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ELECTRONICALLY
FILED

Superior Court of California,
County of San Francisco

05/09/2023
Clerk of the Court

BY: JEFFREY FLORES
Deputy Clerk

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

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

Defendants.

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

10 **PARTIES**

11 **Plaintiff VICTORIA SANCHEZ, Individually and as Successor-in-Interest to the Estate of**
12 **EDWARD SANCHEZ (“Plaintiff SANCHEZ”)**

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

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

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

1 EDWARD SANCHEZ.

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

12 5. On or about December 16, 2022, Plaintiff SANCHEZ timely presented a claim to the
13 CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO DEPARTMENT OF PUBLIC
14 HEALTH, LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER, and SAN
15 FRANCISCO MEDICAL RESPITE & SOBERING CENTER for the damages suffered and
16 incurred by Plaintiff SANCHEZ by reason of the occurrences described herein, all in compliance
17 with the requirements of Government Code § 905. Said claims were rejected on or about March 23,
18 2023. Accordingly, this Complaint was timely filed per Government Code § 945.6.

19 **TSAN VONG, ANH VONG, and KEVIN LIEU, Individually and as Successors-in-Interest to**
20 **the Estate of NGO VI LIEU (collectively the “LIEU Plaintiffs”)**

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

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 LIEU was an elder within the meaning of Welfare & Institutions Code § 15610, et seq. At
5 all times relevant, Decedent LIEU 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 LIEU 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

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

6 **LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM RIVERA,**
7 **HENRY PHAM, and LINDA PHAM, Individually and as Successors-in-Interest to the Estate**
8 **of QUY PHAM (collectively the “PHAM Plaintiffs”)**

9 10. Plaintiff LAN PHAM is and was at all times herein mentioned a resident of the City
10 and County of San Francisco, State of California. Plaintiff QUYEN JENNIFER PHAM is and was
11 at all times herein mentioned a resident of the County of San Mateo, State of California. Plaintiff
12 MAI PHAM is and was at all times herein mentioned a resident of the County of Sacramento, State
13 of California. Plaintiff LY PHAM RIVERA is and was at all times herein mentioned a resident of
14 the County of Marin, State of California. Plaintiff HENRY PHAM is and was at all times herein
15 mentioned a resident of the County of Marin, State of California. Plaintiff LINDA PHAM is and
16 was at all times herein mentioned a resident of the City and County of San Francisco, State of
17 California. Plaintiffs LAN PHAM, QUYEN JENNIFER PHAM, MAI PHAM, LY PHAM
18 RIVERA, HENRY PHAM, LINDA PHAM, and Nominal Defendant PHONG PHAM are the living
19 children of Decedent QUY PHAM (“Decedent PHAM”). Nominal Defendant HOA PHAMLY is
20 Decedent PHAM’s living spouse.

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

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

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

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

21 **DEFENDANTS**

22 14. The Laguna Honda Defendants own and operate, and/or are in the business of
23 providing care at LAGUNA HONDA, located at 375 Laguna Honda Boulevard, San Francisco, CA
24 94116, which is real property owned or controlled by the Laguna Honda Defendants. The Laguna
25 Honda Defendants are located and doing business in the City and County of San Francisco, State of
26 California. The Laguna Honda Defendants, and each of them, owned, leased, licensed, operated,
27 administered, managed, directed, and/or controlled and are “managing agents” of LAGUNA

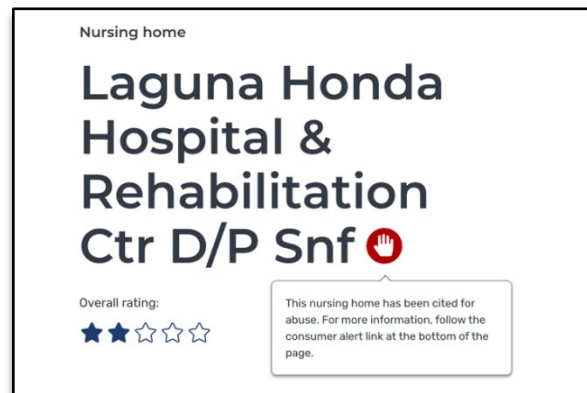
1 HONDA at all relevant times herein and actively participated in and controlled the business of
2 LAGUNA HONDA.

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

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

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

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



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

26 _____
27 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.)

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

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

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

22 The effects of relocation were discussed in terms of mortality and morbidity. In
23 most studies, the health effects of the relocation of older adults suffering from
24 dementia were negative. A decline in physical, mental, behavioral, and functional
25 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

26 ² See “Laguna Honda Hospital and Rehabilitation Center Notification of Closure and Patient Transfer and Relocation
27 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

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

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

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

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

1 reimbursements were withheld to SHLOMO RECHNITZ's facilities from both Medi-Cal and
2 Medicare as a result of "continued and repeated refusals to comply with industry laws and
3 regulations"; (c) on August 22, 2014, California Department of Health Care Services ("DHCS") sent
4 a letter to SHLOMO RECHNITZ's attorney for the failure of SHLOMO RECHNITZ to submit a
5 home office cost report for related entities including defendant BOARDWALK WEST
6 FINANCIAL SERVICES, LLC (formerly known as Boardwalk Financial Services, LLC); and (d)
7 "RECHNITZ and his companies have a history of failing to comply with laws and regulations
8 enforced by the DHCS and the Federal Centers for Medicare and Medicaid." Steven Stroll,
9 SHLOMO RECHNITZ's CPA, who has a principal place of business as 5900 Wilshire Blvd., Suite
10 1600, Los Angeles, California, signed a declaration in bankruptcy court stating that SHLOMO
11 RECHNITZ "through affiliated entities that he controls, is one of the largest if not the largest,
12 owners and operators of skilled nursing facilities." SHLOMO RECHNITZ has admitted that he is
13 the owner of various skilled nursing facilities and entities, and that he does not "know the actual
14 legal names of all my companies." SHLOMO RECHNITZ has repeatedly confused pronouns when
15 referring to his various companies, using the term "me" when it should be the corporation. Based on
16 the Operating Agreements in place for the majority of SHLOMO RECHNITZ' entities, he is or was
17 the manager and had the "capacity to lend money, and I was the lender, but the nursing home that
18 we were putting it into was the borrower, and I was a member of that as well." When one of his
19 facilities wants to make a draw from the line of credit, they have to submit in writing to him
20 personally for his approval. The language from at least one Operating Agreement states that "[t]he
21 manager shall have the general supervision, direction and control of the business of the company
22 and the general powers and duties of management typically vested in the president of the
23 corporation..." SHLOMO RECHNITZ has testified under oath that he gets a monthly financial
24 report from each of his facilities, that "they were supposed to inform me of any surveys that we
25 would fail, any citations we would receive and any lawsuits for care or even a bad outcome that
26 resulted in someone asking for information or a patient file. You know, if you got to that level, they
27 were to notify me." The LIEU Plaintiffs are informed and believe that defendant SHLOMO

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

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

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

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

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

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

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

3 31. DOES 51-60 are the unaffiliated staffing agencies, registries and/or employers of
4 “travelling nurses” and/or temporary or registry nurses, CNAs or other staff who worked at
5 LAGUNA HONDA during the admissions of Decedent SANCHEZ, Decedent LIEU, and/or
6 Decedent PHAM. Plaintiffs are further informed and believe and, on that basis, allege that DOES
7 51-60 are health care providers, including licensed nurses and certified nursing assistants, who were
8 at all times relevant employees of Laguna Honda Defendants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **FACTUAL BACKGROUND**

8 **Plaintiff SANCHEZ**

9 46. Decedent SANCHEZ was admitted to LAGUNA HONDA on approximately April
10 13, 2021. Decedent SANCHEZ was admitted to LAGUNA HONDA with diagnoses including, but
11 not limited to, laryngeal cancer, chronic anemia, cirrhosis of liver, human immunodeficiency virus
12 infection (HIV), impulse control disorder in adult, malignant neoplasm of larynx, nicotine
13 dependence, toxic metabolic encephalopathy, and viral hepatitis C without hepatic coma. Plaintiff
14 SANCHEZ is also informed and believes that Decedent SANCHEZ was on narcotic replacement
15 therapy during his admission to LAGUNA HONDA. Prior to his admission to LAGUNA HONDA,
16 Decedent SANCHEZ experienced chronic homelessness and was hospitalized in approximately
17 November 2020 for suicidality and hepatic encephalopathy. Plaintiff SANCHEZ is informed and
18 believes that Decedent SANCHEZ underwent a laryngectomy in approximately January or February
19 2021, causing him to have difficulty communicating. At all times while at LAGUNA HONDA,
20 Decedent SANCHEZ was dependent on the Laguna Honda Defendants’ staff for assistance with his
21 physical and mental needs due to his multiple medical and mental conditions.

22 47. On June 23, 2022, the Laguna Honda Defendants issued a “Notice of Proposed
23 Transfer/Discharge” to Decedent SANCHEZ, which stated, “The transfer or discharge is appropriate
24 because your health has improved sufficiently so that you no longer need the services provided by
25 the facility.” Said Discharge Notice stated that Decedent SANCHEZ would be transferred to
26 MEDICAL RESPITE and was signed by a LAGUNA HONDA Facility Representative on June 23,
27 2022. Decedent SANCHEZ declined to sign said Discharge Notice. Said Discharge Notice also

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

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

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

1 Defendants' reckless and egregious acts and omissions.

2 50. The SANCHEZ Defendants, and/or their employees/managing agents, owed certain
3 duties to Decedent SANCHEZ while he was under their care and custody at LAGUNA HONDA
4 and/or MEDICAL RESPITE pursuant to various state and federal statutes. (*See* Government Code
5 §§815.2 and 820(a).) Said duties include, but are not limited to, those established and defined by
6 Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq.*, 22 C.C.R. §72311(a)(3)(B), 22
7 C.C.R. §72547, 22 C.C.R. § 2527(a), 22 C.C.R. §72501(e), 22 C.C.R §72509, Health & Safety
8 Code §1599.1(a), Health and Safety Code §1336.2, and 42 C.F.R. §483.70(m). The SANCHEZ
9 Defendants, and/or their employees/managing agents, breached said duties to Decedent SANCHEZ
10 as set forth herein. (*See* Government Code §§815.2 and 820(a).) Each of these acts and omissions
11 by the SANCHEZ Defendants managing agents/employees regarding the care and treatment of
12 Decedent SANCHEZ were undertaken in the course and scope of their employment at LAGUNA
13 HONDA and/or MEDICAL RESPITE. (*See* Government Code §§815.2 and 820(a).)

14 51. The SANCHEZ Defendants, and/or their employees/managing agents, had
15 responsibility for meeting the basic needs of Decedent SANCHEZ, including his safety, medical
16 care, and protecting him from health and safety hazards. (*See* Government Code §§815.2 and
17 820(a).) Although the SANCHEZ Defendants knew of conditions that made Decedent SANCHEZ
18 unable to provide for his own basic needs as described herein, the SANCHEZ Defendants recklessly
19 and egregiously denied and withheld goods or services necessary to meet Decedent SANCHEZ's
20 basic needs. The SANCHEZ Defendants denied and withheld this basic care to him despite the
21 knowledge that by doing so, injury was substantially certain to befall him or with conscious
22 disregard of the high probability of such injury. The SANCHEZ Defendants' reckless and egregious
23 denial and withholding of basic care to Decedent SANCHEZ and the Laguna Honda Defendants'
24 forced transfer of Decedent SANCHEZ to MEDICAL RESPITE caused his injuries.

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

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

2 53. Specifically, as described above, the SANCHEZ Defendants, and/or their
3 employees/managing agents, recklessly and egregiously failed to take the necessary precautions to
4 protect Decedent SANCHEZ from neglect, from violations of his patients' rights, and from transfer
5 trauma, and these failures caused him injury. (*See* Government Code §§815.2 and 820(a).) The
6 SANCHEZ Defendants failed to supervise the staff at LAGUNA HONDA and/or MEDICAL
7 RESPITE, which caused Decedent SANCHEZ injury. The SANCHEZ Defendants failed to provide
8 Decedent SANCHEZ with supervision and assistance that he required and failed to protect him from
9 health and safety hazards which caused him injury. The SANCHEZ Defendants also failed to train
10 staff to prevent physical abuse, neglect, transfer trauma, and failed to investigate to ensure that
11 physical abuse, neglect, transfer trauma was being considered and properly avoided, which caused
12 Decedent SANCHEZ injury. The SANCHEZ Defendants also failed to implement interventions,
13 which caused Decedent SANCHEZ injury. The SANCHEZ Defendants, and/or their
14 employees/managing agents, also failed to ensure that LAGUNA HONDA and/or MEDICAL
15 RESPITE was adequately staffed as required by law, which caused Decedent SANCHEZ injury.
16 Each of these acts and omissions by the SANCHEZ Defendants' managing agents/employees
17 regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope
18 of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (*See* Government Code
19 §§815.2 and 820(a).)

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

1 regarding the care and treatment of Decedent SANCHEZ were undertaken in the course and scope
2 of their employment at LAGUNA HONDA and/or MEDICAL RESPITE. (See Government Code
3 §§815.2 and 820(a).)

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

17 56. This neglect was known to the SANCHEZ Defendants' managing agents, including,
18 but not limited to, LAGUNA HONDA Administrator Roland Pickens and/or Michael Phillips,
19 LAGUNA HONDA Director of Nursing Theresa Dentoni and/or Monica Biley, the MEDICAL
20 RESPITE Administrator and Director of Nursing, and their supervisors, or should have been known
21 to them. Specifically, the SANCHEZ Defendants' staff supervisors and their supervisor knew or
22 should have known of the poor care, inadequate staffing, and insufficient supervision of staff and
23 insufficient monitoring of residents, as well as the fact that LAGUNA HONDA and/or MEDICAL
24 RESPITE does not employ an adequate number of nursing staff to meet the needs of its patients and
25 protect them from abuse, neglect, and violations of their rights. Despite the SANCHEZ Defendants'
26 knowledge of the understaffing of nursing staff at LAGUNA HONDA and/or MEDICAL RESPITE,
27 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

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

12 **The LIEU PLAINTIFFS**

13 59. Decedent LIEU was admitted to LAGUNA HONDA on approximately February 8,
14 2021. Decedent LIEU was admitted to LAGUNA HONDA with diagnoses including, but not
15 limited to, right temporal parietal intracerebral brain hemorrhage (ICH), history of prior left middle
16 cerebral artery stroke, aphasia, dysphagia, hemiparesis affecting his dominant side as late effect of
17 cerebrovascular accident, hypercholesteremia, hypertension, systolic heart failure, and vascular
18 dementia. Before his admission to LAGUNA HONDA, Decedent LIEU suffered a stroke, which
19 caused him to be unable to communicate. During his admission to LAGUNA HONDA, Decedent
20 LIEU was also had a gastrostomy, i.e., a feeding tube, and Decedent LIEU was dependent on the
21 Laguna Honda Defendants' staff to monitor Decedent LIEU for complications related to his feeding
22 tube. During his admission to LAGUNA HONDA, Decedent LIEU was able to remember his family
23 members, who visited often, and was able to non-verbally respond to questions. At all times while at
24 LAGUNA HONDA, Decedent LIEU was dependent on the Laguna Honda Defendants' staff for
25 assistance with his activities of daily living due to his age, dementia, and medical conditions as set
26 forth herein.

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

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

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

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

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

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

22 64. The LIEU Defendants, and/or their employees/managing agents, owed certain duties
23 to Decedent LIEU while he was under their care and custody at LAGUNA HONDA and/or
24 BURLINGAME SKILLED pursuant to various state and federal statutes. (*See* Government Code
25 §§815.2 and 820(a).) Said duties include, but are not limited to, those established and defined by
26 Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq.*, 22 C.C.R. §72311(a)(3)(B), 22
27 C.C.R. §72547, 22 C.C.R. § 2527(a), 22 C.C.R. §72501(e), 22 C.C.R §72509, Health & Safety

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

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

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

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

1 supervision and assistance that he required and failed to protect him from health and safety hazards
2 which caused him injury. The LIEU Defendants also failed to train staff to prevent physical abuse,
3 neglect, transfer trauma, and failed to investigate to ensure that physical abuse, neglect, transfer
4 trauma was being considered and properly avoided, which caused Decedent LIEU injury. The LIEU
5 Defendants also failed to implement interventions, which caused Decedent LIEU injury. The LIEU
6 Defendants, and/or their employees/managing agents, failed to ensure that LAGUNA HONDA
7 and/or BURLINGAME SKILLED was adequately staffed, which caused Decedent LIEU injury.
8 Each of these acts and omissions by the LIEU Defendants' managing agents/employees regarding
9 the care and treatment of Decedent LIEU were undertaken in the course and scope of their
10 employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (*See* Government Code
11 §§815.2 and 820(a).)

12 68. At all times relevant, the LIEU Defendants, and/or their employees/managing agents,
13 knew of Decedent LIEU's declining condition and the critical need to monitor and treat his
14 condition properly and to provide adequate custodial care to him at all times. (*See* Government Code
15 §§815.2 and 820(a).) However, the LIEU Defendants failed to provide custodial care, supervision
16 and protection to Decedent LIEU despite his vulnerable and worsening condition. The LIEU
17 Defendants' conduct, as detailed herein, was reckless and in conscious disregard of Decedent
18 LIEU's rights and safety. Each of these acts and omissions by the LIEU Defendants and/or their
19 managing agents/employees regarding the care and treatment of Decedent LIEU were undertaken in
20 the course and scope of their employment at LAGUNA HONDA and/or BURLINGAME
21 SKILLED. (*See* Government Code §§815.2 and 820(a).)

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

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

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

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

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

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

1 employment at LAGUNA HONDA and/or BURLINGAME SKILLED. (See Government Code
2 §§815.2 and 820(a).)

3 **The PHAM Plaintiffs**

4 73. Decedent PHAM was admitted to LAGUNA HONDA on approximately July 8,
5 2021. Decedent PHAM was admitted to the LAGUNA HONDA with diagnoses including, but not
6 limited to, Alzheimer's dementia, anemia, dizziness and giddiness, enlarged prostate without lower
7 urinary tract symptoms, hearing loss, hyperlipidemia, repeated falls, incontinence of bowel, and
8 urinary incontinence. Prior to being admitted to LAGUNA HONDA, Decedent PHAM was living at
9 home with the assistance of a caregiver. However, by July 2021, Decedent PHAM's dementia
10 worsened, and his care needs increased. At all times while at the LAGUNA HONDA, Decedent
11 PHAM was dependent on the Laguna Honda Defendants' staff for assistance with activities of daily
12 living, including assistance with feeding, transfers, incontinence care, and bathing, and required
13 monitoring and supervision due to his dementia and history of falls.

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

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

1 approximately five voicemails for Plaintiff LAN PHAM and stated that Decedent PHAM was
2 accepted to be transferred to SETON, a general acute care hospital and skilled nursing facility
3 located at 600 Marine Boulevard in Moss Beach, California. The Laguna Honda Defendants' staff
4 stated that if Plaintiff LAN PHAM did not accept the placement for her father at SETON by July 15,
5 2022, Decedent PHAM would be billed \$40,000-50,000 per month. Accordingly, the PHAM
6 Plaintiffs felt that they had no choice but to accept the placement for Decedent PHAM at SETON,
7 and on approximately July 7, 2022, Plaintiff LAN PHAM reluctantly agreed to transfer Decedent
8 PHAM to SETON.

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

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

1 subsequent neglect of Decedent PHAM at SETON.

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

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

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

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

17 82. At all times relevant, the PHAM Defendants, and/or their employees/managing
18 agents, knew of Decedent PHAM's declining condition and the critical need to monitor and treat his
19 condition properly and to provide adequate custodial care to him at all times. (*See* Government Code
20 §§815.2 and 820(a).) However, the PHAM Defendants recklessly and egregiously failed to provide
21 proper custodial care, supervision and protection to Decedent PHAM despite his vulnerable and
22 worsening condition. The PHAM Defendants' conduct, as detailed herein, was reckless and in
23 conscious disregard of Decedent PHAM's rights and safety. Each of these acts and omissions by the
24 PHAM Defendants and/or their managing agents/employees regarding the care and treatment of
25 Decedent PHAM were undertaken in the course and scope of their employment at LAGUNA
26 HONDA and/or SETON. (*See* Government Code §§815.2 and 820(a).)

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

1 employees/managing agents, were not only to Decedent PHAM, but, instead, were part of a
2 continual pattern at LAGUNA HONDA and/or SETON. (See Government Code §§815.2 and
3 820(a).) The pattern of substandard care, insufficient supervision and understaffing was well known
4 to the PHAM's Defendants' managing agents. Specifically, the nurses and other care providers at
5 LAGUNA HONDA and/or SETON who provided care to Decedent PHAM were under the direction
6 of supervisors who were managing agents of the PHAM Defendants. In addition, the supervisors'
7 direct supervisors were managing agents of the PHAM Defendants, such as LAGUNA HONDA
8 Administrator Roland Pickens and/or Michael Phillips, LAGUNA HONDA Director of Nursing
9 and/or Monica Biley, and others. The managing agents of the PHAM Defendants knew or should
10 have known of the continuing lack of proper custodial care and protection to its residents, as well as
11 understaffing and poor training regarding basic custodial care needs, including the prevention of
12 abuse and/or neglect.

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

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

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

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

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

7 **FIRST CAUSE OF ACTION**

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

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

12 88. The above-mentioned acts of DEFENDANTS, and/or their employees/managing
13 agents, constituted "abuse," "neglect" and/or "abandonment" within the meaning of Welfare &
14 Institutions Code §15610 et seq. and caused physical pain and/or mental suffering and/or deprived
15 Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM of the services that were necessary to
16 avoid physical harm or mental suffering. (*See* Government Code §815.2 and §820(a).)
17 DEFENDANTS committed dependent adult/elder neglect as defined under the Elder and Dependent
18 Adult Civil Protection Act by, as set forth in detail above, recklessly failing to protect Decedent
19 SANCHEZ, Decedent LIEU, and Decedent PHAM from abuse and neglect, failing to provide them
20 with adequate custodial care, failing to monitor and supervise them to adequately protect them from
21 abuse and neglect, and failing to protect them from health and safety hazards. (Welf. Inst. Code
22 §15610.57.) With respect to the Laguna Honda Defendants, said defendants' acts and omissions also
23 constitute "abandonment" of Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM as that
24 term is defined in Welfare & Institutions Code § 15610.05, given that said defendants' conduct as
25 described in detail herein constitutes a "desertion or willful forsaking of an elder or a dependent
26 adult by anyone having care or custody of that person under circumstances in which a reasonable
27 person would continue to provide care and custody." Pursuant to Welfare & Institutions Code

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

4 89. As set forth in great detail above, DEFENDANTS have recklessly and egregiously
5 violated their duties to Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM by violating
6 numerous statutes and regulations, including but not limited to Welfare & Institutions Code
7 §15657, Cal. Civ. Code §§ 51 *et seq.*, 22 C.C.R. § 72547, 22 C.C.R. § 72527(a), 22 C.C.R. §
8 72501(e), 22 C.C.R. § 72509, Health & Safety Code § 1599.1(a), Health and Safety Code 1336.2,
9 and/or 42 C.F.R. 483.70(m) in the care and treatment of 42 C.F.R. 483.70(m) at LAGUNA
10 HONDA, MEDICAL RESPITE, BURLINGAME SKILLED, and SETON.

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

20 91. The violation of certain state and/or federal statutes as set forth above, including, but
21 not limited to, Welfare & Institutions Code §15657, Cal. Civ. Code §§ 51 *et seq.*, 22 C.C.R. §
22 72547, 22 C.C.R. § 72527(a), 22 C.C.R. § 72501(e), 22 C.C.R. § 72509, Health & Safety Code §
23 1599.1(a), Health and Safety Code 1336.2, and/or 42 C.F.R. 483.70(m), by DEFENDANTS, and/or
24 their employees/managing agents, was a substantial factor in causing injury to Decedent
25 SANCHEZ, Decedent LIEU, and Decedent PHAM and the damages as alleged herein. (*See*
26 Government Code §815.2 and §820(a).)

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

1 DEFENDANTS, and each of them:

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

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

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

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

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

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- 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;

- 1 g. Failed to maintain dignity and prevent mental and physical abuse of Decedent
2 SANCHEZ, Decedent LIEU, and Decedent PHAM as required by 22 C.C.R.
3 §72527(a);
- 4 h. Failed to maintain nursing and other staffing at levels adequate to meet the needs of
5 all residents, including Decedent SANCHEZ, Decedent LIEU, and Decedent PHAM
6 as required by 22 C.C.R. §72501(e); and
- 7 i. Failed to employ an adequate number of qualified personnel to carry out all of the
8 functions of LAGUNA HONDA, MEDICAL RESPITE, BURLINGAME SKILLED
9 and SETON for the health and safety of their residents as required by California
10 Health & Safety Code §1599.1(a).

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

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

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

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

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

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

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

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

9 **SECOND CAUSE OF ACTION**

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

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

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

1 including privacy in treatment and in care of personal needs.”

2 101. As alleged above, the Laguna Honda Defendants, the Burlingame Skilled Defendants,
3 the Seton Defendants and/or their employees/managing agents, violated the patient rights of Decedent
4 SANCHEZ, Decedent LIEU, and Decedent PHAM repeatedly. (*See* Government Code §815.2 and
5 §820(a).) Each violation of the patient’s rights of Decedent SANCHEZ, Decedent LIEU, and
6 Decedent PHAM, as described in detail above, was a violation of a primary right and is actionable in
7 its own right. As such, each violation of the primary rights of Decedent SANCHEZ, Decedent LIEU,
8 and Decedent PHAM, as discussed in detail above, constitutes a “cause of action.” However, for
9 efficiency’s sake, Plaintiffs are labeling this first cause of action collectively the Violation of
10 Patient’s Rights, which discusses the numerous causes of action subsumed herewith. Thus, this has
11 the force and effect of being multiple causes of action. In addition to other relief, Plaintiffs are
12 accordingly entitled to attorney’s fees and costs against said defendants.

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

14 **THIRD CAUSE OF ACTION**

15 **(Negligence Against All DEFENDANTS)**

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

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

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

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

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

1 **FOURTH CAUSE OF ACTION**

2 **(Wrongful Death Against All DEFENDANTS)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **DAMAGES**

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

- 19 1. For general damages according to law and proof;
- 20 2. For special damage according to law and proof;
- 21 3. For costs of suit;
- 22 4. For attorney's fees pursuant to law;
- 23 5. For pre-death pain and suffering;
- 24 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
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By: 

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