CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
Kathryn Stebner SBN 121088, Sarah Colby SBN 194475, Karman Ratliff SBN 268631
George Kawamoto SBN 280358
Stebner and Associates, A Professional Law Corporation
870 Market Street, Suite 1212, San Francisco, CA 94102
TELEPHONE NO.: 415-362-9800 FAX NO.: 415-362-9801
ATTORNEY FOR (Name): Plaintiffs

FOR COURT USE ONLY

FILED
2012 JUN 25 P 3: 26

SUPERIOR COURT OF CALIFORNIA, COUNTY OF CONTRA COSTA
STREET ADDRESS: 725 Court Street
MAILING ADDRESS:
CITY AND ZIP CODE: Martinez, CA 94553
BRANCH NAME:

CASE NAME:
BROWN, et al. vs. MARINER HEALTH CARE, INC., et al.

CIVIL CASE COVER SHEET

☑ Unlimited (Amount demanded exceeds $25,000) ☐ Limited (Amount demanded is $25,000 or less)

Complex Case Designation
☐ Counter ☐ Joinder
Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)

CASE NUMBER: C12-01479
JUDGE:
DEPT:

Items 1–6 below must be completed (see instructions on page 2).

1. Check one box below for the case type that best describes this case:

Auto Tort
- ☐ Auto (22)
- ☐ Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- ☐ Asbestos (04)
- ☐ Product liability (24)
- ☐ Medical malpractice (45)
- ☐ Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- ☐ Business tort/unfair business practice (07)
- ☐ Civil rights (08)
- ☐ Defamation (13)
- ☐ Fraud (16)
- ☐ Intellectual property (19)
- ☐ Professional negligence (25)
- ☐ Other non-PI/PD/WD tort (35)

Employment
- ☐ Wrongful termination (36)
- ☐ Other employment (15)

Contract
- ☐ Breach of contract/warranty (06)
- ☐ Rule 3.740 collections (09)
- ☐ Other collections (09)
- ☐ Insurance coverage (18)
- ☐ Other contract (37)

Real Property
- ☐ Eminent domain/Inverse condemnation (14)
- ☐ Wrongful eviction (33)
- ☐ Other real property (26)

Unlawful Detainer
- ☐ Commercial (31)
- ☐ Residential (32)
- ☐ Drugs (38)

Judicial Review
- ☐ Asset forfeiture (05)
- ☐ Petition re: arbitration award (11)
- ☐ Writ of mandate (02)
- ☐ Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400–3.403)
- ☐ Antitrust/Trade regulation (03)
- ☐ Construction defect (10)
- ☐ Mass tort (40)
- ☐ Securities litigation (28)
- ☐ Environmental/Toxic tort (30)
- ☐ Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- ☐ Enforcement of judgment (20)

Miscellaneous Civil Complaint
- ☐ RICO (27)
- ☑ Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- ☐ Partnership and corporate governance (21)
- ☐ Other petition *(not specified above)* (43)

2. This case ☐ is ☑ is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. ☐ Large number of separately represented parties
   b. ☐ Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. ☐ Substantial amount of documentary evidence
   d. ☐ Large number of witnesses
   e. ☐ Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. ☐ Substantial postjudgment judicial supervision

3. Remedies sought *(check all that apply)*: a. ☑ monetary b. ☑ nonmonetary; declaratory or injunctive relief c. ☑ punitive
4. Number of causes of action *(specify)*: Two (2)
5. This case ☐ is ☑ is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

BY FAX

Date: June 25, 2012
Kathryn Stebner
(TYPE OR PRINT NAME) (SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE
- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on all other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

SUM-100

SUMMONS
(CITACION JUDICIAL)

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)

FILED

2012 JUN 25 P 3: 28

NOTICE TO DEFENDANT:
(AVISO AL DEMANDADO):

MARINER HEALTH CARE, INC.; MARINER HEALTH CENTRAL, INC.; MARINER HEALTH CARE MANAGEMENT COMPANY;

YOU ARE BEING SUED BY PLAINTIFF:
(LO ESTÁ DEMANDANDO EL DEMANDANTE):

COLETTE ROBIN BROWN; LOIS ZAVODA, as successor in interest to the Estate of JULIE SHULAW; OLIVER ZAVODA, as successor in

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.

¡AVISO! Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.

Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (www.sucorte.ca.gov), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.

Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (www.lawhelpcalifornia.org), en el Centro de Ayuda de las Cortes de California, (www.sucorte.ca.gov) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.

The name and address of the court is:
(El nombre y dirección de la corte es): Contra Costa County Superior Court
725 Court Street
Martinez, CA 94553

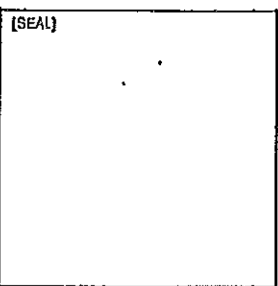
CASE NUMBER: *(Número del Caso):* C12-01479

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):
Kathryn Stebner (SBN 121088) Stebner & Associates, 870 Market St., #1212, San Francisco, CA 94102

DATE: *(Fecha)* JUN 25 2012 Clerk, by *(Secretario)* PER LOCAL RULE 5 THIS CASE IS ASSIGNED TO DEPT ______, Deputy *(Adjunto)*

(For proof of service of this summons, use Proof of Service of Summons (form POS-010).)
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, (POS-010)).

[SEAL]



NOTICE TO THE PERSON SERVED: You are served
1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify)*:
3. ☐ on behalf of *(specify)*:
   under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
   ☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
   ☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
   ☐ other *(specify)*:
4. ☐ by personal delivery on *(date)*:

SHORT TITLE: BROWN vs. MARINER HEALTH CARE, INC., et al.	CASE NUMBER:

INSTRUCTIONS FOR USE

- This form may be used as an attachment to any summons if space does not permit the listing of all parties on the summons.
- If this attachment is used, insert the following statement in the plaintiff or defendant box on the summons: "Additional Parties Attachment form is attached."

List additional parties *(Check only one box. Use a separate page for each type of party.)*:

[✓] Plaintiff [ ] Defendant [ ] Cross-Complainant [ ] Cross-Defendant

interest to the Estate of JULIE SHULAW; SUSAN TORNGREN, as successor in interest to the Estate of JULIE SHULAW; MABEL NUN; JUANITA BLANCO ANGULO, individually and as successor in interest to the Estate of LUIS ANGULO; TONY ANGULO, as successor in interest to the Estate of LUIS ANGULO; and AMALIA CRITTENDON

Form Adopted for Mandatory Use
Judicial Council of California
SUM-200(A) [Rev. January 1, 2007]

ADDITIONAL PARTIES ATTACHMENT
Attachment to Summons

SHORT TITLE: BROWN vs. MARINER HEALTH CARE, INC., et al.	CASE NUMBER:

INSTRUCTIONS FOR USE

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- If this attachment is used, insert the following statement in the plaintiff or defendant box on the summons: "Additional Parties Attachment form is attached."

List additional parties *(Check only one box. Use a separate page for each type of party.)*:

☐ Plaintiff ☑ Defendant ☐ Cross-Complainant ☐ Cross-Defendant

MHC WEST HOLDING COMPANY; GRANCARE, LLC; CREEKSIDE HEALTH CARE CENTER; JANET ROTICH; and Does 1 through 100, inclusive.

KATHRYN A. STEBNER (SBN 121088)
SARAH COLBY (SBN 194475)
KARMAN RATLIFF (SBN 267631)
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Attorneys for Plaintiffs

FILED
2012 JUN 25 P 3:26

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF CONTRA COSTA

COLETTE ROBIN BROWN; LOIS ZAVODA, as successor in interest to the Estate of JULIE SHULAW; OLIVER ZAVODA, as successor in interest to the Estate of JULIE SHULAW; SUSAN TORNGREN, as successor in interest to the Estate of JULIE SHULAW; MABEL NUN; JUANITA BLANCO ANGULO, individually and as successor in interest to the Estate of LUIS ANGULO; TONY ANGULO, as successor in interest to the Estate of LUIS ANGULO; and AMALIA CRITTENDON,

Plaintiffs,

vs.

MARINER HEALTH CARE, INC.; MARINER HEALTH CENTRAL, INC.; MARINER HEALTH CARE MANAGEMENT COMPANY; MHC WEST HOLDING COMPANY; GRANCARE, LLC; CREEKSIDE HEALTH CARE CENTER; JANET ROTICH; and Does 1 through 100, inclusive,

Defendants.

CASE NO.

COMPLAINT FOR DAMAGES AND DEMAND FOR A JURY TRIAL

1. **Patient's Rights (Cal. H&S Code § 1430(b)**
2. **Unfair Competition (Cal. B&P Code §17200 et seq.)**

BY FAX

PER LOCAL RULE 5 THIS CASE IS ASSIGNED TO DEPT ______

Plaintiffs, based on information and belief and the investigation of counsel, except for information based on personal knowledge, hereby allege as follows:

NATURE OF ACTION

1. Plaintiffs bring this lawsuit under California Health and Safety Code section 1430(b) and the Unfair Competition Law, California Business & Professions Code sections 17200 *et seq.*, to redress the pervasive and intentional violation of the patients' rights of elderly and dependent adult residents at Creekside Health Care Center, a skilled nursing facility owned, licensed, operated, administered, managed, directed, and/or controlled by Defendants within the State of California.

2. Plaintiffs have joined their individual claims against all Defendants in this common action for the purposes of judicial efficiency and economy. Their claims arise out of common experiences and a series of common occurrences. The questions of law are identical for all plaintiffs, and there are many common questions of fact.

PARTIES

3. Plaintiff COLETTE ROBIN BROWN ("Plaintiff BROWN") is a resident of CREEKSIDE HEALTH CARE CENTER ("CREEKSIDE") and has been since 2007. She has Multiple Sclerosis ("MS") and was at all times relevant to this complaint a dependent adult as defined in W&I Code § 15610.23 and a disabled person as defined in Cal. Civ. Code § 1761(g). COLLEEN ADAMS ("ADAMS") is her mother and holds the power of attorney for business and health care decisions. She is and was at all times herein mentioned a resident of the County of Contra Costa, State of California.

4. Plaintiff LOIS ZAVODA is the mother and successor in interest to the Estate of JULIE SHULAW ("SHULAW"), who died on March 31, 2012. Plaintiff OLIVER ZAVODA is the father and successor in interest to the Estate of SHULAW. Plaintiff SUSAN TORNGREN is the sister and successor in interest to the Estate of SHULAW. SHULAW was a resident at CREEKSIDE from November 2009 through March 31, 2012. At all times relevant to this complaint, SHULAW had MS and was a dependent adult as defined in W&I Code § 15610.23 and a disabled person as defined in Cal. Civ. Code § 1761(g). She was at all times herein mentioned a resident of the County of Contra Costa, State of California. Plaintiffs LOIS ZAVODA and OLIVER ZAVODA are residents of the County of Contra Costa, State of California. Plaintiff SUSAN TORNGREN is a resident of Sacramento County.

5. Plaintiff MABEL NUN ("Plaintiff NUN") was a resident at CREEKSIDE from approximately June 2011 through April 2012. She has numerous health conditions and mobility impairments. At all times mentioned in this complaint, Plaintiff NUN was an elder as defined in W&I Code § 15610.27 and a senior citizen as defined in Cal. Civ. Code § 1761(f). BETTY JOURBERT ("JOURBERT") is her daughter and holds the power of attorney for business and health care decisions. Plaintiff NUN is and was at all times herein mentioned a resident of the County of Contra Costa, State of California.

6. Plaintiff JUANITA BLANCO ANGULO ("Plaintiff ANGULO") was a resident at CREEKSIDE from approximately July 17, 2011 to September 1, 2011. At all times mentioned in this complaint, Plaintiff ANGULO was an elder as defined in W&I Code § 15610.27 and a senior citizen as defined in Cal. Civ. Code § 1761(f). Plaintiff ANGULO is also, along with her son TONY ANGULO, the successor in interest to the Estate of LUIS ANGULO, her husband. LUIS ANGULO was a resident at CREEKSIDE from approximately August 1, 2011 until his death on September 7, 2011. At all times mentioned in this complaint, LUIS ANGULO was an elder as defined in W&I Code § 15610.27 and a senior citizen as defined in Cal. Civ. Code § 1761(f). Plaintiff ANGULO and her husband LUIS ANGULO were at all times herein mentioned residents of the County of Contra Costa, State of California.

7. Plaintiff TONY ANGULO ("Plaintiff TONY ANGULO") is the son and successor in interest to the Estate of LUIS ANGULO. He is a resident of the County of Contra Costa, State of California.

8. Plaintiff AMALIA CRITTENDON ("Plaintiff CRITTENDON") was a resident at CREEKSIDE from approximately June 9, 2011 through July 4, 2011, for rehabilitation after knee replacement surgery. At all times mentioned in this complaint, Plaintiff CRITTENDON was an elder as defined in W&I Code § 15610.27 and a senior citizen as defined in Cal. Civ. Code § 1761(f). Plaintiff CRITTENDON is and was at all times herein mentioned a resident of the County of Contra Costa, State of California.

9. Defendant GRANCARE, LLC ("GRANCARE") is a Delaware limited liability company with its principal place of business at One Ravinia Drive, Suite 1250, Atlanta, Georgia. It is the licensee

for Defendant CREEKSIDE HEALTH CARE CENTER ("CREEKSIDE") located at 1900 Church Lane, San Pablo, in the County of Contra Costa, State of California.

10. Defendant MHC WEST HOLDING COMPANY ("MHC WEST") is a Delaware Corporation with its principal place of business at One Ravinia Drive, Suite 1250, Atlanta, Georgia. It is the parent corporation of GRANCARE.

11. Defendant MARINER HEALTH CARE MANAGEMENT COMPANY ("MHC MANAGEMENT") is Delaware Corporation with its principal place of business at One Ravinia Drive, Suite 1400, Atlanta, Georgia. MHC MANAGEMENT operates 21 leased skilled nursing facilities in California.

12. Defendant MARINER HEALTH CENTRAL, INC. ("MARINER HEALTH CENTRAL") is a Delaware corporation with its principal place of business at One Ravinia Drive, Suite 1400, Atlanta, Georgia.

13. Defendant MARINER HEALTH CARE, INC. ("MARINER HEALTH CARE") is a Delaware corporation with its principal place of business at One Ravinia Drive, Suite 1400, Atlanta, Georgia. It is the parent corporation of MHC WEST, GRANCARE, MHC MANAGEMENT, and MARINER HEALTH CENTRAL.

14. Defendant JANET ROTICH ("Defendant ROTICH") has been the Administrator at CREEKSIDE since December 3, 2007. Defendant ROTICH lists on her license renewal applications to the state that her employer is "Mariner Healthcare." Plaintiffs allege on information and belief that Defendant ROTICH is and was at all times relevant to this complaint a resident of the County of Contra Costa, State of California.

15. Defendants CREEKSIDE, GRANCARE, MHC MANAGEMENT, MHC WEST, and MARINER HEALTH CENTRAL are all wholly owned subsidiaries of MARINER HEALTH CARE.

16. Defendants GRANCARE, MHC WEST, MHC MANAGEMENT, MARINER HEALTH CENTRAL and MARINER HEALTH CARE will be referred to collectively as "the MARINER HEALTH CARE Defendants".

17. Defendants CREEKSIDE, ROTICH, GRANCARE, MHC WEST, MHC MANAGEMENT, MARINER HEALTH CENTRAL, and MARINER HEALTH CARE will be referred

to collectively as "the MARINER Defendants". The MARINER Defendants are in the business of providing long-term care as defined in Health & Safety Code section 1250(c).

18. At all times herein mentioned, the MARINER Defendants have all regularly conducted business throughout the State of California, including, but not limited to, the ownership, licensing, administration, operation, management, and/or supervision of CREEKSIDE and 20 other skilled nursing facilities in California.

Defendants Are Alter Egos of One Another and form Part of a Single Enterprise

19. The MARINER HEALTH CARE Defendants are alter egos of one another and form part of a single enterprise. There is a sufficient unity of interest and ownership among the MARINER HEALTH CARE Defendants, and between each of them, such that the acts of one are for the benefit and can be imputed to the acts of the others.

Defendants Divert Assets From Creekside and Treat the Funds of One Entity as the Funds of Others

20. The MARINER HEALTH CARE Defendants treat the assets of one as the assets of all, and MARINER HEALTH CARE siphons funds and assets from CREEKSIDE. CREEKSIDE pays large administrative fees to MARINER HEALTH CARE. In its 2010 Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report submitted to California's Office of Statewide Health Planning and Development ("OSHPD report") CREEKSIDE lists "Administrative Services" fees of $527,715 for the year 2010 under the heading "Related Party Transactions – Statement of Income." A chart titled "Statement of Changes in Equity" in the same report indicates that the General Fund balance decreased by almost $3 million dollars during 2010, from $5,340,358 at the beginning of 2010 to $2,601,960 at the end of the year. This calculation included an "Intercompany Transfer" of $4,801,545 out of CREEKSIDE.

21. Additionally, the MARINER HEALTH CARE Defendants provide the physical and occupational therapies and charge CREEKSIDE. For example, physical and occupational therapies alone generated revenues for the MARINER HEALTH CARE Defendants of $1,592,448 in 2009, and $1,442,945 in 2010.

22. MARINER HEALTH CENTRAL pays the licensing renewal fees for CREEKSIDE to DPH.

Defendants Have Agreed to Be Jointly and Severally Liable for the Debts of One Another

23. The MARINER HEALTH CARE Defendants have agreed to be jointly and severally liable for the debts of one another. Plaintiffs are informed and believe and thereon allege that the MARINER HEALTH CARE Defendants are parties to a credit facility agreement from which operating expenses are drawn. Plaintiffs allege on information and belief that the MARINER HEALTH CARE Defendants have agreed to be jointly and severally liable for one another's debts under the terms of the agreement.

Defendants' Equitable Ownership Is Identical

24. The MARINER HEALTH CARE Defendants' equitable ownership is identical. Harry Grunstein owns 100% of GRANCARE, MHC WEST, MARINER HEALTH CARE, MHC MANAGEMENT, and MARINER HEALTH CENTRAL.

Defendants Share Employees

25. The MARINER HEALTH CARE Defendants share employees, and employees move between the separate entities as if within divisions for the same employer. For example, Defendant ROTICH has been the Administrator at CREEKSIDE since December 3, 2007. From November 2008 to February 2009, she was simultaneously employed as an Administrator by Pine Ridge Care Center, another MARINER HEALTH CARE skilled nursing facility in California. Defendant ROTICH was also the Assistant Administrator at Pine Ridge from February to April of 2007, and its Administrator from April to December 2007. Defendant ROTICH was the Assistant Administrator of Hayward Hills Healthcare Center, another MARINER HEALTH CARE skilled nursing facility, from July 2006 to February 2007. Prior to that, Defendant ROTICH was the Food Service Director at Vale Healthcare Center, another MARINER HEALTH CARE skilled nursing facility, from April 2000 to March 2006. In a form filed with DPH by Defendant ROTICH, she lists her employer as "Mariner Healthcare" for each of these positions.

26. Plaintiffs are informed and believe and thereon allege that when MARINER HEALTH CARE facilities are short-staffed, they often receive temporary staffing help from another MARINER HEALTH CARE facility.

Defendants Share Common Officers

27. The MARINER HEALTH CARE Defendants share common officers. Harry Grunstein has been the CEO and Secretary of GRANCARE, MHC WEST, MARINER HEALTH CENTRAL, MHC MANAGEMENT, and MARINER HEALTH CARE since approximately 2009. None of these companies has a CFO, although Boyd P. Gentry was the CFO of each of them prior to 2009.

Defendants' Headquarters Are Located at the Same Address

28. The MARINER HEALTH CARE Defendants' corporate headquarters are located at the same addresses. All of the MARINER HEALTH CARE Defendants have their principal place of business at One Ravinia Drive, Suite 1250, Atlanta, Georgia. GRANCARE and MHC WEST are located in Suite 1250, and MARINER HEALTH CARE, MHC MANAGEMENT, and MARINER HEALTH CENTRAL are located in Suite 1400.

Defendants Are Undercapitalized

29. The MARINER HEALTH CARE Defendants are undercapitalized. When National Senior Care, Inc. ("NSC"), the parent of the MARINER HEALTH CARE Defendants, acquired MARINER HEALTH CARE in 2004, it did so in a complicated, highly leveraged deal. To finance the deal, NSC obtained a credit facility of approximately $150 million secured by MARINER HEALTH CARE's accounts receivable and other assets. Additionally, post-purchase, NSC sold approximately two-thirds of the real estate held by MARINER HEALTH CARE to another company. That company set up separate real estate holding companies and leased these facilities back to MARINER HEALTH CARE. The interest expense payments on MARINER HEALTH CARE's Medicare costs reports—indicating how much debt had been incurred—increased by 145 percent from 2004 to 2005.

Defendants Share Trademarks, Branding, and a Website and Present Themselves to the Public as a Single Enterprise

30. The MARINER HEALTH CARE Defendants present themselves to the public as a single enterprise. The MARINER HEALTH CARE Defendants share trademarks and branding. MARINER

HEALTH CARE owns the trademark used by CREEKSIDE and the other skilled nursing facilities licensed by GRANCARE. The same trademark is also used by MARINER HEALTH CENTRAL and MHC MANAGEMENT.

31. CREEKSIDE has no website of its own. It is one in a list of MARINER HEALTH CARE facilities on www.marinerhealthcare.com. Those who work at CREEKSIDE, as well as the other GRANCARE facilities, are part of the MARINER HEALTH CARE intranet and are assigned email addresses ending with @marinerhealthcare.com.

32. In addition to using the same website, email addresses, and branding, the MARINER HEALTH CARE Defendants communicate with the California Department of Public Health ("DPH") on behalf of CREEKSIDE/GRANCARE. For example, the facility license renewal application is submitted to the DPH on MARINER HEALTH CARE stationary. The OSHPD reports are completed by MARINER HEALTH CENTRAL, and a MARINER HEALTH CENTRAL employee is listed as the contact person.

Injustice Will Result if the Corporate Form of Defendants Is Not Disregarded

33. Injustice will result if the corporate form of the MARINER HEALTH CARE Defendants is not disregarded. Injustice will result if the Court does not disregard the fiction of the separate corporate entities the MARINER HEALTH CARE Defendants have constructed to conceal and misrepresent the identity of the responsible ownership of, management of and financial interest in CREEKSIDE/GRANCARE. The MARINER HEALTH CARE Defendants have created a complex ownership and management structure in order to shield themselves from liability and to carry out their single enterprise with financial impunity. The MARINER HEALTH CARE Defendants manage and control CREEKSIDE and make all critical decisions regarding staffing budgets and census, resulting in nurse staffing which falls below the legal minimum. The MARINER HEALTH CARE Defendants benefit financially from their policies, decisions, control and management of CREEKSIDE in the form of income and profits received from them, but hide behind their elaborate corporate structure to escape financial and legal liability. The MARINER HEALTH CARE Defendants pledge their assets as collateral in furtherance of their single enterprise goals, but shield those same assets behind the corporate structure to avoid responsibility when their operations cause harm or violate the law. The MARINER HEALTH CARE Defendants bank on their branding and recognition of the "Mariner" name to draw residents to their facilities, including

CREEKSIDE. The MARINER HEALTH CARE Defendants present themselves publicly as a unified nationwide operation, through brochures, marketing materials, their website, communications with the media, and other publications in order to draw residents to their facilities, including CREEKSIDE. If the MARINER HEALTH CARE Defendants are not treated as a single enterprise or alter egos of each other, a severe injustice will result to California consumers, including Plaintiffs. The MARINER HEALTH CARE Defendants have caused CREEKSIDE to violate the rights of its residents in order to maximize their own profits. The MARINER HEALTH CARE Defendants have stripped CREEKSIDE of millions of dollars, which monies were obtained through wholesale violations of California's patients' rights laws. For these and other reasons alleged herein, allowing the MARINER HEALTH CARE Defendants to avoid legal responsibility for actions taken at the facility level, which they directed and caused, would be unfair and unjust.

Defendants are Agents of One Another

34. Defendant ROTICH, CREEKSIDE, and GRANCARE are agents of the MARINER HEALTH CARE Defendants. The MARINER HEALTH CARE Defendants exercise pervasive and continual control over CREEKSIDE, GRANCARE and ROTICH, such that they are mere agents or instrumentalities of MARINER HEALTH CARE.

35. Plaintiffs allege on information and belief that the MARINER HEALTH CARE Defendants make and approve key decisions concerning CREEKSIDE's day-to-day operations, such as staffing levels, employee hiring and firing, budgets and related issues, which decisions and directives, on information and belief, were made at the direction of and/or the benefit of the MARINER HEALTH CARE Defendants. These decisions are carried out by ROTICH.

36. Mariner Health Care has a standard employment application packet under MARINER branding. Applicants who sign it authorize "Mariner Health Care" to perform confidential reference checks, background checks, credit checks, licensing/certification checks, and substance abuse testing. Applicants are required to acknowledge receipt of and agree to the "Company Employment Dispute Resolution Program," which is an agreement to final and binding arbitration and a forfeiture of their rights to a jury trial. "I understand that no representative of the Company, other than an officer of the company at the level of Senior Vice President or above, has the authority to make an agreement contrary to the forgoing or to alter the Company's EDR Program." Additionally, Mariner has a company-wide

1 "Substance Abuse and Testing Policy" which all applicants must acknowledge and agree to obey.
2 Mariner Health Care also requires applicants to acknowledge receipt of and agree to abide by the
3 Company's "Code of Conduct and Employee Handbook".

4 37. The MARINER HEALTH CARE Defendants required CREEKSIDE, GRANCARE, and
5 ROTICH to procure labor, services and/or merchandise from MARINER HEALTH CARE subsidiaries
6 or entities with which MARINER HEALTH CARE had a special relationship. In its qui tam complaint
7 against MARINER and the pharmaceutical company Omnicare, Inc. ("Omnicare"), the U.S. Justice
8 Department alleged that MARINER HEALTH CARE had solicited kickbacks from Omnicare in
9 exchange for guaranteeing that its nursing home facilities would use Omnicare as its sole supplier of
10 pharmaceuticals for its residents.

11 38. Plaintiffs allege on information and belief that CREEKSIDE's budget is drafted by
12 MARINER HEALTH CARE employees, and all significant expenditures must be approved by
13 MARINER HEALTH CARE.

14 39. Plaintiffs allege on information and belief that ROTICH and other administrative
15 employees at CREEKSIDE and other GRANCARE licensed facilities are eligible for bonuses based on
16 their ability to meet budget targets set by MARINER HEALTH CARE. These bonuses and their
17 amounts must be approved by MARINER HEALTH CARE.

18 40. The MARINER HEALTH CARE Defendants' corporate budget process has a direct
19 impact on the compliance with resident rights at CREEKSIDE, such as the provision of adequate
20 nursing staff. The staffing levels at CREEKSIDE, including nurse staffing levels, are set at levels
21 designed to maximize corporate profit margins, but at levels that make it inevitable that CREEKSIDE
22 will fail to meet adequate staffing requirements.

23 41. CREEKSIDE employees must submit to a MARINER HEALTH CARE application
24 process, including a standardized application form, and consider themselves employees not of
25 GRANCARE but of MARINER HEALTH CARE.

26 42. Plaintiffs allege on information and belief that training manuals and all policy and
27 procedure manuals for the MARINER HEALTH CARE facilities are consistent throughout the
28 company.

1 *Defendants Are Participating in a Joint Venture*

2 43. Defendants are engaged in a joint venture. They share a community of interest in the object and
3 purpose of CREEKSIDE and other GRANCARE facilities' operation. They use and have a right to share in the
4 control of the operation of CREEKSIDE during relevant times regardless of whether such right is or was actually
5 exercised.

6 44. Defendants have agreed to manage, operate, obtain licenses for, and collect and distribute the
7 profits and assets of CREEKSIDE, GRANCARE, GRANCARE's other skilled nursing facilities in California,
8 and the other MARINER HEALTH CARE Defendants. The same entity, GRANCARE, holds the SNF license
9 for all of MARINER HEALTH CARE's twenty-one skilled nursing facilities in California.

10 45. The www.marinerhealthcare.com website describes its common purpose to the public as such:
11 "At Mariner Health Care, we understand. We are committed to providing compassionate and comprehensive care
12 in a pleasant, comfortable environment. At Mariner, we focus on the people we serve and the care we provide.
13 Throughout our network of 21 skilled nursing facilities located in southern and northern California, we provide
14 24-hour care ranging from short-term rehabilitation therapy to quality long-term restorative nursing care."

15 46. However, the true purpose of Defendants' joint venture is to reap and share significant profits
16 from the operation of skilled nursing facilities in California, while simultaneously attempting to limit their
17 liability. For example, the reimbursements received by CREEKSIDE and GRANCARE from Medi-Cal and
18 Medicare are diverted to other MARINER HEALTH CARE defendants for "Administrative Services."
19 CREEKSIDE's 2010 OSHPD report to the state listed a payment of $527,715 to "Related Parties" for such
20 services. In the same report, a chart titled "Statement of Changes in Equity" indicates that CREEKSIDE's
21 General Fund balance decreased by almost $3 million dollars during 2010, from $5,340,358 at the beginning of
22 2010 to $2,601,960 at the end of the year. This calculation included an "Intercompany Transfer" of $4,801,545
23 out of CREEKSIDE.

24 47. Defendants control the operation, planning, management, and quality control of CREEKSIDE.
25 The authority Defendants exercise over CREEKSIDE includes, but is not limited to, control of marketing, human
26 resources management, training, staffing, creation and implementation of policy and procedure manuals used by
27 CREEKSIDE and other GRANCARE facilities, federal and state Medicare and Medi-Cal reimbursement, quality
28

care assessment and compliance, licensure and certification, legal services, and financial, tax, and accounting control through fiscal policies established by the MARINER HEALTH CARE Defendants.

48. The Defendants operate as a joint venture for the purpose of streamlining and furthering their similar business interests, as they are all owned by one individual and are controlled by the same corporate decision-makers.

49. Because the Defendants were and are engaged in a joint venture, the acts and omissions of each participant in the joint venture are imputable to all other participants. The actions of the Defendants and each of its servants, agents and employees as set forth herein, are imputed to each of the Defendants, jointly and severally.

50. The MARINER HEALTH CARE Defendants, and each of them, form a community of pecuniary interest and are jointly and separately responsible for the conduct alleged herein and the injuries to Plaintiffs. The MARINER HEALTH CARE Defendants operate as a joint venture, single enterprise, are agents of one another, are alter egos, and/or conspire to increase profits by ignoring residents' rights. The MARINER HEALTH CARE Defendants, and each of them, are directly liable because their actions have caused CREEKSIDE to ignore residents' rights requirements and thereby caused harm to the Plaintiffs.

51. The true names and capacities, whether individual, corporate, associate, or otherwise, of the defendants designated herein as Does 1 through 100, inclusive, are presently unknown to Plaintiffs and thus sued by such fictitious names. On information and belief, each of the defendants designated herein as "Doe" is legally responsible for the events and actions alleged herein, and proximately caused or contributed to the injuries and damages as hereinafter described. Plaintiffs will seek leave to amend this complaint, in order to show the true names and capacities of such parties, when the same has been ascertained. On information and belief, at all times herein mentioned, the MARINER Defendants, and each of them, were the agent, partner, joint venturer, representative, and/or employee of the remaining defendants, and was acting within the course and scope of such agency, partnership, joint venture, and/or employment. Furthermore, in engaging in the conduct described below, the MARINER Defendants were all acting with the express or implied knowledge, consent, authorization, approval, and/or ratification of their co-defendants.

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JURISDICTION AND VENUE

52. This Court has jurisdiction over all causes of action asserted herein. Defendants are subject to the personal jurisdiction of this Court because each defendant has sufficient minimum contacts in California, or otherwise intentionally avails itself of the California market through participation in skilled nursing facilities located in California, derivation of substantial revenues from California, and other activities, so as to render the exercise of jurisdiction over it by the California courts consistent with traditional notions of fair play and substantial justice.

53. Venue is proper in the County of Contra Costa based on the facts, without limitation, that: this Court is a court of competent jurisdiction; defendants were subject to personal jurisdiction in the District at the time this action commenced based on conducting substantial business in this District, including without limitation, the ownership, administration, management, and/or operation of CREEKSIDE; the events or omission giving rise to the plaintiffs' claims arose in this District; all but one of the Plaintiffs reside in this District; Defendant ROTICH resides in this District; Defendants' liability arose in this District; and the acts upon which this action is based occurred in part in this District.

GENERAL FACTUAL ALLEGATIONS

54. Defendants own, license, administer, manage, direct, and/or control numerous skilled nursing facilities in California, including CREEKSIDE. Defendants must therefore comply with California statutory and regulatory law governing the operation of skilled nursing facilities. Defendants have violated and continue to violate these regulations and statutes on a daily basis.

A. Inadequate and Unqualified Staff

55. Understaffing is one of the primary causes of inadequate care and unsafe conditions in skilled nursing facilities. Numerous studies have shown a direct correlation between inadequate staffing and serious care problems including, but not limited to, a greater likelihood of falls, pressure sores, significant weight loss, incontinence, and premature death.

56. In response to such studies linking inadequate staffing and serious care problems, all skilled nursing facilities in California since January 1, 2000 have been required to provide at least 3.2 hours of direct nursing hours per patient day ("NHPPD"), pursuant to Health & Safety Code section

1276.5. The 3.2 NHPPD requirement under Section 1276.5 represents the *minimum* staffing required for patients at skilled nursing facilities.

57. Depending on patient needs and other factors, higher levels of direct nursing hours may be warranted. Significantly, after extensive research into the staffing levels required to meet patient needs, the federal government has increased the minimum recommended level for skilled nursing staffing to 4.1 NHPPD.

58. Cal. H&S Code § 1599.1(a) requires that skilled nursing facilities "shall employ an adequate number of qualified personnel to carry out all of the functions of the facility."

59. CREEKSIDE has a patient population with very high acuity, meaning its residents have more needs and require more services than the average skilled nursing facility population. Based on CREEKSIDE's own reports made to the State of California, its "case mix index"—a measurement of resident acuity—was 1.59 times the national average in 2009 and 1.58 times the national average in 2010, the most recent year for which this report is currently available. CREEKSIDE also has a very high Medicare population, another indication of high acuity. Its Medicare population in 2009 was 33.39% of total patient days and 31.08 percent of total patient days in 2010.

60. The higher the acuity of its residents and the more services they are supposedly receiving, the higher CREEKSIDE's reimbursement rate is from the federal government.

61. Because of its high case mix index, CREEKSIDE needs to provide more than the minimum required NHPPD in order to meet the requirement for adequate and qualified staffing under H&S Code § 1599.1.

62. Staffing studies conducted by experts have concluded that a skilled nursing facility with a high acuity resident population such as CREEKSIDE's require a NHPPD of at least 4.2.

63. Yet the direct care nursing staff at CREEKSIDE is grossly inadequate to care for the high acuity patient population. The annual aggregate nursing staff levels reported by GRANCARE were as follows:

a. In 2009, the annual aggregate NHPPD numbers were .43 for RNs, .82 for LVNs, and 2.16 for CNAs. The total aggregate NHPPD was 3.41.

b. In 2010, the annual aggregate NHPPD numbers were .45 for RNs, .81 for LVNs, and 2.12 for CNAs. The total aggregate NHPPD was 3.38.

64. These annual averages indicate that on many days during those years, despite the high acuity of its residents, CREEKSIDE did not even meet the minimum direct nursing care staffing requirement of 3.2 NHPPD.

65. In fact, on January 7, 2009, the California Department of Public Health ("DPH") found CREEKSIDE failed to meet the minimum nurse staffing level of 3.2 NHPPD, on four randomly sampled dates. The staffing at the facility was as low as 2.39 NHPPD on one of those days.

66. The above-described inadequate nursing staff levels resulted in significant negative impacts on the patient population, including the following quality measures:

a. 21% = Percent of long-term residents whose need for help with activities of daily living has increased. [Cal. average is 11%]

b. 30% = Percent of high-risk long-stay residents who have pressure sores. [Cal. average is 12%]

c. 13% = Percent of long-stay residents who were physically restrained. [Cal. average is 5%]

d. 16% = Percent of long-stay residents who had a UTI. [Cal. average is 7%]

e. 29% = Percent of short-stay residents who have pressure sores. [Cal. average is 18%]

67. On every day of 2011 and 2012 to the present, CREEKSIDE has not had adequate qualified nursing staff. Plaintiffs do not have the average NHPPD numbers reported by CREEKSIDE to the state for 2011 and the first half of 2012. However, CREEKSIDE nursing staff tell residents on a daily basis that they cannot timely assist them with their needs, if at all. In some cases, staff directly tell residents that there are not enough nurses or nursing aides to attend to them. As a result, call lights are not answered; residents are not bathed or groomed; residents are not turned or repositioned; residents are not assisted in toileting nor are their diapers changed in a timely fashion; security is compromised because there are not enough staff to watch the front desk or observe visitors; nursing staff do not follow care plans or physicians' orders; residents are injured in falls because there are not enough nursing staff

to assist them with transfers; and the facility is unsanitary and unhygienic, increasing risk of infection. These are just some of the indignities and harms residents have suffered and continue to suffer as a result of Defendants' failure to provide adequate qualified nursing staff.

B. Lack of Supervision/Training

68. There is high turnover of nursing staff at CREEKSIDE. For this and other reasons, the nursing staff lack the training and experience necessary to care for residents and their needs. For example, although the facility admits and bills for providing services to residents with MS, its staff do not have the necessary training to care for those residents and cannot operate or maintain the equipment prescribed for and used by them. Further, because staff do not stay long at CREEKSIDE, there is no continuity and staff have little knowledge of the residents or their needs.

69. Staff regularly work overtime or double-shifts. As a result, they are often tired, irritable, abusive, and prone to making mistakes in caring for residents. Staff do not communicate well with one another when shifts change, thus failing to report changes in a resident's condition and other crucial aspects of resident care.

70. CREEKSIDE often moves staff from one position to another to bump up nurse staffing hours. As a result, staff do not know their job responsibilities or how to perform them.

C. Inadequate Security

71. CREEKSIDE does not provide the security necessary to insure that residents are free from violence and/or abuse.

72. At least four residents were raped and/or sexually assaulted on multiple occasions at the facility from January through May 2010. Julio Mestre ("MESTRE") was arrested on May 9, 2010 and convicted of four counts of sexual battery on an institutionalized victim, pursuant to California Penal Code section 243.4(b), on September 20, 2011. MESTRE was the husband of a woman from a nearby church. CREEKSIDE staff allowed him to roam the facility freely. CREEKSIDE nurses were aware and even told residents that MESTRE had been in residents' rooms on several occasions while the residents were sleeping, but those same employees did nothing.

73. During the assaults, residents screamed for help, sometimes for more than 30 minutes, but no one came. One resident pressed her call light repeatedly to ask for help while her roommate was being sexually assaulted by MESTRE, but no one responded.

74. When several of the victims reported the attacks to CREEKSIDE nursing staff, they refused to believe the residents and did not conduct an investigation or report the matter. Some nurses even laughed and told the residents no one would believe them.

75. After MESTRE was arrested on May 9, 2010, Administrator ROTICH consciously decided not to report these sexual assaults to the Department of Public Health, in violation of state law.

76. As a result of the assaults, residents and their family members brought grievances to the CREEKSIDE administration about security lapses, including but not limited to the following:

a. Any visitor can walk in through the front door and access almost any part of the facility, except the Administrator's office, without being stopped at the reception desk or supervised within the facility.

b. The doors to the facility and the gates leading to the nearby creek are left unlocked. The parking lot is also left unlit at night.

c. The screens on residents' windows are loose.

d. There are no security cameras at the facility.

e. There is no security guard at the facility.

77. Following the sexual assaults, individuals from MARINER's corporate entities came to the facility and promised to take the necessary security measures, including the installation of security cameras and providing a security guard.

78. A security guard was initially hired, but the facility no longer uses one.

79. The front desk is usually left unattended. As a result, the visitor registration system is hit-or-miss; usually, anyone can still walk in.

80. The screens on residents' windows are still loose.

81. Plaintiffs are informed and believe and thereon allege that there are no working security cameras in the facility

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D. Failure to Provide or Respond to Call Lights

82. Staff fail to insure that residents' call buttons can be reached by residents. Even when residents are able to use them, staff do not respond promptly or, in some cases, at all. Residents frequently wait more than 30 minutes to several hours at a time for response. Staff often come into a resident's room to turn off the call light, tell the resident they are too busy and will return, and leave the room without providing care. Often they do not return at all. On many occasions, staff say they do not have time to offer assistance and defer to staff working the following shift.

E. Inadequate Supplies

83. The facility has a constant shortage of diapers. Residents have been informed by nursing staff that there is a daily limit of three diapers per resident. As a result, residents are left in dirty or wet diapers. In some cases, they are left unclothed on their sheets, which are not cleaned following incontinence. Because of a shortage of linens and towels, those which are dirty or used to wipe feces or urine are often left on residents' beds or reused.

F. Failure to Provide Assistance with Eating or Prescribed Special Diets

84. CREEKSIDE does not provide for the residents' individual dietary needs, such as a pureed diet or low-sodium diet. Residents do not receive necessary assistance to eat or drink and become undernourished and/or dehydrated. The staff regularly swaps food items and plates from one tray to another, increasing the risk of improper medication administration from medications dissolved or sprinkled on foods. Additionally, there are also shortages of food caused by staff stealing from the kitchen.

85. On July 14, 2009, the DPH issued CREEKSIDE a deficiency for failure to ensure a resident received a therapeutic diet, increasing the resident's risk for weight loss. Staff failed to assist a resident who required total assistance during meals in violation of the care plan. Staff merely left food trays in front of the resident, and meals went uneaten.

86. On March 18, 2011, the DPH issued CREEKSIDE a deficiency for failing to ensure each resident was properly nourished and hydrated.

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G. Failure to Provide Rehabilitative Services

87. Although CREEKSIDE bills the government and residents for rehabilitative services, it regularly does not provide them. Residents who need physical therapy are instead kept in their bed or a wheelchair for hours or days at a time. Their conditions do not improve and in many cases decline. Many residents leave CREEKSIDE in worse condition than when they entered.

H. Failure to Provide Proper Hygiene

88. Staff regularly neglect to change residents' diapers for hours, leaving them in soiled and wet diapers. Residents who are continent are told to use diapers because staff do not have time to assist with toileting. These residents often become incontinent during their stay at CREEKSIDE. CREEKSIDE has a constant shortage of diapers, which staff must ration, resulting in residents' sitting in wet or soiled diapers or using sheets as diapers. Even when diapers are changed, staff often fail to clean the residents properly. Residents develop UTIs and decubitus ulcers.

89. Residents are not regularly bathed or provided proper dental, nail and foot care. Residents often smell, are uncomfortable and/or contract infections as a result.

I. Improper Wound Care and Prevention

90. CREEKSIDE staff do not provide adequate wound care and/or prevention. They leave residents sitting in wheelchairs or lying in bed for long stretches of time and do not regularly turn and reposition them. Residents have witnessed staff removing turning schedules from the residents' walls when state inspectors visit the facility. In addition, CREEKSIDE's failure to provide proper nutrition and hygiene increases the risk of developing wounds and prevents them from healing.

91. On May 9, 2011, DPH issued CREEKSIDE a deficiency for failing to provide adequate nursing services to address a resident's high risk for wounds and falls.

J. Unsanitary Facility/Inadequate Infection Controls

92. CREEKSIDE is a dirty and unsanitary facility. Further, defendants do not maintain adequate infection controls.

93. Urine bags are left on residents' beds. Bathrooms are not regularly or properly cleaned, and feces is left on surfaces.

94. The facility smells of urine and feces.

1 95. Soiled diapers, used exam gloves, and other unsanitary items are left in residents' waste
2 baskets.
3 96. Linens and towels are used to wipe feces and are not changed.
4 97. Residents are left lying in feces and urine on their beds.
5 98. On July 14, 2009, the DPH issued CREEKSIDE a deficiency for failure to maintain a
6 "sanitary, orderly, and comfortable" facility. Dirty resident care equipment was stored improperly
7 creating "a potential for residents to use unsanitary equipment." DPH also found that CREEKSIDE
8 failed to dispose of garbage and refuse properly, and unsanitary items such as used examination gloves
9 were on the ground risking contamination.
10 **K. Physical and Verbal Abuse/ Failure to Treat Residents With Respect**
11 99. Hurried, overworked, and exhausted staff handle CREEKSIDE residents roughly, often
12 leaving bruises on their arms and legs.
13 100. Staff have called at least one resident "fat" and "lazy."
14 101. When the victims of MESTRE's sexual assaults complained to nursing staff, they were
15 laughed at and told no one would believe them.
16 102. Additionally, residents are denied dignity and respect when, among other things, they are
17 told to use a diaper though continent; left in soiled and/or wet diapers for hours; repeatedly ignored and
18 told by staff that they do not have time to attend to them; unable to get water or food despite repeated
19 pleas; and left dirty and ungroomed.
20 103. Residents are too intimidated to complain or assert their rights for fear of retaliation.
21 104. On July 24, 2009, DPH issued CREEKSIDE a deficiency for failing to treat a resident
22 with "consideration, respect and full recognition of dignity and individuality, including privacy in
23 treatment and in care of personal needs."
24 **L. Creekside Discourages Residents from Asserting Their Rights and Does Not**
25 **Address Complaints**
26 105. Plaintiffs, their family members and other residents have complained to CREEKSIDE
27 nursing staff and Administrator Janet Rotich ("ROTICH") about, among other things, abusive staff,
28 problems with security at the facility, inadequate staffing and training, regular repositioning of residents,

untimely and/or nonexistent responses to call lights, inadequate supplies, failure to provide therapeutic diets or assist with feeding, and the unsanitary conditions at the facility. However, Defendants have not addressed these problems. ROTICH instead has told residents and family members she will take care of things without actually doing anything. She has also blamed residents and/or family members for the problems.

106. ROTICH discourages residents or families from talking with the Family Council or attending Family Council meetings. In approximately the autumn of 2011, ROTICH sent CREEKSIDE staff to Family Council meetings uninvited, discouraging an open discussion about the inadequacies of care. ROTICH also removed Family Council meetings from the facility calendar.

107. In response to her advocacy on behalf of residents, ROTICH has made false accusations against Colleen Adams, head of the Family Council and mother of Plaintiff Colette Robin Brown.

108. ROTICH did not report the sexual assaults to the DPH as required by state law.

ADDITIONAL FACTUAL ALLEGATIONS SPECIFIC TO INDIVIDUAL PLAINTIFFS

A. Facts Specific to Plaintiff Colette Robin Brown ("BROWN")

109. Plaintiff BROWN is 53 years old and has advanced multiple sclerosis ("MS"). She has been a resident of CREEKSIDE since 2007, with the exception of a brief stay 2-3 day stay in October 2008 at Vale Healthcare Center, another skilled nursing facility owned by the MARINER HEALTH CARE Defendants. She currently resides at CREEKSIDE.

110. BROWN is severely restricted in mobility and requires two people to transfer her from her bed to her wheelchair. Frequently only one person transfers, and in those cases BROWN is often placed in an improper position and her seatbelt is not fastened. Like other residents, she has been left unattended, even after having slid from her wheelchair to the floor. BROWN has asked the CNAs to get someone else to help with her transfer was told there were not enough staff. The CNAs have asked BROWN's mother, Colleen Adams, if she could help. This is an ongoing problem which began as soon as BROWN arrived and continues to this day.

111. Although BROWN'S care plan and limited mobility require that she be turned and/or repositioned every two hours to prevent pressure sores, this does not happen. On every day of her residence at CREEKSIDE, staff have failed to follow this requirement. As a result, BROWN has

developed pressure sores. In particular, BROWN developed a pressure sore on her coccyx in 2008 as a result of being left in her wheelchair too long. It has not resolved in over three years, because the staff do not provide proper wound care. BROWN's sister, Leslie Ricks, suggested to staff that they use a sign-in sheet to track turning and repositioning of BROWN, but this idea was rejected. Staff also bathe BROWN using a regular chair, which re-opens the wound. The failure to provide proper wound care and prevention to BROWN is an ongoing problem which began as soon as she arrived and continues to this day.

112. Sometime in or around February or March 2012, staff left BROWN lying in bed in the same position for so long that she developed a contracture in her neck and her head just hung over to one side. The family obtained a doctor's order prescribing physical therapy. For two weeks, staff ignored the order. Finally, BROWN's mother complained and demanded that CREEKSIDE provide the physical therapy ordered by the physician. Once they began to provide it, the contracture improved.

113. Due to her MS, BROWN cannot grasp or hold utensils or cups. She requires assistance to eat. Staff rarely provide this assistance, and BROWN regularly resorts to eating what she can grab with her hands. This is an ongoing problem which began as soon as she arrived and continues to this day.

114. Staff do not change BROWN's diapers as needed. She often sits in dirty diapers for hours because staff do not have time to change them. Creekside employees have told BROWN's mother that they have been instructed to ration diapers and are limited to three per day per resident. This not only increases the risk of contracting or aggravating a pressure sore, but also denies BROWN her dignity. In September 2011, BROWN's mother observed that the pressure sore on her buttocks had become filled with feces. The failure to change BROWN's diapers regularly and to properly clean her is an ongoing problem which began as soon as she arrived and continues to this day.

115. Staff do not keep BROWN clean or attend to her hygiene. She receives a bath or shower only once a week, at most. She becomes dirty and develops a rash under her neck due to sweat. BROWN's hair is cleaned only once every two weeks at most and is frequently dirty. Her clothing is not changed regularly. Staff do not clean her fingernails, which are often filled with dried and rotting food. Sometime within the last year, BROWN's sister complained to CREEKSIDE nursing staff

because no one had noticed that a ring on her finger was restricting circulation and it had turned purple. The ring had to be cut off.

116. BROWN's toenails are not cleaned. Sometime in or around early 2009, her toenail became infected, and it was not treated by the staff. BROWN almost lost her foot. This failure to properly clean BROWN's feet and toenails is an ongoing problem which began as soon as she arrived and continues to this day.

117. Because of her MS, BROWN uses a suprapubic catheter. Staff do not clean it regularly or properly, and the insertion site frequently becomes infected. This is an ongoing problem which began as soon as she arrived and continues to this day.

118. CREEKSIDE staff do not notify BROWN's mother, the responsible party, when there is a change in BROWN's medication or condition. BROWN's suprapubic catheter has come out at least fifteen times, and staff neither notified BROWN'S mother (the responsible party) nor called the hospital. If BROWN had not called her mother, she would not have been sent to the hospital to have it re-inserted.

119. BROWN also uses a baclofen pump to reduce severe spasticity. CREEKSIDE staff do not know how to operate it to ensure the baclofen administration is properly regulated. As a result, BROWN was placed in danger of a baclofen overdose, which could result in a coma.

120. CREEKSIDE staff do not respond to BROWN's call lights in a timely manner. Sometimes they do not respond at all. Her sister has timed the responses to BROWN's call light at 45 minutes to an hour on many occasions during the day and at night. Frequently, staff will enter BROWN's room, turn off the call light, tell her they will return soon and then neglect to do so. Staff do not insure that BROWN is able to reach her call light, and it is often found on the floor or otherwise out of her reach. This is an ongoing problem which began as soon as she arrived and continues to this day.

121. Staff are verbally abusive to BROWN. The nurses call her fat, lazy, and disgusting. At least one nurse told her she was too fat to get a shower. This verbal abuse is an ongoing problem which began as soon as she arrived and continues to this day.

122. Staff are physically abusive to BROWN. She is often grabbed forcefully and has bruises on her arms. This is an ongoing problem which began as soon as she arrived and continues to this day.

123. BROWN'S family brings her food from outside. This food and many of her personal items have been stolen by staff. This is an ongoing problem which began as soon as she arrived and continues to this day.

124. In or around August 2011, BROWN was left outside in the sun too long by staff and suffered sunburn on her leg. The staff have not cared for the burn properly and it has become another open wound, which has not healed.

125. On February 9, 2012, a Creekside CNA was pushing BROWN in her wheelchair when the footrest came undone. BROWN's tibia was fractured, and staff told her not to speak with anyone about the incident. Moreover, CREEKSIDE failed to properly and promptly assess the injury, preventing her from receiving treatment for more than five days and causing the leg to swell significantly.

B. Facts Specific to Plaintiff JULIE SHULAW ("SHULAW")

126. Julie Shulaw ("SHULAW") was a resident at CREEKSIDE from November 2009 until her death on March 31, 2012. She had advanced MS.

127. Although CREEKSIDE had accepted SHULAW as a resident and charged the state and federal government for providing the additional services and treatments required by individuals with MS, CREEKSIDE staff lacked training in this area and did not know how to care for her.

128. During her stay at CREEKSIDE, SHULAW's diapers were not changed as needed. She often sat in dirty or wet diapers for hours because staff did not have time to change them. This not only increased her risk of contracting or aggravating a pressure sore or a UTI, but also denied SHULAW her dignity. SHULAW developed severe UTIs as a result of her diapers not being regularly changed and was taken to the hospital with a fever of 104-105 degrees approximately once a month throughout 2011 and 2012.

129. Creekside staff did not respond to SHULAW's call lights in a timely manner. Sometimes they did not respond at all. LOIS ZAVODA and OLIVER ZAVODA noticed that response times averaged 30 to 45 minutes. Staff did not insure that SHULAW was able to reach her call light, and it was often found on the floor or otherwise out of her reach. When nurses did come, they simply turned off the call light without providing any assistance or asking what she needed.

130. SHULAW's water was also left out of her reach on a regular basis, resulting in dehydration and aggravation of her UTIs.

131. LOIS ZAVODA noticed that SHULAW was frequently "out of it" and overmedicated, so as to reduce SHULAW's demands on CREEKSIDE staff.

132. SHULAW required a lift and two people to transfer. On or around winter 2011, SHULAW was transferred improperly from her bed to her wheelchair and fell. Her foot was twisted in the fall, causing severe bruising and swelling on both her ankle and foot.

133. On January 8, 2012, LOIS ZAVODA went to the facility and found SHULAW in bed without a diaper on lying on an absorbent mat, soaked with feces and urine. When LOIS ZAVODA asked the CNA why her daughter did not have a diaper, the CNA stated that this was the new policy at CREEKSIDE. LOIS ZAVODA complained to the head nurse that this new policy meant her daughter would be lying on a feces and urine soaked mat all the time. The head nurse told LOIS ZAVODA that the CNA had "misunderstood" the new policy. SHULAW went back to wearing diapers, but staff still did not regularly change them.

134. SHULAW used a breathing machine with a suction device. It was not kept clean or maintained by staff, and the tubes were often clogged with mucus. When LOIS ZAVODA complained to CREEKSIDE staff, she was told no one there knew how to maintain or operate the machine.

135. On March 27, 2012, SHULAW was put on her breathing machine at 8 a.m. When LOIS ZAVODA arrived at the facility around 1 p.m., she observed that her daughter still had the mask from the breathing treatment on her face, but it had slid down her nose and was blocking her nostrils. LOIS ZAVODA removed the mask and saw dried blood and spittle all around the mask from SHULAW fighting to breath. LOIS ZAVODA got a nurse and showed her the condition her daughter was found in. As they cleaned SHULAW's face of blood and spittle and re-fixed the nasal cannula that she needed to breathe, LOIS ZAVODA asked the nurse what she thought about the situation. The nurse walked out of the room without responding.

136. SHULAW and LOIS ZAVODA often refrained from complaining or asserting SHULAW's rights because they feared retaliation against SHULAW, who was essentially helpless due to her advanced MS.

C. Facts Specific to Plaintiff MABEL NUN ("NUN")

137. NUN resided at CREEKSIDE from approximately June 2011 through April 2012. She is 87 years old and suffers from numerous mobility and other health impairments.

138. During her stay at CREEKSIDE, NUN was kept heavily medicated and confined to her bed so as to reduce demands on staff.

139. CREEKSIDE did not provide the physical therapy NUN needed which had been ordered by a physician. Staff kept her in bed and worked only on her arms, causing her legs to contract. NUN's daughter, BETTY JOURBERT, complained and said NUN needed to be up, out of bed, washed, dressed, and taken to physical therapy. Although NUN complained that she did not want to lie in bed all day, staff simply kept NUN in bed to reduce demands on their time, and NUN's problems with her legs worsened.

140. NUN's needs were not properly communicated among the nursing staff. Due to CREEKSIDE's failure to provide physical therapy, NUN's legs deteriorated and she required a two-person assist for transfers. This was not properly documented or communicated among staff, and a CNA who returned from vacation tried to transfer NUN by herself in or around November 2011. NUN fell on the floor, twisted her leg, and suffered from knee and hip pain.

141. NUN's diapers were not changed as needed. She often lay in wet or dirty diapers for hours because staff did not have time to change them. When staff did change her diapers, they did not clean her properly, and NUN would ask family members to re-clean her. NUN developed sores on her buttocks and UTIs. The failure to change NUN's diapers regularly and to properly clean her began as soon as she arrived and continued throughout her stay. This not only increased the risk of contracting or aggravating a pressure sore, but also denied NUN her dignity.

142. NUN was not regularly turned or repositioned as required by her plan of care, thus increasing her risk of contracting and/or aggravating pressure sores. As a result, NUN developed stage two pressure wounds on her buttock in or around December 2011, which healed in January 2012.

143. JOURBERT would complain, but any improvement was inconsistent and short-lived. JOURBERT was often told by staff that they were too busy serving lunch to attend to NUN.

144. NUN was bathed only once per week, and as a result, was often dirty. When staff did bathe NUN, they allowed shampoo to get in her eyes and handled her roughly, causing her fear, pain and bruises.

145. In or around October 2011, NUN fell from her wheelchair in her room because CREEKSIDE had not provided a lap buddy or buckled her seatbelt. Her face hit the floor and she sustained a cut on her forehead. Staff would not take NUN to the hospital. Instead, JOURBERT took NUN to Alta Bates for an assessment and a CT scan of her head.

146. NUN's call light was regularly kept out of reach. When she was able to use the call light, staff failed to respond. Staff would promise to "come right back" but then fail to return.

147. NUN suffered from several health conditions, including high blood pressure, GERD (gastro-esophageal reflux disease), and gout. These were known to CREEKSIDE staff, as was the fact that NUN needed a special diet. She was frequently given foods which aggravated her conditions. Despite several complaints to the Administrator and the nutritionist, CREEKSIDE failed to provide the resident with a proper special diet, explaining that the meals were pre-packaged and could not be changed. As a result, family members had to bring food from outside so that NUN had something to eat. Additionally, staff did not provide NUN with the time or help she needed to eat.

148. NUN's GERD required that her head be kept slightly elevated to reduce symptoms. Despite regular complaints from JOURBERT, CREEKSIDE staff failed to elevate the head of NUN's bed. As a result, NUN's acid reflux was aggravated, causing her pain and vomiting.

149. NUN was often kept overmedicated. During her stay, CREEKSIDE increased her Zoloft dose. As a result, NUN was sleeping all the time. In or around September 2011, JOURBERT told staff to decrease the Zoloft, and NUN no longer slept all the time.

150. JOURBERT was afraid to complain or assert NUN's rights because she noticed that staff were rough with NUN when she complained. NUN feared some of the nursing staff for this reason. JOURBERT spoke to the CNA and the charge nurse about this on at least two separate occasions.

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D. **Facts Specific to LUIS LORENZO ANGULO ("LUIS ANGULO")**

151. LUIS LORENZO ANGULO ("LUIS ANGULO") was a resident at CREEKSIDE from approximately August 1 to September 7, 2011. He was sent to CREEKSIDE for rehabilitation following an intestinal infection. He died on September 14, 2011, at the age of 93.

152. While LUIS ANGULO was at CREEKSIDE, he lost over nine pounds over the course of one week. Staff did not note this rapid weight loss in ANGULO's chart until prompted by his son, JUAN ANTONIO ANGULO ("TONY ANGULO"). When asked about the weight loss, staff said it was probably due to water loss. They had no response to TONY ANGULO's questions about dehydration.

153. LUIS ANGULO was treated roughly by the staff who resented requests and the fact that his son asserted LUIS ANGULO's rights on his behalf. The resident himself was afraid to complain for fear of retaliation and more rough treatment by staff.

154. Staff regularly ignored LUIS ANGULO's call light, and he usually waited more than 25 minutes for them to respond. While visiting his father, TONY ANGULO could hear residents yelling for help for over 30 minutes at a time and witnessed staff walking past their rooms without asking what they needed.

155. TONY ANGULO often discovered that LUIS ANGULO did not have water available. He would get water and make it available not only to his father but also to other residents who were asking for water from the staff to no avail.

156. TONY ANGULO noticed that LUIS ANGULO was overmedicated while at CREEKSIDE so as to decrease his demands on staff.

157. Staff ignored complaints requests for changes in his father's treatment made by TONY ANGULO. For example, LUIS ANGULO had difficulty swallowing, but was given his antibiotic in a large pill. On approximately August 1, 2011, TONY ANGULO pointed this out to both the administrator and the director of nursing and asked that his father receive his antibiotic intravenously as he had in the hospital. Both said they would take care of it, but did nothing.

158. The staff did not properly assess LUIS ANGULO's condition, and was late in hospitalizing him after he developed pneumonia. On September 7, 2011, TONY ANGULO arrived at

the facility and found his father shaking and in pain. TONY ANGULO told a nurse his father was not feeling well and asked them to call the ambulance immediately. The nurse did not want to call the ambulance, saying they should handle the situation "internally" and wait until the doctor visited the following day. TONY ANGULO said he would call an ambulance if they did not, forcing the staff to do so. When the ambulance arrived, the EMT told TONY ANGULO his father's vitals were very low and that he should have been in the hospital a week ago.

159. LUIS ANGULO died one week later. TONY ANGULO subsequently requested a meeting with CREEKSIDE staff to discuss what had happened. The nurse who had initially refused to call the ambulance (who TONY ANGULO believes was the Director of Nursing or a charge nurse) walked out in the middle of the meeting stating, "I don't need to be insulted. I'm leaving."

E. Facts Specific to Plaintiff JUANITA BLANCO ANGULO ("ANGULO")

160. Juanita Blanco Angulo ("ANGULO") is the widow of LUIS ANGULO. She was also a resident of CREEKSIDE from approximately July 17, 2011 to September 1, 2011. She is 81 years old. She brings these claims in her individual capacity and as successor in interest to the Estate of LUIS ANGULO.

161. ANGULO went to CREEKSIDE for rehabilitation for a pinched nerve in her back.

162. While she was at CREEKSIDE, ANGULO often waited 20 to 30 minutes for staff to respond to her call light. She also heard residents yelling for assistance and saw staff members ignoring their cries for help. She witnessed staff ignore her husband's requests for assistance and was afraid to complain for fear of retaliation against her husband or herself.

163. Staff did not maintain ANGULO's room or the facility in a hygienic manner or use proper infection controls. The hallways smelled of feces and urine because staff members did not change the diapers of residents who were incontinent or assist continent residents to the bathroom. ANGULO's linens were not regularly changed, and soiled linens which had been used to clean urine or feces remained in her room. Her bathroom was not cleaned on a regular basis.

F. Facts Specific to AMALIA CRITTENDON

164. CRITTENDON was a resident of CREEKSIDE from June 9 through July 4, 2011, for rehabilitation after knee replacement surgery. She is 83 years old.

165. Although she went for rehabilitation and the federal government paid CREEKSIDE to provide such services, the facility failed to provide her with prescribed physical therapy. Instead, staff left her in her wheelchair or bed causing her leg strength to decline significantly during her admission. When CRITTENDON was transferred to CREEKSIDE from the hospital three days after her knee surgery, she was walking with the assistance of a walker. Contrary to doctor's orders, CREEKSIDE staff refused to let her use a walker and placed her in a wheelchair for the 20 days she was there. She lost all progress she had made in three days at the hospital.

166. CRITTENDON left CREEKSIDE on July 4, 2011 because she had to go back to the hospital to have her knee straightened. She was placed in a cast and endured a great deal of pain.

167. CREEKSIDE also failed to provide adequate wound care to CRITTENDON's knee surgery site, causing it to become infected. She had to undergo a 10-day course of antibiotics.

168. When CRITTENDON used her call light at CREEKSIDE, she would wait for 30 minutes or more for staff to respond. Sometimes they simply ignored her. When CRITTENDON complained to staff about inadequate care and responsiveness to her calls for help, the staff did not provide any more care. They simply blamed shortcomings on other staff or made empty promises to provide better care.

FIRST CAUSE OF ACTION
HEALTH & SAFETY CODE SECTION 1430(b)
BROUGHT BY ALL PLAINTIFFS
AGAINST ALL DEFENDANTS

169. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs.

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

171. Section 1430(b) provides for a remedy of statutory damages "up to $500" per violation, together with a right to injunctive relief, attorneys' fees and costs. H&S Code §1430(b). The remedies in Section 1430(b) are cumulative to any other remedies provided by law. H&S Code §1430(c).

172. Defendants have violated and continue to violate Section 1430(b) by violating rights under numerous state and federal statutes and regulations.

173. Section 72527 of Title 22 of the California Code of Regulations contains a Resident's Bill of Rights for skilled nursing facilities. In addition to listing specific rights, it incorporates the requirements of Health & Safety Code § 1599.1. Violations of the rights listed in either Title 22 section 72527 or H&S Code § 1599.1 constitute violations of H&S Code § 1430(b).

174. Additionally, violations of the federal regulations regarding skilled nursing facilities are violations of H&S Code § 1430(b).

175. Defendants' violations of Patients' Rights under Section 1430(b) include, but are not limited to, those listed below.

Right to Adequate, Qualified and Well-Trained Nursing Staff

176. Residents have a right to adequate, qualified and well-trained nursing staff.

177. Pursuant to **Cal. Health & Safety Code § 1599.1(a)**, "[t]he facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility." An essential function of a skilled nursing facility is the provision of nursing services.

178. At all relevant times, Defendants have been required to employ adequate numbers of qualified nursing staff given aggregate patient acuity levels at CREEKSIDE and to employ sufficient numbers of registered nurses. They have failed to do so and therefore violated state and federal regulations requiring adequate qualified staffing necessary to maintain the health, safety and well-being of its residents.

179. Defendants portray and promote CREEKSIDE as meeting or exceeding all statutory and regulatory nurse staffing requirements. In its standard admission agreements and in postings at the Facilities, CREEKSIDE and the MARINER Defendants uniformly and systematically claim to adhere to the Patient's Bill of Rights, as set forth in Section 72527 of the California Administrative Code, which in part requires Defendants to provide an "adequate number of qualified personnel." The admission agreement states that by signing it, the resident agrees that s/he has read the list of patients' rights, resolved any questions, and received a copy.

180. In addition, Defendants have also promised the State of California that they will meet all state and federal requirements regarding the operation, management, administration and/or ownership of skilled nursing facilities. In particular, as part of the initial licensing and annual renewal process for the Facilities, defendants promise to comply with the Health and Safety Code and applicable regulations, which include minimum and adequate staffing requirements.

181. Defendants' representations track their duty under California law to provide sufficient nursing staff and related services. Unfortunately, the actual nurse staffing Defendants provide falls well short of their representations and their legal duty. On information and belief, Defendants have failed to employ adequate numbers of qualified nursing staff given aggregate patient acuity levels at CREEKSIDE, and/or to employ sufficient numbers of registered nurses on many days. Defendants have failed to disclose and concealed these continuing legal violations to the public and to Plaintiffs.

182. Despite their failure to adequately staff CREEKSIDE, Defendants wrongly received in the millions of dollars in aggregate payments from residents and/or their family members. These monies were solicited and collected under the false and misleading pretense that Defendants complied with California staffing laws and would remain in compliance.

183. Defendants have violated the rights of Plaintiffs to adequate qualified nursing staff and, in the case of Plaintiff BROWN, continue to violate that right.

Right to Be Free from Abuse

184. Residents have the right to be free from abuse.

185. Under **22 CCR § 72527(a)(9)**, residents have the right "[t]o be free from mental and physical abuse."

186. Defendants have violated all named plaintiffs' rights to be free from physical and verbal abuse. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Dignity and Respect

187. Residents have a right to be treated with respect and in a manner that preserves their dignity.

188. Under **22 CCR § 72527(a)(11)**, residents have the right "[t]o be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs."

189. Defendants have violated all of the named Plaintiffs' rights to be treated with dignity and respect. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Good Hygiene, Care to Prevent Bedsores, and Incontinence-Prevention Measures

190. Residents have a right to good hygiene, care to prevent decubitus ulcers and incontinence prevention measures.

191. Under **Cal. Health & Safety Code § 1599.1(b)**, "[e]ach patient shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient."

192. Defendants have violated Plaintiffs' rights to good hygiene, care to prevent decubitus ulcers and incontinence prevention measures. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Proper Nutrition

193. Residents have a right to food that meets their nutritional and special dietary needs, including assistance and support in feeding.

194. Under Cal. **Health & Safety Code § 1599.1(c)**, "[t]he facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders."

195. Defendants have violated Plaintiffs' rights to proper nutrition and assistance with eating. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Clean and Sanitary Environment, Including Adequate Infection Controls

196. Residents have a right to a clean and sanitary environment that includes adequate infection controls.

197. Pursuant to **Cal. Health & Safety Code § 1599.1(e)**, "[t]he facility shall be clean, sanitary, and in good repair at all times."

1 198. Defendants have violated Plaintiffs' rights to a clean and sanitary environment.
2 Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

3 ***Right to Operating Call System***

4 199. Residents have a right to an operating call system accessible to patients at all times.

5 200. Pursuant to **Cal. Health & Safety Code § 1599.1(f)**, "[a] nurses' call system shall be
6 maintained in operating order in all nursing units and provide visible and audible signal communication
7 between nursing personnel and patients. Extension cords to each patient's bed shall be readily accessible
8 to patients at all times."

9 201. Defendants have violated Plaintiffs' rights to an operating call system. Defendants
10 continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

11 ***Right to Information on Health Status and Participate in Treatment Decisions***

12 202. Residents have a right to receive and/or to have their family members receive information
13 on their health status and changes in condition and to participate in treatment decisions.

14 203. Under **22 CCR § 7252(a)(3)** residents have the right "to be fully informed by a physician
15 of his or her total health status and to be afforded the opportunity to participate on an immediate and
16 ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial
17 needs and the planning of related services.

18 204. Under **22 CCR § 7252(a)(4)** residents have the right "to consent to or to refuse any
19 treatment or procedure . . . "

20 205. Under **22 CCR § 7252(a)(5)** residents have the right "to receive all information that is
21 material to an individual patient's decision concerning whether to accept or refuse any proposed
22 treatment or procedure."

23 206. Defendants have violated Plaintiffs' rights to be informed or to have their family
24 members be informed of changes in their condition and to participate in treatment decisions. Defendants
25 continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

26 ***Right to Be Free from Improper Restraints***

27 207. Residents have a right to be free from improper restraints, including chemical restraints imposed
28 for the purpose of discipline or staff convenience.

208. Under **22 CCR § 72527(a)(23)**, residents have the right "[t]o be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018 . . . , except in an emergency which threatens to bring immediate injury to the patient or others."

209. Defendants have violated the rights of BROWN, LUIS ANGULO, SHULAW, and NUN to be free from improper chemical restraints. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Keep Personal Possessions

210. Residents have a right to keep personal possessions at the facility.

211. Under **22 CCR § 72527(a)(15)**, residents have the right "[t]o retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients."

212. Defendants have violated all of the named Plaintiffs' rights to keep personal possessions at the facility. Defendants continue to violate these rights of Plaintiff BROWN. These violations are detailed above.

Right to Voice Grievances and to Exercise One's Rights

213. Residents have a right to voice their grievances without interference or fear of retaliation. Further, they have a right to participate freely and without intimidation or retaliation in Resident Councils and to have family members participate in Family Councils, one function of which is to advocate for the rights of patients.

214. Under **22 CCR § 72527(a)(7)**, residents have the right "to be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal."

215. Defendants have violated all of the named Plaintiffs' rights and to voice grievances, to exercise their rights, or to have family members participate in family councils without interference or

fear of retaliation. Defendants continue to violate these rights of Plaintiff BROWN. These violations are described in detail above.

216. As a result of defendants' conduct, plaintiffs have suffered injury and are entitled to statutory damages in an amount to be determined at trial, as well as injunctive relief, attorneys' fees and costs

SECOND CAUSE OF ACTION FOR UNLAWFUL, UNFAIR AND DECEPTIVE BUSINESS PRACTICES AGAINST ALL DEFENDANTS

217. Plaintiffs refer to, and incorporate herein by this reference, all preceding paragraphs.

218. Defendants, and each of them, have engaged in unlawful and unfair business acts and practices in violation of Business and Professions Code section 17200 *et seq.*

219. In particular, defendants, and each of them, have engaged in unlawful business acts and practices in violation of Business and Professions Code section 17200 *et seq.* by violating numerous laws, statutes and regulations including, without limitation:

a. Health & Safety Code §§ 1599.1(a), (b), (c), (e) and (f);

b. Health & Safety Code § 1430(b);

c. Title 22 of the California Code of Regulations §72527; and

d. Systematically and uniformly failing to disclose, concealing and/or misrepresenting the lack of adequate staffing and pervasive residents' rights violation at CREEKSIDE in violation of Business & Professions Code section 17500 *et seq.*

220. By virtue of the conduct alleged herein, Defendants, and each of them, have also engaged in fraudulent business practices in connection with the representations, promises, omissions, and other statements made concerning the conditions, staffing levels and services provided to residents admitted to CREEKSIDE.

221. Members of the general public (including without limitation persons admitted to and/or residing at CREEKSIDE, and their family members and/or representatives) have been and are likely to be deceived by the statements, representations, omissions, and other conduct by defendants as alleged herein.

222. The acts and practices of Defendants, and each of them, also constitute unfair business acts and practices within the meaning of Business & Professions Code section 17200, *et seq*., in that the conduct alleged herein is immoral, unscrupulous and contrary to public policy, and the detriment and gravity of that conduct outweighs any benefits attributable to such conduct. Further, Defendants' conduct threatens actual and incipient violations of numerous laws and regulations intended to protect elderly and/or disabled residents, and in addition, Defendants' conduct violates the policy or spirit of these laws and otherwise results in a significant harm or threat of harm to elderly and/or disabled residents.

223. Defendants' conduct presents a continuing threat of harm to the public in that, among other things, defendants continue to mislead elderly and/or disabled persons (and their family members and/or representatives) into agreeing to be admitted to CREEKSIDE based on the false and misleading representations and failure to disclose that CREEKSIDE is not adequately staffed or equipped to honor and respect patients' rights or to provide them the care and services necessary to maintain their health and safety.

224. As a direct and proximate result of Defendants' unlawful business practices, Plaintiffs have been injured in fact, lost money and sustained substantial economic harm as alleged herein. Likewise, as a direct and proximate result of Defendants' unlawful business practices, members of the general public have been harmed and continue to be harmed by Defendants' conduct.

225. Plaintiffs seek an injunction that requires that Defendants immediately cease acts of unfair and fraudulent business acts or practices as alleged herein, and to enjoin Defendants from continuing to engage in any such acts or practices in the future. Plaintiffs also seek restitution, attorneys' fees, and all other remedies permitted by law.

226. Plaintiffs paid money from their own funds to the defendants based on the reasonable expectation that CREEKSIDE would be staffed in compliance with applicable laws and that they would comply with the rights of residents under state and federal law. In addition, all Plaintiffs paid money to defendants, or otherwise incurred costs and expenses, for nursing services that failed to meet reasonable expectations. The true facts are that the Facilities regularly violated residents' rights. These Plaintiffs lost money and sustained injury in fact as a result of defendants' conduct. As a direct and proximate

result of the defendants' unfair, unlawful and deceptive business practices, Plaintiffs and members of the general public have been harmed and continue to be harmed by Defendants' conduct.

227. Plaintiffs seek an injunction that requires that Defendants immediately cease acts of unfair and fraudulent business acts or practices as alleged herein, and to enjoin Defendants from continuing to engage in any such acts or practices in the future. In addition, Plaintiffs also seek attorneys' fees and all other remedies permitted by law.

PRAYER

WHEREFORE, Plaintiffs pray for judgment as follows:

1. For injunctive relief prohibiting defendants' violations of the Health & Safety Code § 1430(b) in the future;
2. For a Court order requiring that defendants immediately cease acts that constitute unlawful, unfair, and fraudulent business practices, as alleged herein, and to enjoin defendants from continuing to engage in any such acts or practices in the future;
3. For statutory damages in an amount to be proven at trial, including $500.00 in statutory damages for each violation of each Plaintiff's rights pursuant to Health & Safety Code § 1430(b);
4. For restitution and any other monetary relief permitted by law;
5. For punitive damages;
6. For pre-judgment interest, according to law;
7. For attorneys' fees and costs; and
8. For such other and further relief as the Court may deem just and proper.

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JURY TRIAL DEMANDED

Plaintiffs demand a jury trial on all issue so triable.

Dated: 6·25·12

STEBNER & ASSOCIATES

By:

Kathryn Stebner
Sarah Colby
Karman Ratliff
George Kawamoto

Attorneys for Plaintiffs

SUPERIOR COURT - MA...INEZ
COUNTY OF CONTRA COSTA
MARTINEZ, CA 94553

COLETTE ROBIN BROWN VS. MARINER HEALTH CARE INC
MSC12-01479

NOTICE OF ASSIGNMENT TO DEPARTMENT SEVENTEEN FOR CASE MANAGEMENT DETERMINATION

THIS FORM, A COPY OF THE NOTICE TO PLAINTIFFS, THE ADR INFORMATION SHEET, AND A BLANK CASE MANAGEMENT STATEMENT ARE TO BE SERVED UPON ALL OPPOSING PARTIES, ALL PARTIES SERVED WITH SUMMONS AND COMPLAINT/CROSS-COMPLAINT.

1. This matter has been assigned to Department 17, Judge B. Goode presiding, for all purposes; Department 17 is designated as the complex litigation department of the Court and as such (a) hears all cases wherein a designation of complex case has been made and (b) conducts hearings, in cases that this court determines, on a preliminary basis may be complex, to determine whether the case should remain in the complex litigation program.

2. All counsel are required to appear in Dept. 17 on 11/13/12 at 8:30am.
   (a) If the case has been designated as complex, and no counter-designation has been filed, the Court will hold its first case management conference at that time.
   (b) If the case has been assigned to Department 17 on a preliminary basis the Court will hold a hearing to determine if the matter is, or is not, complex. If the matter is determined to be complex, the Court will then proceed with the first case management conference.

3. Each party shall file and serve a Case Management Conference Statement five (5) days before this hearing and be prepared to participate effectively in the Conference, including being thoroughly familiar with the case and able to discuss the suitability of the case for private mediation, arbitration or the use of a special master or referee.

4. Prior to the conference counsel for plaintiff shall meet and confer with counsel for each other party in an effort to precisely define the the issues in the case, discuss the possiblity of early mediation, the identities of possible other parties, and their respective plans for discovery.

5. Until the time of the conference the following INTERIM ORDERS shall be in effect:

A. Plaintiff shall diligently proceed in locating and serving each and every defendant. It is the Court's intention that each party be served in sufficient time to have entered an appearance within the time allowed by law and to attend the first conference.
B. All discovery shall be stayed excepting as all parties to the action might otherwise stipulate or the Court otherwise order.
C. No party shall destroy any writing or other evidence in its possession or under its control which bears in any way upon the matters which are the subject of this litigation.

D. Within the time for any party to file an answer or demurrer such party may alternatively file a notice of general appearance. In such event the time for filing of an answer or demurrer shall be extended to twenty (20) days following the first conference unless the Court shall, at that time, set a different schedule.

E. Counsel for each party shall do a conflict check to determine whether such counsel might have a possible conflict of interest as to any present or contemplated future party.

BY ORDER OF THE COURT

Superior Court of California, County of Contra Costa

NOTICE TO PLAINTIFFS

In Unlimited Jurisdiction Civil Actions

AFTER YOU FILE YOUR COURT CASE:

1. **Have the forms the clerk gives you served on all defendants in this case:**
   a. The Complaint
   b. The Summons
   c. The Notice of Case Management Conference (shows hearing date and time)
   d. The Notice to Defendants (Local Court Form CV-655d)
   e. Blank: Case Management Statement (Judicial Council Form CM-110)
   f. Blank: Stipulation and Order to Attend ADR and Delay First Case Management Conference 90 Days (Local Court Form CV-655b)
   g. Alternative Dispute Resolution (ADR) Information (Local Court Form CV-655c)

2. Within 60 days of the date you filed the complaint **you must prove that the forms have been served on (delivered to) the defendants correctly** by filing the ***Proof of Service*** form (POS-010) (completed by the person who did the service) with the court.

3. **Go to the case management conference on the date indicated on** The Notice of Case Management Conference.

4. **Consider using mediation, arbitration, or neutral case evaluation (ADR) to resolve the dispute.** All parties must answer questions about ADR on the *Case Management Statement* form. For more information, see the enclosed ADR information, visit *www.cc-courts.org/adr*, or call (925) 957-5787.

5. **You may delay the first case management conference while you try to resolve the dispute in ADR.** If all parties agree to use ADR, complete and file the Stipulation and Order to Attend ADR and Continue First Case Management Conference 90 Days form to tell the court you want to use this option.

All civil actions *(except juvenile, probate, family, unlawful detainer, extraordinary writ, and asset forfeiture*[1]*)* and personal injury cases where a party is claiming damages[2] must meet the Civil Trial Delay Reduction time limits for filing documents and moving their cases forward. These time limits are listed in California Rule of Court 3.110 and Local Court Rule 5. If parties miss these deadlines, a judge might issue an order (*Order to Show Cause*) for them to explain in court why they should not have to pay a fine or have their case dismissed.

VIEW LOCAL COURT RULES AT: (WWW.CC-COURTS.ORG/RULES)

[1] *Health and Safety Code §11470 et seq.*
[2] *Including claims for emotional distress and/or wrongful death.*

Superior Court of California, County of Contra Costa

NOTICE TO DEFENDANTS

In Unlimited Jurisdiction Civil Actions

YOU ARE BEING SUED. The packet you have been served should contain:

a. The Summons
b. The Complaint
c. The Notice of Case Management (shows hearing date and time)
d. Blank: Case Management Statement (Judicial Council Form CM-110)
e. Blank: Stipulation and Order to Attend ADR and Delay First Case Management Conference 90 Days (Local Court Form CV-655b)
f. Alternative Dispute Resolution (ADR) Information (Local Court Form CV-655c)

WHAT DO I DO NOW?

You must:

1. **Prepare your response** YOU COULD LOSE YOUR CASE—even before it is heard by a judge or before you can defend yourself, if you do not prepare and file a response on time. See the other side of this page for types of responses you can prepare.
2. **Complete the *Case Management Statement* (CM-110)**
3. **File and serve your court papers on time** Once your court forms are complete, you must file 1 original and 2 copies of the forms at court. An adult who is NOT involved in your case must serve one set of forms on the Plaintiff. If you were served in person you must file your response in 30 days. If the server left a copy of the papers with an adult living at your home or an adult in charge at your work or you received a copy by mail you must file your response in 40 days.
4. **Prove you served your court papers on time** by having your server complete a *Proof of Service; (Judicial Council form POS-040)*, that must be filed at the court within 60 days.
5. **Go to court** on the date and time given in the *Notice of Case Management Conference.*
6. **Consider trying to settle your case before trial** If you and the other party to the case can agree to use mediation, arbitration or neutral case evaluation, the *Stipulation and Order to Attend ADR and Delay First Case Management Conference 90 Days* can be filed with your other papers. For more information read the enclosed ADR information, visit www.cc-courts.org/adr, or call (925) 957-5787.

IMPORTANT! The court recommends consulting an attorney for all or part of your case. While you may represent yourself, lawsuits can be complicated, and the court cannot give you legal advice.

COURT FEES: You must pay court fees the first time you file your papers. If you also file a motion, you must pay another fee. If you cannot afford the fees, you may ask the court to waive (allow you not to pay) fees. Use Judicial Council forms FW-001-INFO [information sheet]; FW-001 [application]; and FW-003 [order].

COURT FORMS: Buy forms at the Forms Window in the Family Law Building or download them for free at: www.courtinfo.ca.gov/forms/

WHAT KIND OF RESPONSES CAN I FILE?

1. If you disagree with some or all of what the plaintiff says in the complaint because you believe, or know it is not true, you can file an ANSWER.
2. If you have a claim in the same case against the plaintiff, you may file a CROSS-COMPLAINT.
3. If you want to ask the court to do something on your behalf, you may file a MOTION *(See TYPES OF MOTIONS below)*

HOW DO I PREPARE AN ANSWER?

There are two kinds of Answers you can use, depending on whether the Complaint was verified. You can tell if a Complaint is verified because it says "Verified Complaint" and/or has a signed oath on the last page.

For complaints that are NOT verified:

Use Judicial Council form PLD-050 – General Denial

For complaints that ARE verified:

a. For personal injury, property damage, and wrongful death claims, use Judicial Council PLD-PI-003 (do not check number 2).

b. For contract claims, use Judicial Council PLD-C-010 (do not check number 3a).

c. Be sure to deny every claim with which you disagree. For example, you might write: *"I believe, or know, that the information in paragraph #__ is untrue/incorrect."* Continue your list until you have addressed each paragraph in the Complaint.

NOTE: The Judicial Council Answer forms have spaces for your affirmative defenses. Be sure to include them or you may not be able to use them later. To find out what your affirmative defenses might be, go to the law library and ask the librarian to help you find the information you need.

If you want to file a Cross-Complaint, you must do so at the same time you file the Answer.

a. For a personal injury, property damage, and/or wrongful death Cross-Complaint, use Judicial Council form PLD-PI-002.

b. For a contract Cross-Complaint, use Judicial Council PLD-C-001.

TYPES OF MOTIONS

Written motions are documents that ask the court to do something. You may have to file an *Answer* at the same time. At this point in the case, you can only make Motions from the following list:

1. Demurrer *(the facts stated in the complaint are wrong, or the deadline to file the lawsuit has passed)*;
2. Motion to Strike *(the complaint is unclear; does not follow the law, "doesn't matter", etc.)*;
3. Motion to Transfer *(the complaint is in the wrong court or there's a more appropriate court)*;
4. Motion to Quash Service of Summons *(you were not legally served)*;
5. Motion to Stay *(put the case on hold)*; or
6. Motion to Dismiss *(stops the case)*.

NOTE: Motions are very complicated and you may want to hire a lawyer to help you.

WHERE CAN I GET MORE HELP?

- **Lawyer Referral Service:** (925) 825-5700
- **Bay Area Legal Aid:** (800) 551-5554
- **Contra Costa County Law Library** Martinez: (925) 646-2783 Richmond: (510) 374-3019
- **Ask the Law Librarian:** www.247ref.org/portal/access_law3.cfm

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF CONTRA COSTA

____

____
Plaintiff(s) / Cross Plaintiff(s)

vs.

____

____
Defendant(s) / Cross Defendant(s)

ADR Case Management Stipulation and Order
(Unlimited Jurisdiction Civil Cases)

CASE NO: ______________

- ALL PARTIES STIPULATING TO ADR AND DELAYING THEIR CASE MANAGEMENT CONFERENCE 90 DAYS **MUST SUBMIT THE ORDER FOR THE JUDGE'S SIGNATURE AND FILE THIS FORM AT LEAST 15 DAYS BEFORE THEIR CASE MANAGEMENT CONFERENCE.** (NOT AVAILABLE IN COMPLEX LITIGATION CASES.)
- PARTIES MUST ALSO SEND A COPY OF THIS FILED STIPULATION AND ORDER TO THE ADR OFFICE: FAX: (925) 957-5689 MAIL: P.O. BOX 911, MARTINEZ, CA 94553

Counsel and all parties agree to delay their case management conference 90 days to attend ADR and complete pre-ADR discovery as follows:

1. Selection and scheduling for Alternative Dispute Resolution (ADR):
   a. The parties have agreed to ADR as follows:
      i. ☐ Mediation (☐ Court-connected ☐ Private)
      ii. ☐ Arbitration (☐ Judicial Arbitration (non-binding) ☐ Private (non-binding) ☐ Private (binding))
      iii. ☐ Neutral case evaluation
   b. The ADR neutral shall be selected by *(date)*: ______________ *(no more than 14 days after filing this form)*
   c. ADR shall be completed by *(date)*: ______________ *(no more than 90 days after filing this form)*
2. The parties will complete the following discovery plan:
   a. ☐ Written discovery: (☐ Additional page(s) attached)
      i. ☐ Interrogatories to:
      ii. ☐ Request for Production of Documents to:
      iii. ☐ Request for Admissions to:
      iv. ☐ Independent Medical Evaluation of:
      v. ☐ Other:
   b. ☐ Deposition of the following parties or witnesses: (☐ Additional page(s) attached)
      i. ______________
      ii. ______________
      iii. ______________
   c. ☐ No Pre-ADR discovery needed
3. The parties also agree: ______________
4. Counsel and self-represented parties represent they are familiar with and will fully comply with all local court rules related to ADR as provided in Appendix C, will pay the fees associated with these services, and understand that if they do not, without good cause, comply with this stipulation and all relevant local court rules, they may be subject to sanctions.

Counsel for Plaintiff *(print)*	Fax	Counsel for Defendant *(print)*	Fax
Signature		Signature	
Counsel for Plaintiff *(print)*	Fax	Counsel for Defendant *(print)*	Fax
Signature		Signature	

Pursuant to the Stipulation of the parties, and subject to the *Case Management Order* to be filed, **IT IS SO ORDERED** that the Case Management Conference set for ______________ is vacated and rescheduled for ________ at (8:30 a.m. / ________) **Plaintiff / Plaintiff's counsel must notify all parties of the new case management conference.**

Dated: ______________

____
Judge of the Superior Court

ATTORNEY OR PARTY WITHOUT ATTORNEY (*Name, State Bar number, and address*):

TELEPHONE NO.: FAX NO. (*Optional*):
E-MAIL ADDRESS (*Optional*):
ATTORNEY FOR (*Name*):

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF
STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME:

PLAINTIFF/PETITIONER:
DEFENDANT/RESPONDENT:

CASE MANAGEMENT STATEMENT

(*Check one*): ☐ UNLIMITED CASE (Amount demanded exceeds $25,000) ☐ LIMITED CASE (Amount demanded is $25,000 or less)

CASE NUMBER:

A CASE MANAGEMENT CONFERENCE is scheduled as follows:
Date: Time: Dept.: Div.: Room:
Address of court (*if different from the address above*):

☐ Notice of Intent to Appear by Telephone, by (*name*):

INSTRUCTIONS: All applicable boxes must be checked, and the specified information must be provided.

1. **Party or parties** (*answer one*):
   a. ☐ This statement is submitted by party (*name*):
   b. ☐ This statement is submitted jointly by parties (*names*):

2. **Complaint and cross-complaint** (*to be answered by plaintiffs and cross-complainants only*)
   a. The complaint was filed on (*date*):
   b. ☐ The cross-complaint, if any, was filed on (*date*):

3. **Service** (*to be answered by plaintiffs and cross-complainants only*)
   a. ☐ All parties named in the complaint and cross-complaint have been served, or have appeared, or have been dismissed.
   b. ☐ The following parties named in the complaint or cross-complaint
      (1) ☐ have not been served (*specify names and explain why not*):
      (2) ☐ have been served but have not appeared and have not been dismissed (*specify names*):
      (3) ☐ have had a default entered against them (*specify names*):
   c. ☐ The following additional parties may be added (*specify names, nature of involvement in case, and the date by which they may be served*):

4. **Description of case**
   a. Type of case in ☐ complaint ☐ cross-complaint (*Describe, including causes of action*):

Form Adopted for Mandatory Use
Judicial Council of California
CM-110 [Rev. January 1, 2009]

Cal. Rules of Court, rules 3.720–3.730
www.courtinfo.ca.gov

American LegalNet, Inc.
www.FormsWorkflow.com

PLAINTIFF/PETITIONER:	CASE NUMBER:
DEFENDANT/RESPONDENT:	

4. b. Provide a brief statement of the case, including any damages. *(If personal injury damages are sought, specify the injury and damages claimed, including medical expenses to date [indicate source and amount], estimated future medical expenses, lost earnings to date, and estimated future lost earnings. If equitable relief is sought, describe the nature of the relief.)*

☐ *(If more space is needed, check this box and attach a page designated as Attachment 4b.)*

5. **Jury or nonjury trial**
The party or parties request ☐ a jury trial ☐ a nonjury trial. *(If more than one party, provide the name of each party requesting a jury trial):*

6. **Trial date**
   a. ☐ The trial has been set for *(date):*
   b. ☐ No trial date has been set. This case will be ready for trial within 12 months of the date of the filing of the complaint *(if not, explain):*
   c. Dates on which parties or attorneys will not be available for trial *(specify dates and explain reasons for unavailability):*

7. **Estimated length of trial**
The party or parties estimate that the trial will take *(check one):*
   a. ☐ days *(specify number):*
   b. ☐ hours (short causes) *(specify):*

8. **Trial representation** *(to be answered for each party)*
The party or parties will be represented at trial ☐ by the attorney or party listed in the caption ☐ by the following:
   a. Attorney:
   b. Firm:
   c. Address:
   d. Telephone number:
   e. Fax number:
   f. E-mail address:
   g. Party represented:

☐ Additional representation is described in Attachment 8.

9. **Preference**
☐ This case is entitled to preference *(specify code section):*

10. **Alternative Dispute Resolution (ADR)**
   a. Counsel ☐ has ☐ has not provided the ADR information package identified in rule 3.221 to the client and has reviewed ADR options with the client.
   b. ☐ All parties have agreed to a form of ADR. ADR will be completed by *(date):*
   c. ☐ The case has gone to an ADR process *(indicate status):*

PLAINTIFF/PETITIONER:	CASE NUMBER:
DEFENDANT/RESPONDENT:	

10. d. The party or parties are willing to participate in *(check all that apply)*:
   (1) [ ] Mediation
   (2) [ ] Nonbinding judicial arbitration under Code of Civil Procedure section 1141.12 (discovery to close 15 days before arbitration under Cal. Rules of Court, rule 3.822)
   (3) [ ] Nonbinding judicial arbitration under Code of Civil Procedure section 1141.12 (discovery to remain open until 30 days before trial; order required under Cal. Rules of Court, rule 3.822)
   (4) [ ] Binding judicial arbitration
   (5) [ ] Binding private arbitration
   (6) [ ] Neutral case evaluation
   (7) [ ] Other *(specify)*:

e. [ ] This matter is subject to mandatory judicial arbitration because the amount in controversy does not exceed the statutory limit.
f. [ ] Plaintiff elects to refer this case to judicial arbitration and agrees to limit recovery to the amount specified in Code of Civil Procedure section 1141.11.
g. [ ] This case is exempt from judicial arbitration under rule 3.811 of the California Rules of Court *(specify exemption)*:

11. Settlement conference
[ ] The party or parties are willing to participate in an early settlement conference *(specify when)*:

12. Insurance
a. [ ] Insurance carrier, if any, for party filing this statement *(name)*:
b. Reservation of rights: [ ] Yes [ ] No
c. [ ] Coverage issues will significantly affect resolution of this case *(explain)*:

13. Jurisdiction
Indicate any matters that may affect the court's jurisdiction or processing of this case, and describe the status.
[ ] Bankruptcy [ ] Other *(specify)*:
Status:

14. Related cases, consolidation, and coordination
a. [ ] There are companion, underlying, or related cases.
   (1) Name of case:
   (2) Name of court:
   (3) Case number:
   (4) Status:
[ ] Additional cases are described in Attachment 14a.
b. [ ] A motion to [ ] consolidate [ ] coordinate will be filed by *(name party)*:

15. Bifurcation
[ ] The party or parties intend to file a motion for an order bifurcating, severing, or coordinating the following issues or causes of action *(specify moving party, type of motion, and reasons)*:

16. Other motions
[ ] The party or parties expect to file the following motions before trial *(specify moving party, type of motion, and issues)*:

PLAINTIFF/PETITIONER:	CASE NUMBER:
DEFENDANT/RESPONDENT:	

17. **Discovery**
    a. ☐ The party or parties have completed all discovery.
    b. ☐ The following discovery will be completed by the date specified *(describe all anticipated discovery):*

Party	Description	Date

    c. ☐ The following discovery issues are anticipated *(specify):*

18. **Economic litigation**
    a. ☐ This is a limited civil case (i.e., the amount demanded is $25,000 or less) and the economic litigation procedures in Code of Civil Procedure sections 90 through 98 will apply to this case.
    b. ☐ This is a limited civil case and a motion to withdraw the case from the economic litigation procedures or for additional discovery will be filed *(if checked, explain specifically why economic litigation procedures relating to discovery or trial should not apply to this case):*

19. **Other issues**
    ☐ The party or parties request that the following additional matters be considered or determined at the case management conference *(specify):*

20. **Meet and confer**
    a. ☐ The party or parties have met and conferred with all parties on all subjects required by rule 3.724 of the California Rules of Court *(if not, explain):*
    b. After meeting and conferring as required by rule 3.724 of the California Rules of Court, the parties agree on the following *(specify):*

21. Total number of pages attached *(if any):* ________

I am completely familiar with this case and will be fully prepared to discuss the status of discovery and ADR, as well as other issues raised by this statement, and will possess the authority to enter into stipulations on these issues at the time of the case management conference, including the written authority of the party where required.

Date:

________________________ ▶ ________________________
(TYPE OR PRINT NAME) (SIGNATURE OF PARTY OR ATTORNEY)

________________________ ▶ ________________________
(TYPE OR PRINT NAME) (SIGNATURE OF PARTY OR ATTORNEY)

☐ Additional signatures are attached.

CONTRA COSTA COUNTY SUPERIOR COURT
ALTERNATIVE DISPUTE RESOLUTION (ADR) INFORMATION

All judges in the Civil Trial Delay Reduction Program agree that parties should consider using Alternative Dispute Resolution (ADR) to settle their cases. To tell the court you will use ADR:

- Choose ADR on the *Case Management Form* (CM-110);
- File a *Stipulation and Order to Attend ADR and Continue First Case Management Conference 90-Days* (local court form); or
- Agree to ADR at your first court appearance.

Questions? Call (925) 957-5787, or go to www.cc-courts.org/adr

MEDIATION

Mediation is often faster and less expensive than going to trial. Mediators help people who have a dispute talk about ways they can settle their case. Parties call or visit the ADR Programs office to get a list of mediators. After parties have agreed on a mediator, they must write a summary (5 pages or less) explaining the facts, legal arguments, and legal authority for their position. They must send this summary to the other parties and the mediator at least 5 court days before mediation starts.

ALL parties and attorneys must go to mediation. Mediation can be held whenever and wherever the parties and the mediator want, as long as they finish before the court deadline. In some kinds of court cases, parties have the chance to mediate in the courthouse on their trial day.

Most mediators begin by talking with the parties together, helping them focus on the important issues. The mediator may also meet with each party alone. Mediators often ask parties for their ideas about how to settle the case. Some mediators tell the parties how much money they think a case is worth, or tell them what they think might happen if the case went to trial. Other mediators help the parties decide these things for themselves. No matter what approach a mediator takes, decisions about settling a case can only be made when all the parties agree.

If the parties go through the court ADR program, mediators do not charge fees for the first half hour spent scheduling or preparing for mediation. They also do not charge fees for the first two hours of mediation. If parties need more time, they must pay that person's regular fees. Some mediators ask for a deposit before mediation starts. Mediators who do this must give back whatever is left after counting the time he or she spent preparing for or doing the mediation. A party whose court fees have been waived (cancelled) may ask if their mediation fees or deposit can be waived.

If parties agree about how they will settle their case, they can choose to keep it private, write it up as a contract, or ask the judge to make it a court order. What parties say and agree to in mediation is confidential (private).

PRIVATE MEDIATION

Private mediation works in the same way as judicial mediation, but the parties do not go through the ADR Programs office. Parties choose a mediator on their own, and pay the mediator's normal fees.

JUDICIAL ARBITRATION (non-binding)
In judicial arbitration, an independent attorney (arbitrator) looks at the evidence, listens to the parties and their witnesses, and decides how the case will be settled. Judicial arbitration is less formal than court. Parties call or visit the ADR Programs office to get a list of arbitrators. If they cannot agree on an arbitrator, the court will assign one. The judge can send cases to arbitration if there is less than $50,000 in dispute. The person who started the court case can make sure the case goes to arbitration if they agree to limit the amount they are asking for to $50,000. Parties can also agree they want to use judicial arbitration. The arbitrator must send their decision (award) to the court within 10 days of the last hearing. The award becomes a court judgment unless a party asks the court to review the case within 30 days. Parties must use the ADR 102 form to ask for a new court hearing (called a trial de novo.) Judicial arbitrators charge $150 per case or per day.

PRIVATE ARBITRATION (non-binding and binding)
Private, non-binding arbitration is the same as judicial arbitration, except that the parties do not go through the ADR Programs office to choose an arbitrator, and the arbitrator's award will not become a judgment of the court unless all parties agree. Parties must pay the arbitrator's normal fees.

Binding arbitration is different from judicial or private non-binding arbitration because the arbitrator's decision is final. Parties give up their right to have a judge review their case later (except for reasons listed in California Code of Civil Procedure, Section 1286.2.) Binding arbitration rules are listed in California Code of Civil Procedure, Sections 1280-1288.8. Parties may also agree any time before the judge has made a decision that ends the case to switch to binding arbitration. Parties choose the arbitrator on their own, and must pay the arbitrator's normal (not $150) fees.

SETTLEMENT MENTOR CONFERENCE
Settlement mentors are independent, experienced trial attorneys that a judge has assigned to help parties look for ways to settle their case. The conference is free and is held in the courthouse. It is often held on the morning of trial, but it can be scheduled anytime. These conferences usually last two or three hours. Parties do not present evidence and do not call witnesses. Parties can ask the settlement mentor to keep some information confidential (private) from the other party, but not from the judge. The settlement mentor can share any information with the judge, or involve the judge in settlement discussions. All principals, clients, and claims representatives must attend the settlement mentor conference.

NEUTRAL CASE EVALUATION
In neutral case evaluation, an independent attorney (evaluator) reviews documents and listens to each party's side of the case. The evaluator then tells the parties what they think could happen if the case went to trial. Many people use the evaluator's opinion to reach an agreement on their own, or use this information later in mediation or arbitration to settle their case.

Parties call or visit the ADR Programs office to get a list of evaluators. After parties have agreed on an evaluator, they must write a summary (5 pages or less) explaining the facts, legal arguments, and legal authority for their position. They must send this summary to the other parties and the evaluator at least 5 court days before evaluation starts. ALL parties and their attorneys must go to neutral case evaluation. The evaluation can be held whenever and wherever the parties and the evaluator want, as long as they finish before the court deadline. If the parties go through the court's ADR program, evaluators do not charge any fees for the first half hour spent scheduling or preparing for the evaluation conference. They also do not charge fees for the first two hours of the evaluation. If parties need more time, they must pay that person's regular fees. Some evaluators ask for a deposit before evaluation starts. Evaluators who do this must give back whatever is left after counting the time he or she spent preparing for or doing the evaluation. A party whose court fees have been waived (cancelled) may ask if their evaluation fees or deposit can be waived.

TEMPORARY JUDGE

Some parties want a trial, but want to choose who will decide the case and when the trial will take place. Parties can agree on an attorney that they want the court to appoint as a temporary judge for their case. (See Article 6, Section 21 of the State Constitution and Rule 2.830 of the California Rules of Court.) Temporary judges have nearly the same authority as a superior court judge to conduct a trial and make decisions. As long as the parties meet the court deadline, they can schedule the trial at their own and the temporary judge's convenience.

Each of the temporary judges on the court's panel has agreed to serve at no charge for up to 5 court days. If the parties need more time, they must pay that person's regular fees. All parties and their lawyers must attend the trial, and provide a copy of all briefs or other court documents to the temporary judge at least two weeks before the trial. These trials are similar to other civil trials, but are usually held outside the court. The temporary judge's decision can be appealed to the superior court. There is no option for a jury trial. The parties must provide their own court reporter.

SPECIAL MASTER

A special master is a private lawyer, retired judge, or other expert appointed by the court to help make day-to-day decisions in a court case. The special master's role can vary, but often includes making decisions that help the discovery (information exchange) process go more smoothly. He or she can make decisions about the facts in the case. Special masters can be especially helpful in complex cases. The trial judge defines what the special master can and cannot do in a court order.

Special masters often issue both interim recommendations and a final report to the parties and the court. If a party objects to what the special master decides or reports to the court, that party can ask the judge to review the matter. In general, the parties choose (by stipulation) whom they want the court to appoint as the special master, but there are times (see California Code of Civil Procedure Section 639), when the court may appoint a special master or referee without the parties' agreement. The parties are responsible to pay the special master's regular fees.

COMMUNITY MEDIATION SERVICES

Mediation Services are available through non-profit community organizations. These low-cost services are provided by trained volunteer mediators. For more information about these programs contact the ADR Program at (925) 957-5787