

1 Christopher J. Healey, State Bar No. 105798
Aaron T. Winn, State Bar No. 229763
2 LUCE, FORWARD, HAMILTON & SCRIPPS LLP
600 West Broadway, Suite 2600
3 San Diego, California 92101-3372
Telephone No.: 619.236.1414
4 Fax No.: 619.232.8311

5 William L. Marchant, State Bar No. 154445
LUCE, FORWARD, HAMILTON & SCRIPPS LLP
6 Rincon Center II
121 Spear Street, Suite 200
7 San Francisco, CA 94105-1582
Telephone No.: 415.356.4600
8 Fax No.: 415.356.4610

9 Michael D. Thamer, State Bar No. 101440
LAW OFFICES OF MICHAEL D. THAMER
10 Old Callahan School House
12444 South Highway 3
11 Post Office Box 1568
Callahan, California 96014-1568
12 Telephone No.: (530) 467-5307
Facsimile No.: (530) 467-5437
13

14 Attorneys for CALIFORNIA ADVOCATES
FOR NURSING HOME REFORM;
15 PATRICIA ANN BRYANT; JULIE FUDGE

16 SUPERIOR COURT OF THE STATE OF CALIFORNIA

17 FOR THE COUNTY OF SAN FRANCISCO

CPF -05 505719

18 CALIFORNIA ADVOCATES FOR
NURSING HOME REFORM; PATRICIA
19 ANN BRYANT; JULIE FUDGE, taxpayers,

20 Plaintiffs,

21 v.

22 CALIFORNIA DEPARTMENT OF HEALTH
23 SERVICES; SANDRA SHEWRY, in her
official capacity as Director of the California
24 Department of Health Services; BRENDA
KLUTZ, in her official capacity as Deputy
25 Director of Licensing and Certification of the
California Department of Health Services and
26 DOES 1-10,

27 Defendants.
28

ENDORSED
FILED
San Francisco County Superior Court

OCT 17 2005

GORDON PARK-LI, Clerk
BY: CRISTINA E. BAUTISTA
Deputy Clerk

Case No.

**PETITION FOR WRIT OF MANDATE;
COMPLAINT FOR INJUNCTIVE AND
DECLARATORY RELIEF**

1 **INTRODUCTION**

2 1. This lawsuit seeks mandamus and other relief to compel the California Department
3 of Health Services (“DHS”) to investigate complaints made against nursing homes and other long-
4 term health care facilities within the mandatory 10-day period required under Health & Safety
5 Code § 1420(a).

6 2. The issue is of critical importance to the day-to-day health and well-being of
7 thousands of elderly and infirm citizens who reside in skilled nursing homes and other long-term
8 care facilities in California. Defendants’ failure to comply with the law exposes nursing home
9 residents to real and substantial harm, including abuse, neglect, exploitation, suffering and
10 avoidable death. Defendants’ conduct is particularly egregious, given that the Legislature has
11 expressly recognized that elderly residents in long-term care facilities are among the most
12 vulnerable members of our society. (See Welfare & Institutions Code § 15600 (a)-(d)).

13 3. Among other relief, plaintiffs seek a writ of mandate to compel DHS and other
14 defendants to comply with Health and Safety Code § 1420(a) by conducting an onsite inspection
15 or investigation within 10 working days of the receipt of a complaint made against a long-term
16 health care facility.

17 **PARTIES**

18 4. Plaintiff/Petitioner California Advocates for Nursing Home Reform (“CANHR”) is
19 a California not-for-profit corporation which advocates on behalf of elderly individuals and
20 individuals receiving Medicare and Medi-Cal, and their families. It is headquartered in San
21 Francisco, California. For many years, CANHR has advocated for the rights of the elderly to
22 receive appropriate, safe, sanitary and affordable nursing home care. CANHR has taken an active
23 role in pursuing legislative initiatives and litigation to protect the rights of nursing home residents
24 and their families including the right to demand accountability and safe and effective service and
25 care from nursing homes and their owners. CANHR has litigated on its own behalf and on behalf
26 of its members several lawsuits against DHS involving the Department’s policies governing
27 nursing home care. *See, e.g., Bucholtz v. Belshe* (9th Cir. 1997) 114 F.3d 923; *Dalzin v. Belshe*

28 ///

1 (N.D.Cal. 1997) 993 F.Supp. 732; *California Advocates for Nursing Home Reform v. Bonta*
2 (2003) 106 Cal.App.4th 498.

3 5. Plaintiff/Petitioner Patricia Ann Bryant (“Bryant”) is a citizen and resident of San
4 Jose, California. She is assessed for and is liable to pay, and within one year prior to the
5 commencement of this action has paid, taxes to the State of California. She is a “taxpayer” within
6 the meaning of California Code of Civil Procedure § 526a.

7 6. Plaintiff/Petitioner Julie Fudge (“Fudge”) is a citizen and resident of Los Gatos,
8 California. She is assessed for and is liable to pay, and within one year prior to the
9 commencement of this action has paid, taxes to the State of California. She is a “taxpayer” within
10 the meaning of California Code of Civil Procedure § 526(a).

11 7. Defendant/Respondent California Department of Health Services (“DHS” or
12 “Department”) is the agency that administers and enforces the provisions of the Health and Safety
13 Code relating to licensing and certification of health care facilities, including skilled nursing
14 facilities and intermediate care facilities.

15 8. Defendant/Respondent Sandra Shewry (“Shewry”) is the Director of the California
16 Department of Health Services and as such is authorized to interpret and enforce the laws of the
17 State of California pertaining to DHS’ oversight of long-term health care facilities, including
18 DHS’ inspections and investigations undertaken in response to complaints made regarding health
19 care services and medical assistance provided in long-term health care facilities. She administers,
20 makes policy, and gives policy direction to employees and agents of the Department of Health
21 Services who implement and enforce laws relating to the matters alleged herein. Defendant
22 Shewry is sued in her official capacity.

23 9. Defendant/Respondent Brenda Klutz (“Klutz”) is the Deputy Director of Licensing
24 and Certification for DHS, and as such, is authorized to administer and enforce the laws of the
25 State of California pertaining to licensing and certification of long-term health care facilities, and
26 the laws pertaining to DHS’ inspections and investigations undertaken in response to complaints
27 made against long-term health care facilities, including skilled nursing facilities. She administers,
28 makes policy, and gives policy direction to employees and agents of the Licensing and

1 Certification Program of the Department with respect to the matters alleged herein. Defendant
2 Klutz is sued in her official capacity.

3 10. Plaintiffs do not know the true names and capacities of defendants/respondents
4 Does 1 through 10, inclusive, which defendants are therefore sued by such fictitious names.
5 Plaintiffs are informed and believe and therefore allege on information and belief that each person
6 or entity designated as Doe 1 through 10, is responsible in some manner for the unlawful acts
7 alleged in this complaint. Plaintiffs will seek leave to amend this complaint when the true names
8 and capacities of each Doe defendant has been ascertained.

9 **FACTS**

10 **The Requirements of Health & Safety Code Section 1420(a)**

11 11. DHS oversees the operation of long-term health care facilities in California,
12 including skilled nursing facilities. DHS licenses and regulates those facilities. As part of its
13 oversight responsibilities, DHS is charged with responding to complaints made against long-term
14 health care facilities. Defendants Shewry and Klutz are responsible for DHS' regulation and
15 oversight of long-term health care facilities, including skilled nursing facilities.

16 12. Health & Safety Code § 1420 establishes specific deadlines for DHS to respond to
17 any oral or written complaint received by the Department concerning long-term health care
18 facilities, including skilled nursing facilities. For purposes of section 1420, a "complaint" means
19 any oral or written notice to DHS, other than a report from the facility, of an alleged violation of
20 the applicable requirements of state or federal law, or any alleged facts that might constitute such a
21 violation. Health & Safety Code § 1420(f).

22 13. Among other requirements, Section 1420(a)(1) imposes the following mandatory
23 requirement: "Unless the State department determines that the complaint is willfully intended to
24 harass a licensee or is without any reasonable basis, it shall make an onsite inspection or
25 investigation within 10 working days of the receipt of the complaint." Health & Safety Code §
26 1420(a)(1).

27 ///

28 ///

1 **DHS' Pervasive Failure to Comply With Section 1420(a)**

2 14. As demonstrated by ample evidence, DHS has failed, and continues to fail, to
3 comply with the mandatory 10-day response requirements of Section 1420(a).

4 15. On July 20, 2005, the DHS submitted testimony to the Joint Informational Hearing
5 of the California Senate Committee on Health and Subcommittee on Aging and Long-term Care.
6 In testimony submitted in connection with the Senate hearing, DHS acknowledged that "due to
7 resource limitations," it has postponed the investigation of many complaints that allege harm to
8 residents until the Department's next on-site visit to the facility, which in many cases will not
9 occur until months after the complaint is submitted to DHS. At the hearing, several affected
10 California citizens testified about the lengthy delays in DHS' investigation concerning their
11 complaints of nursing home neglect.

12 16. On July 31, 2005, in an article entitled "Nursing Home Scrutiny Lagging," the Los
13 Angeles Times reported that nursing home complaints in California have risen from 9,650 in 2000
14 to 15,512 in 2004, an increase of more than 60 percent. Notwithstanding this increase, defendant
15 Brenda Klutz acknowledged in the article that DHS often failed to meet the State requirement that
16 inspectors respond to complaints within 10 days because the State does not have enough
17 inspectors. According to the article, Ms. Klutz also stated that the lag in investigations often meant
18 that complaints could not be verified. As Ms. Klutz acknowledged: "No one likes it. It's not how
19 we would design a system that is supposed to be protecting vulnerable populations."

20 17. As the Los Angeles Times article noted, some nursing home residents have actually
21 died before DHS investigated complaints submitted to DHS by family members. For example,
22 Alberto Perez, age 87, entered a nursing home in Petaluma, California in February 2005. Within
23 days of his placement, family members noticed a small cut on his foot. Fearing the wound would
24 become infected, they urged the facility staff to pay close attention. Several months later, seeing
25 that the wound was getting worse, family members made oral and written complaints to DHS. By
26 June, the wound was five inches across and Mr. Perez was transferred to a hospital. Doctors were
27 forced to amputate his leg and, on June 27, 2005, Mr. Perez died of multiple causes, including

28 ///

1 widespread infection. Yet, as of July 2005, when family members were interviewed by the Times,
2 they had heard nothing from DHS about their complaint.

3 18. DHS' failure to comply with the complaint investigation requirements of Section
4 1420(a) has apparently been adopted as Department policy. As reported in a Ventura County Star
5 article dated April 11, 2004, entitled "Complaints About Nursing Homes Can Sit for Months,"
6 DHS issued a "verbal directive" in 2004 that DHS investigations of all complaints (other than
7 those which DHS views as involving a threat of imminent death or serious bodily harm) are to be
8 deferred until the next "scheduled survey" at the subject nursing home facility. Because scheduled
9 facility surveys are generally conducted every nine to 15 months, that means DHS' complaint
10 investigations can be delayed for months if not years. According to DHS' spokesperson, Robert
11 Miller, this "verbal directive" was never reduced to writing, but was communicated to DHS
12 personnel by "headquarters."

13 19. DHS' blatant failure to comply with the time requirements of Section 1420(a) is
14 confirmed by the Department's own records. Since approximately 1990, DHS has maintained
15 data related to regulatory enforcement of health care facilities, including data related to complaints
16 made against long-term health care facilities, in a data system called the Automated Certification
17 Licensing Administration Information Management System (also know as "ACLAIMS").
18 Starting in approximately 2004, DHS has phased out its ACLAIMS system in favor of newer data
19 systems, including the Automated Survey Processing Environment ("ASPEN").

20 20. In December 2004, the California HealthCare Foundation issued a report entitled
21 "Report on California's Nursing Homes, Home Health Agencies and Hospice Programs," stating
22 that DHS' ACLAIMS data in 2003 showed that the 10-day response deadline was not met as to
23 over 40 percent of complaints subject to the Section 1420(a) requirements, and that the average
24 complaint investigation was 94 days past due. The report also states that the lack of timely
25 complaint investigations in California is one reason that the number of substantiated complaints is
26 lower than in the past.

27 21. Most recently, on September 9, 2005, the Department provided data regarding
28 DHS' complaint investigations in response to CANHR's July 1, 2005 request under the California

1 Public Records Act. The data provided confirm that the Department has failed to timely respond
2 to the vast majority of complaints that DHS itself acknowledges are subject to the 10-day
3 requirement.

4 **Impact of DHS' Non-Compliance**

5 22. DHS' systematic failure to comply with the requirements of Section 1420 has a
6 direct and material impact on the health, safety and welfare of patients in California long-term
7 care facilities. DHS is charged with oversight responsibilities over all such facilities within the
8 State. The complaint investigation process is a crucial aspect of effective oversight by DHS to
9 ensure that long-term care facilities comply with their statutory and regulatory requirements to
10 properly care for the elderly and vulnerable residents in their facilities.

11 23. As a result of DHS' failure to investigate complaints in a timely and diligent
12 manner, DHS' regulatory oversight is undermined, which necessarily results in reduced
13 enforcement of laws and regulations specifically enacted to protect the health, safety and well-
14 being of patients in long-term care facilities. With each day of additional delay in responding to
15 complaints, memories fade and evidence disappears, further reducing the chance that violations
16 and other wrongs committed against elderly and vulnerable residents of long-term facilities will be
17 properly investigated and redressed. As a result, elderly and vulnerable residents are deprived of
18 their statutorily-mandated rights to an expeditious consideration of the complaints regarding their
19 care at long-term health care facilities. Further, the underlying violations that gave rise to the
20 complaints in the first instance are often never subject to a timely and proper investigation, such
21 that the same violations continue unabated, further impacting the rights and well-being of other
22 vulnerable residents in the subject facilities. In short, the complaint investigation process, which
23 is a critical aspect of effective oversight and enforcement by DHS, is severely compromised by the
24 Department's non-compliance with Section 1420(a).

25 24. Another troubling effect of DHS' delay in conducting onsite inspections or
26 investigations is that the percentage of complaints that DHS deems as "unsubstantiated" has risen
27 dramatically in recent years. But, an "unsubstantiated" finding does not mean that the abuse,
28 neglect and other conduct complained of did not actually occur. Rather, because of DHS' delayed

1 investigation, evidence is lost, nursing home staff leave and other witnesses become unavailable,
2 thereby resulting in no action against a facility which, if a proper and timely investigation had
3 been conducted, would otherwise have received a deficiency notice, citation or other sanction by
4 DHS.

5 25. Individual plaintiffs, Patricia Bryant and Julie Fudge, have direct knowledge of the
6 tragic consequences of DHS' failure to comply with the response time requirements of Section
7 1420.

8 26. Patricia Bryant's mother, Catherine Ann Bryant, a resident at Terenno Gardens
9 Extended Care, a skilled nursing facility located in Los Gatos, California, died on September 21,
10 2004. Shortly before her mother's death, Ms. Bryant learned that a charge nurse on her mother's
11 unit ignored a physician's treatment orders regarding a pressure wound on her mother's coccyx.
12 Ms. Bryant also discovered that the same nurse falsified medication records. On October 6, 2004,
13 Ms. Bryant called the San Jose Licensing & Certification District Office of DHS to file a
14 complaint about the neglect, which was instrumental in the decline and premature death of her
15 mother. Ms. Bryant followed up with a written complaint on October 11, 2004.

16 27. DHS acknowledged receipt of Ms. Bryant's complaint on October 20, 2004 and
17 assigned it Complaint No. CA000333444. Yet, despite numerous follow-up contacts by Ms.
18 Bryant seeking a prompt and thorough investigation of her complaint, DHS did not make an onsite
19 inspection of the facility until November 30, 2004, roughly seven weeks after Ms. Bryant's initial
20 complaint and well beyond the 10-day response period required under Section 1420.

21 28. By letter dated April 26, 2005, DHS acknowledged that the allegations in the
22 Bryant complaint were substantiated, which resulted in DHS issuing a statement of deficiencies to
23 the subject facility. DHS' findings supported Ms. Bryant's contention that the neglect led to a
24 severe infection that resulted in her mother's death.

25 29. Plaintiff Julie Fudge's mother, Marian Rodgers, lived for nearly six years at the
26 Saratoga Retirement Community Health Center, a licensed skilled nursing facility located in
27 Saratoga, California. Ms. Rodgers suffered from dementia, pneumonia and vascular disease.
28 During a routine visit on April 24, 2004, Julie discovered that her mother's oxygen levels had

1 fallen to a dangerous level and that the assigned nurse had not performed necessary oxygen checks
2 or administered ordered breathing treatments. Ms. Fudge also observed the nurse treat her mother
3 in an unprofessional and undignified manner. Subsequently, her mother became comatose and
4 died six days later.

5 30. On May 14, 2004, Ms. Fudge filed a telephone complaint with the Department of
6 Health Services. She followed up that telephone complaint with an 8-page written complaint to
7 DHS dated May 17, 2004. On May 19, 2004, DHS confirmed receipt of Ms. Fudge's complaint
8 and notified her of the assigned complaint number, CA00024298.

9 31. Having not heard from DHS for several weeks, Ms. Fudge made repeated follow-
10 up calls to the assigned DHS investigator, Geri Fisher. Fisher told Ms. Fudge that her DHS office
11 was very understaffed and unable to respond to many complaints. In fact, Fisher told Ms. Fudge
12 that she was working on another complaint that had been filed in 1999. On September 28, 2004,
13 still having heard nothing back from DHS regarding her complaint, Ms. Fudge wrote Lilija
14 Tushinski, a DHS District Office Manger, seeking action on her complaint.

15 32. Ms. Fudge called Geri Fisher again on December 3, 2004, expressing concerns that
16 she had not received any findings. Ms. Fisher told her that the report was delayed because her
17 supervisor was away. In a follow-up conversation on December 10, 2004, Ms. Fisher told Julie
18 Fudge that the supervisor had complained that the report was too long and needed changes.

19 33. By letter dated March 21, 2005, more than 10 months after Ms. Fudge filed the
20 initial complaint, DHS responded. In that letter, DHS stated for the first time that an unannounced
21 inspection of the facility had been conducted on June 8, 2004 (although this information had not
22 previously been provided to Ms. Fudge.) DHS had concluded the complaint was not
23 substantiated. Even if the onsite inspection took place on June 8, 2004, as DHS contends, it was
24 still conducted six days after the date required by statute.

25 34. Plaintiffs are informed and believe that the violations of law, neglect and other
26 concerns raised by the Bryant and Fudge complaints were not limited to the specific patients
27 identified in those complaints. Rather, the problems that gave rise to the Bryant and Fudge
28 complaints had the clear potential to impact other nursing home residents, who continued to live in

1 the subject facilities, even as DHS dragged its bureaucratic feet in its delayed response. On
2 information and belief, DHS' failure to timely inspect, investigate and otherwise respond to the
3 Bryant and Fudge complaints resulted in a continuation of inadequate care and dangerous
4 conditions for other elderly and vulnerable residents.

5 **Plaintiffs' Pre-Litigation Efforts to Secure Compliance**

6 35. CANHR has met with Brenda Klutz several times during the last year to discuss
7 this issue. For example, on September 17, 2004, CANHR wrote Ms. Klutz expressing concern
8 about the rising tide of complaints and the failure of Licensing and Certification to respond in a
9 timely or thorough manner. Ms. Klutz has acknowledged that the Department has a large backlog
10 of complaints.

11 36. By September 15, 2005, CANHR formally demanded that DHS comply with the
12 10-day response requirement of Section 1420(a). Despite this demand, DHS has refused to
13 comply with Section 1420(a).

14 37. Plaintiffs have no adequate remedy at law to redress defendants' ongoing violations
15 of law, as alleged herein.

16 **FIRST CAUSE OF ACTION**

17 **(Writ of Mandate -- Defendants' Violation of California Health and Safety Code § 1420(a))**

18 38. Plaintiffs reallege and incorporate herein by reference each and every allegation of
19 paragraphs 1 through 37.

20 39. Defendants have a clear and present duty under the Health and Safety Code
21 § 1420(a) to make an onsite inspection or investigation within 10 working days of the receipt of all
22 complaints received with respect to long-term care facilities, unless DHS determines the complaint
23 is willfully intended to harass a licensee or is without any reasonable basis.

24 40. As alleged above, defendants have failed to comply with Health and Safety Code
25 § 1420(a) by, among other things, failing to conduct an onsite inspection or investigation within
26 the required timeframe with respect to thousands of complaints that DHS itself acknowledges are
27 subject to the 10-day requirement.

28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

PRAYER FOR RELIEF

Wherefore plaintiffs respectfully pray:

1. For a peremptory writ of mandate pursuant to Code of Civil Procedure §1085 permanently requiring defendants, their successors, employees and agents to comply with Health and Safety Code § 1420(a).
2. In the alternative, for appropriate injunctive relief requiring defendants, their successors, employees and agents and all persons working in concert or participation with them to comply with Health and Safety Code § 1420(a).
3. For an order declaring that defendants have unlawfully failed to comply with Health and Safety Code § 1420(a).
4. For costs and reasonable attorneys' fees, as provided by law.
5. For such further relief that is equitable and proper.

DATED: October 17, 2005

LUCE, FORWARD, HAMILTON & SCRIPPS LLP

By: *Christopher J. Healey*
Christopher J. Healey
Attorneys for CALIFORNIA ADVOCATES FOR
NURSING HOME REFORM; PATRICIA ANN
BRYANT; JULIE FUDGE

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

VERIFICATION

I, Julie Fudge, am one of the plaintiffs herein. I have read the foregoing Petition for Writ of Mandate and Complaint for Injunctive and Declaratory Relief. I have personal knowledge of certain of the allegations set forth therein and, as to the balance of the allegations, I am informed and believe that such allegations are also true. On that basis, I declare under penalty of perjury that the foregoing is true and correct.

Executed at Los Gatos, California this 14th day of October, 2005.

Julie Fudge
Name: Julie Fudge
Title: Taxpayer

2105142.3

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

VERIFICATION

I, Patricia Ann Bryant, am one of the plaintiffs herein. I have read the foregoing Petition for Writ of Mandate and Complaint for Injunctive and Declaratory Relief. I have personal knowledge of certain of the allegations set forth therein and, as to the balance of the allegations, I am informed and believe that such allegations are also true. On that basis, I declare under penalty of perjury that the foregoing is true and correct.

Executed at San Jose, California this 14 day of October, 2005.

Patricia Ann Bryant
Name: Patricia Ann Bryant
Title: _____

2105142.3

VERIFICATION

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

I, Patricia L. McGinnis, am the Executive Director of petitioner California Advocates for Nursing Home Reform (CANHR), one of the plaintiffs herein. On behalf of CANHR, I have read the foregoing Petition for Writ of Mandate and Complaint for Injunctive and Declaratory Relief. I have personal knowledge of certain of the allegations set forth therein and, as to the balance of the allegations, I am informed and believe that such allegations are also true. On that basis, I declare under penalty of perjury that the foregoing is true and correct.

Executed at San Francisco, California this 13th day of October, 2005.

Patricia L. McGinnis
Name: PATRICIA L. MCGINNIS
Title: Executive Director

2105142.3