numbers of nursing and other similar staff to assist them. The PHAM Defendants had a duty to employ adequately trained staff. Yet the PHAM Defendants recklessly and egregiously failed to provide medical care and custodial care sufficient to meet Decedent PHAM's physical and mental health needs and failed to protect him from health and safety hazards, as described in detail herein. The PHAM Defendants knew that Decedent PHAM was an elder who required assistance to meet his basic needs and was substantially more vulnerable than the general population, yet transferred him to an unsafe and hazardous environment, even with knowledge of Decedent PHAM's high risk for injury, his fragile mental state, his need for assistance, and the substantial

certainty that Decedent PHAM would be injured if these needs were not provided for. The PHAM Defendants' failure to provide Decedent PHAM with the care, assistance, and monitoring that he required caused him injury. Each of these acts and omissions by the PHAM Defendants' managing agents/employees regarding the care and treatment of Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).).

FIRST CAUSE OF ACTION

(Dependent Adult/Elder Abuse/Neglect Pursuant to Welfare & Institutions Code §15657 and/or Government Code §815.2 and §820(a) Against all DEFENDANTS)

87. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs to this cause of action as though fully set forth herein.

88. The above-mentioned acts of DEFENDANTS, and/or their employees/managing agents, constituted "abuse," "neglect" and/or "abandonment" within the meaning of Welfare & Institutions Code §15610 et seq. and caused physical pain and/or mental suffering and/or deprived Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM of the services that were necessary to avoid physical harm or mental suffering. (*See* Government Code §815.2 and §820(a).) DEFENDANTS committed dependent adult/elder neglect as defined under the Elder and Dependent Adult Civil Protection Act by, as set forth in detail above, recklessly failing to protect Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM from abuse and neglect, failing to provide them with adequate custodial care, failing to monitor and supervise them to adequately protect them from abuse and neglect, and failing to protect them from health and safety hazards. (Welf. Inst. Code §15610.57.) With respect to the Laguna Honda Defendants, said defendants' acts and omissions also constitute "abandonment" of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM as that term is defined in Welfare & Institutions Code § 15610.05, given that said defendants' conduct as described in detail herein constitutes a "desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody." Pursuant to Welfare & Institutions Code

§15610.57(a)(1), DEFENDANTS, and/or their employees/managing agents, negligently failed to exercise that degree of care that a reasonable person in a like position would exercise. (*See* Government Code §815.2 and §820(a).)

89. As set forth in great detail above, DEFENDANTS have recklessly and egregiously violated their duties to Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM by violating numerous statutes and regulations, including but not limited to Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq*., 22 C.C.R. § 72547, 22 C.C.R. § 72527(a), 22 C.C.R. § 72501(e), 22 C.C.R § 72509, Health & Safety Code § 1599.1(a), Health and Safety Code 1336.2, and/or 42 C.F.R. 483.70(m) in the care and treatment of 42 C.F.R. 483.70(m) at LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED, and SETON.

90. In addition to DEFENDANTS' direct liability, an entity is vicariously liable for the tortious acts and omissions of its employees committed within the scope of employment under circumstances in which the employee would be personally liable for the conduct. (*See* Government Code §815.(a).) As it relates to a public entity, the effect of the statute is to incorporates general standards of tort liability as the primary basis for *respondeat superior* liability of public entities. Furthermore, an employee of a public entity is liable for his torts to the same extent as a private person (Government Code §820(a)), and the public entity is vicariously liable for any injury which its employee causes (Government Code §815.2(a)) to the same extent as a private employer (Government Code §815(b)).

91. The violation of certain state and/or federal statutes as set forth above, including, but not limited to, Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq*., 22 C.C.R. § 72547, 22 C.C.R. § 72527(a), 22 C.C.R. § 72501(e), 22 C.C.R § 72509, Health & Safety Code § 1599.1(a), Health and Safety Code 1336.2, and/or 42 C.F.R. 483.70(m), by DEFENDANTS, and/or their employees/managing agents, was a substantial factor in causing injury to Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM and the damages as alleged herein. (*See* Government Code §815.2 and §820(a).)

92. In addition to the above referenced specific failures by DEFENDANTS,

DEFENDANTS, and each of them:

a. As to the Laguna Honda Defendants, failed to take reasonable steps to transfer affected residents, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, safely and minimize possible transfer trauma as required by Health & Safety Code §1336.2 by:

    a. Failing to ensure that Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM's attending physicians completed a medical assessment of each of their condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being given, which include recommendations for counseling, follow up visits, and other recommended services and for preventing or ameliorating potential adverse health consequences in the event of transfer as required by Health & Safety Code § 1336.2(a)(1);

    b. Failing to ensure that Decedent SANCHEZ, Decedent LIEU and Decedent PHAM were evaluated and assessed by a licensed clinical social worker, psychologist, psychiatrist or licensed professional clinical counselor and the LAGUNA HONDA nursing staff of their physical functioning before written notice of transfer was given to the residents in violation of Health & Safety Code § 1336.2(a)(2);

    c. Failing to evaluate the relocation needs of Decedent SANCHEZ, Decedent LIEU and Decedent PHAM including proximity to their representatives and failing to determine the most appropriate and available type of future care and services for Decedent SANCHEZ, Decedent LIEU and Decedent PHAM before written notice of transfer was given to them as required by Health & Safety Code § 1336.2(a)(3)(A);

    d. Failing to inform Decedent SANCHEZ, Decedent LIEU or Decedent PHAM or their representatives of alternative facilities that are available and adequate

to meet their needs as required by Health & Safety Code § 1336.2(a)(4); and

e. Failing to arrange for appropriate future medical care and services for Decedent SANCHEZ, Decedent LIEU and Decedent PHAM as required by Health & Safety Code § 1336.2(a)(5)

b. Failed to establish and implement a patient care plan for Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM based upon and including without limitation an ongoing process of identifying, reviewing, evaluating and updating their care needs, as required by 22 C.C.R. §72311(a)(3)(B);

c. Failed to maintain accurate and complete records of the condition of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, as required by 22 C.C.R. §72547;

d. As to the Laguna Honda Defendants, failed to permit Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM to remain in LAGUNA HONDA, and not transfer or discharge them from LAGUNA HONDA unless all requirements were met pursuant to 42 C.F.R. § 483.15(c)(1);

e. As to the Laguna Honda Defendants, failed to implement an effective discharge planning process focusing on the resident's discharge goals, the preparation of residents to active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions or other adverse consequences as to Decedent SANCHEZ, Decedent LIEU and Decedent PHAM as required by 42 C.F.R. §483.21(c);

f. As to the Laguna Honda Defendants, failed to protect the right of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM to remain in LAGUNA HONDA for up to 60 days after the approved written notice of LAGUNA HONDA's intent to transfer the resident if an appropriate placement based on the relocation assessment and relocation recommendations has not been made, as required by Health and Safety Code 1336.2;

g. Failed to maintain dignity and prevent mental and physical abuse of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM as required by 22 C.C.R. §72527(a);

h. Failed to maintain nursing and other staffing at levels adequate to meet the needs of all residents, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM as required by 22 C.C.R. §72501(e); and

i. Failed to employ an adequate number of qualified personnel to carry out all of the functions of LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED and SETON for the health and safety of their residents as required by California Health & Safety Code §1599.1(a).

93. The foregoing regulations define the duties of care owed to the residents of facilities such as LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED and SETON. Violations of these regulations by DEFENDANTS, and/or their employees/managing agents, constitute a negligent failure to exercise the care that a similarly situated reasonable person would exercise and/or a failure to protect Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM from abuse, neglect and health and safety hazards. (*See* Government Code §815.2 and §820(a).) Further, DEFENDANTS, and/or their employees/managing agents, falsely promoted, advertised, and held LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED and SETON out in its respective marketing materials as facilities with knowledge, care, and expertise to provide Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM with specialized care. (*See* Government Code §815.2 and §820(a).)

94. As a direct result of the abuse, neglect and/or abandonment of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM by Laguna DEFENDANTS, and/or their employees/managing agents, Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM were caused to incur the expense of emergency medical services, all to their special damage in a sum to be established according to proof. (*See* Government Code §815.2 and §820(a).)

95. By the conduct, acts and omissions of DEFENDANTS, and/or their

employees/managing agents, as alleged in detail above, they are guilty of recklessness, oppression, and/or malice. (*See* Government Code §815.2 and §820(a).) The specific facts set forth above show DEFENDANTS' conscious disregard of the high probability that Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM would be injured. In addition to special damages, Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM are therefore entitled to an award against DEFENDANTS, and each of them, of the reasonable attorney's fees and costs incurred in prosecuting this case pursuant to Welfare & Institutions Code §15657, as well as the pre-death pain and suffering of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM. As a direct result of the abuse, neglect and/or abandonment of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM by DEFENDANTS, and each of them, Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM suffered fear, anxiety, humiliation, physical pain and discomfort, and emotional distress, all to his general damage in a sum to be established according to proof.

96. In addition to their direct liability for the damages set forth above, DEFENDANTS are vicariously liable for damages caused by each of its employees/managing agents. (*See* Government Code §815.2 and §820(a).)

97. In committing the tortious acts alleged herein, the Laguna Honda Defendants and the Medical Respite Defendants, and/or their employees/managing agents, were not exercising discretion within the meaning of Government Code §820.2 (which grants immunity only for conduct involving basic policy decisions and which does not immunize conduct that is ministerial or operational, such as the carrying out of basic policy decisions). The Laguna Honda Defendants and the Medical Respite Defendants, and/or their employees/managing agents, are also not immune from liability for their tortious acts under Government Code sections 818.6 or 821.4 (which grant immunity for failure to make inspection, or for making negligent inspections, of private property), Government Code section 855.6 (which grants immunity for failure to perform adequate public health examinations, such as public tuberculosis examinations, physical examinations to determine the qualifications of boxers and other athletes, and eye examinations for vehicle operator applicants and does not apply to examinations for the purpose of treatment such as are made in doctors' offices

and public hospitals for which the ordinary rules of liability would apply), or Government Code section 855.8 (which declares an immunity from liability for diagnosing or failing to diagnose that a person is afflicted with a condition for which he may be committed to an institution for the mentally ill or addicted and which also provides an immunity for failing to prescribe for mental illness or addiction, but it does not provide immunity for malpractice where a public employee undertakes to prescribe for mental illness or addiction).

98. WHEREFORE, Plaintiffs pray for judgment against DEFENDANTS as hereinafter set forth.

SECOND CAUSE OF ACTION

(Violation of Patient's Rights Pursuant to Health & Safety Code §1430(b) and/or Government Code §815.2 and §820(a) Against the Laguna Honda Defendants, the Burlingame Defendants, and the Seton Defendants Only)

99. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs to this cause of action as though fully set forth herein.

100. The acts and omissions alleged above constitute violations of patients' rights within the meaning of 22 C.C.R. § 72527(a) and Health and Safety Code § 1430(b). This statute and regulation require that residents be treated with dignity and be free from mental or physical abuse and require that patients shall have all other rights as specified in Health and Safety Code §1599.1, which states that skilled nursing facilities (SNFs) such as LAGUNA HONDA, BURLINGAME SKILLED, and SETON "shall employ an adequate number of qualified personnel to carry out all of the functions of [the SNF]." 22 C.C.R. § 72527(a)(6) also states that residents such as Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM have the right "[t]o be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge" and that "[s]uch actions shall be documented in the patient's health record." 22 C.C.R. § 72527(a)(12) also states that residents such as Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM have the right "[t]o be treated with consideration, respect and full recognition of dignity and individuality,

including privacy in treatment and in care of personal needs."

101. As alleged above, the Laguna Honda Defendants, the Burlingame Skilled Defendants, the Seton Defendants and/or their employees/managing agents, violated the patient rights of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM repeatedly. (*See* Government Code §815.2 and §820(a).) Each violation of the patient's rights of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, as described in detail above, was a violation of a primary right and is actionable in its own right. As such, each violation of the primary rights of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM, as discussed in detail above, constitutes a "cause of action." However, for efficiency's sake, Plaintiffs are labeling this first cause of action collectively the Violation of Patient's Rights, which discusses the numerous causes of action subsumed herewith. Thus, this has the force and effect of being multiple causes of action. In addition to other relief, Plaintiffs are accordingly entitled to attorney's fees and costs against said defendants.

WHEREFORE, Plaintiffs pray for judgment against said defendants as hereinafter set forth.

THIRD CAUSE OF ACTION

(Negligence Against All DEFENDANTS)

102. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs to this cause of action as though fully set forth herein.

103. At all times herein mentioned, DEFENDANTS, and each of them, did negligently and carelessly care for Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM in the manner herein alleged. DEFENDANTS, and each of them, failed to exercise that degree of skill and care commonly required of health care institutions and/or care providers.

104. As a legal result of the negligence and carelessness of DEFENDANTS, and each of them, as stated in detail above, Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM were severely injured and died.

105. DEFENDANTS are vicariously liable for the damages set forth above caused by each of its employees/managing agents. (*See* Government Code §815.2 and §820(a).)

WHEREFORE, Plaintiffs pray for judgment against DEFENDANTS as hereinafter set forth.

FOURTH CAUSE OF ACTION

(Wrongful Death Against All DEFENDANTS)

106. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs to this cause of action as though fully set forth herein.

107. Plaintiff SANCHEZ is Decedent SANCHEZ's surviving parent. Decedent SANCHEZ did not have a spouse or children.

108. Plaintiff TSAN VONG is Decedent LIEU's living spouse. Plaintiffs ANH VONG and KEVIN LIEU, along with Nominal Defendants KENNETH LIEU, KIN KINH LIEU, and LOI LIEU, are Decedent LIEU's living children.

109. Plaintiffs LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA, HENRY PHAM, LINDA PHAM, along with Nominal Defendant PHONG PHAM, are Decedent PHAM's surviving children. Nominal Defendant HOA PHAMLY is Decedent PHAM's surviving spouse.

110. As a result of DEFENDANTS' acts and omissions as alleged above, Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM died.

111. As a direct and legal result of the acts and omissions of DEFENDANTS alleged herein above, Plaintiff SANCHEZ was deprived of a kind and loving son and of Decedent SANCHEZ's love, comfort, companionship, society, and emotional support.

112. As a direct and legal result of the acts and omissions of DEFENDANTS alleged herein above, the LIEU Plaintiffs were deprived of a king and loving husband and father and of Decedent LIEU's love, comfort, companionship, society, and emotional support.

113. As a direct and legal result of the acts and omissions of DEFENDANTS alleged hereinabove, the PHAM Plaintiffs were deprived of a kind and loving father and of Decedent PHAM's love, comfort, companionship, society, and emotional support.

114. As a further proximate result of the acts and omissions of DEFENDANTS, and each of them, the Estate of EDWARD SANCHEZ and/or Plaintiff SANCHEZ incurred burial and funeral expenses for the proper disposition of the remains of Decedent SANCHEZ, the exact cost of said

services is unknown at this time and leave of Court will be sought to amend this Complaint to specify these damages when fully ascertained.

115. As a further proximate result of the acts and omissions of DEFENDANTS, and each of them, the Estate of NGO VI LIEU and/or the LIEU Plaintiffs incurred burial and funeral expenses for the proper disposition of the remains of Decedent LIEU, the exact cost of said services is unknown at this time and leave of Court will be sought to amend this Complaint to specify these damages when fully ascertained.

116. As a further proximate result of the acts and omissions of DEFENDANTS, and each of them, the Estate of QUY PHAM and/or the PHAM Plaintiffs incurred burial and funeral expenses for the proper disposition of the remains of Decedent PHAM, the exact cost of said services is unknown at this time and leave of Court will be sought to amend this Complaint to specify these damages when fully ascertained.

117. DEFENDANTS are vicariously liable for the damages set forth above caused by each of its employees/managing agents. (*See* Government Code §815.2 and §820(a).)

WHEREFORE, Plaintiffs pray for judgment against DEFENDANTS as hereinafter set forth.

DAMAGES

WHEREFORE, Plaintiffs make a claim against DEFENDANTS, and each of them, as follows:

1. For general damages according to law and proof;
2. For special damage according to law and proof;
3. For costs of suit;
4. For attorney’s fees pursuant to law;
5. For pre-death pain and suffering;
6. For punitive damages against the non-public entity defendants, only;

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7. For pre-judgment interest according to law; and

8. For such other and further relief as may be deemed proper.

Dated: May 8, 2023

STEBNER GERTLER GUADAGNI & KAWAMOTO
A Professional Law Corporation

By: ______________________________

Kathryn Stebner
Karman Guadagni
Deena Zacharin
Kelsey Craven

Attorneys for Plaintiffs