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8 SUPERIOR COURT OF THE STATE OF CALIFORNIA
9 COUNTY OF VENTURA
10

11 JEAN KOHUT,

12 Plaintiff,

13 vs.

14 DIGNITY HEALTH, and DOES 1 through 250
15 inclusive,

16 Defendant.

CASE NO.

COMPLAINT FOR DAMAGES

1) Wrongful Death

17 COMES NOW Plaintiff and alleges upon information and belief as follows:
18

THE PARTIES

19 1. Plaintiff JEAN KOHUT (hereinafter sometimes referred to as "PLAINTIFF") was at
20 all times relevant hereto a resident of the State of California. PLAINTIFF brings her wrongful death
21 claim as the sole heir of DECEDENT, Milton Kohut.

22 2. Defendants DIGNITY HEALTH and DOES 1 through 50 (hereinafter referred to as
23 the "HOSPITAL") were at all relevant times in the business of providing care as a 58-bed general
24 acute care hospital under the fictitious name St. John's Pleasant Valley Hospital which is located at
25 2309 Antonio Avenue, Camarillo, California 93010, and were subject to the requirements of federal
26 and state law regarding the operation of general acute care hospitals operating in the State of
27 California.

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1 3. Defendants and DOES 51 through 100 (hereinafter the “MANAGEMENT
2 DEFENDANTS”) were at all relevant times the HOSPITAL’S owners, operators, parent company,
3 and/or management company of the HOSPITAL and actively participated and controlled the
4 business of the HOSPITAL and thus provided care as a general acute care hospital (hereinafter the
5 HOSPITAL and the MANAGEMENT DEFENDANTS are collectively sometimes jointly referred
6 to as “DEFENDANTS”).

7 4. The liability of the MANAGEMENT DEFENDANTS for the abuse of DECEDENT
8 as alleged herein arises from their own direct misconduct as alleged herein as well as all other legal
9 basis and according to proof at the time of trial.

10 5. Therein the OSHPD Report filed by HOSPITAL with a period end date of June 30,
11 2019, DIGNITY HEALTH is listed as a “related party” of the HOSPITAL to which the HOSPITAL
12 funnels cash for non-existent phantom services and obligations which are simply efforts by the
13 MANAGEMENT DEFENDANTS to move money, goods and services around from one commonly
14 owned entity to another with no regard to legal separation. Most specifically, the HOSPITAL reports
15 “HO Salary”, “HO Benefits” and “HO Purchase Service” with paid value of \$18,853,181.00. Upon
16 information and belief, DIGNITY HEALTH provides nothing near such value and rather this is a
17 manner to carry out the “Single Enterprise” designed to siphon off monies for the sole purpose of
18 unjustly enriching the MANAGEMENT DEFENDANTS and others who mandate payment from
19 the HOSPITAL for nonexistent phantom services at the expense of legally mandated minimum
20 quality care for dependent and infirm hospital patients such as the case here concerning
21 DECEDENT.

22 6. And the fact of the matter is that by unlawfully siphoning off required funds for
23 resident care, the MANAGEMENT DEFENDANTS and others left insufficient funds to safely and
24 lawfully operate the HOSPITAL in accordance with applicable regulation. This is exemplified by
25 the simple fact that in the year 2019, the HOSPITAL received 5 DPH survey deficiencies and 23
26 DPH complaints/reported incidents when the average for California hospitals were 4 and 6,
27 respectively. This continues into the present year when the HOSPITAL received 4 DPH
28 complaints/reported incidents, and 2 deficiencies while the average for California hospitals is zero.

1 7. Plaintiff is informed and believes and therefore alleges that at all times relevant to
2 this complaint, DOES 101-250 were licensed and unlicensed individuals and/or entities, and
3 employees of the defendants rendering care and services to DECEDENT and whose conduct caused
4 the injuries and damages alleged herein. It is alleged that at all times relevant hereto, the
5 DEFENDANTS were aware of the unfitness of DOES 101-250 to perform their necessary job duties
6 and yet employed these persons and/or entities in disregard of the health and safety of DECEDENT.

7 8. Plaintiff is ignorant of the true names and capacities of those Defendants sued herein
8 as DOES 1 through 250, and for that reason has sued such Defendants by fictitious names. Plaintiff
9 will seek leave of the Court to amend this Complaint to identify said Defendants when their
10 identities are ascertained.

11 9. The DEFENDANTS, by and through the corporate officers and directors including,
12 Darren Lee (Administrator), Stacy Hutchison (DON), Lloyd Dean, Mitch Melfi, Daniel Morissette,
13 Kevin Lofton, Judith Carle, Mark DeMichele, Peter Hanelt, Tessie Guillermo, Antoinette Hardy-
14 Waller, Barbara Hagedorn, Christopher Lowney, Gary Yates, James Hamill, Kent Bradley, Patrick
15 Steele; and others presently unknown to Plaintiff and according to proof at time of trial, ratified the
16 conduct of their co-defendants and the HOSPITAL, in that they were aware of the understaffing of
17 the HOSPITAL, in both number and training, the relationship between understaffing and sub-
18 standard provision of care to patients of the HOSPITAL, including DECEDENT, the rash, and truth,
19 of lawsuits against the DEFENDANTS general acute care hospitals including the HOSPITAL, and
20 the HOSPITAL'S customary practice of being issued deficiencies by the State of California's
21 Department of Public Health as alleged herein. That notwithstanding this knowledge, these officers,
22 directors, and/or managing agents meaningfully disregarded the issues even though they knew the
23 understaffing could, would and did lead to unnecessary injuries to patients of their HOSPITAL,
24 including the DECEDENT.

25 10. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS,
26 which led to the injuries to DECEDENT as alleged herein, was the direct result and product of the
27 financial and control policies and practices forced upon the HOSPITAL by the financial limitations
28 imposed upon the HOSPITAL by DIGNITY HEALTH and the MANAGEMENT DEFENDANTS

1 by and through the corporate officers and directors enumerated in paragraph 9 of the complaint and
2 others presently unknown and according to proof at time of trial.

3 11. That, based upon information and belief, DOES 101-110 were members of the
4 "Governing Body" of the HOSPITAL in whom the final authority and responsibility is vested for
5 conduct of the HOSPITAL pursuant to 22 C.C.R. §§70035 and 70701. That these members, as
6 executives, managing agents and/or owners of the HOSPITAL, were focused on unlawfully
7 increasing the earnings in the operation of DEFENDANTS' businesses as opposed to providing the
8 legally mandated minimum care to be provided to elder and/or infirm patients in their general acute
9 care hospitals, including DECEDENT. That the focus of these individuals on their own attainment
10 of profit played a part in the under-funding of the HOSPITAL which led to the HOSPITAL violating
11 state and federal rules, laws and regulations and led to the injuries to DECEDENT as alleged herein.

12 12. The HOSPITAL and the MANAGEMENT DEFENDANTS operated in such a way
13 as to make their individual identities indistinguishable, and are therefore, the mere alter-egos of one
14 another.

15 13. At all relevant times, the HOSPITAL and MANAGEMENT DEFENDANTS and
16 each of their tortious acts and omissions, as alleged herein, were done in concert with one another
17 in furtherance of their common design and agreement to accomplish a particular result, namely
18 maximizing profits from the operation of the HOSPITAL by underfunding and understaffing the
19 HOSPITAL. Moreover, the DEFENDANTS aided and abetted each other in accomplishing the acts
20 and omissions alleged herein. (See Restatement (Second) of Torts §876 (1979)).

21 **FACTUAL ALLEGATIONS**

22 14. At all relevant times, DECEDENT was over the age of 65 and thus was an "elder"
23 as that term is defined in the *Welfare and Institutions Code* §15610.27.

24 15. That DEFENDANTS were to provide "care or services" to DECEDENT and were
25 to be "care custodians" of DECEDENT and in a trust and fiduciary relationship with DECEDENT.
26 That the DEFENDANTS provided "care or services" to dependent adults and the elderly, including
27 DECEDENT, and housed dependent adults and the elderly, including the DECEDENT.

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1 16. That the DEFENDANTS “neglected” DECEDENT as that term is defined in *Welfare*
2 *and Institutions Code* §15610.57 in that the DEFENDANTS themselves, as well as their employees,
3 failed to exercise the degree of care that reasonable persons in a like position would exercise as is
4 more fully alleged herein.

5 17. While a patient of the HOSPITAL, DECEDENT suffered an entirely preventable fall
6 that caused DECEDENT to suffer two separate fractures in his pelvis.

7 18. DECEDENT’s history of falls was well known to the HOSPITAL. On July 4, 2019,
8 DECEDENT went to the HOSPITAL emergency department following a fall at 3:30 a.m. that day
9 where he lost his balance and fell onto the floor at home. The electronic records from this
10 HOSPITAL visit indicate that DECEDENT was fall prone with multiple falls. Luckily, he did not
11 suffer a fracture on this occasion and only suffered a contusion.

12 19. On July 8, 2019, only 4 days later, DECEDENT again went to the HOSPITAL
13 emergency department complaining of pain post-fall. In what will become a disturbing and
14 dangerous pattern of misinformation regarding DECEDENT’s fall risk potential, the nursing staff
15 documented that DECEDENT did not have any history of falling.

16 20. On August 10, 2019, DECEDENT returned to the HOSPITAL emergency
17 department because he felt sick. Once again, the nursing staff wrongly documented that
18 DECEDENT has no fall history.

19 21. On August 19, 2019, DECEDENT returned to the HOSPITAL emergency
20 department complaining of back pain. Once again, the nursing staff wrongly documented that
21 DECEDENT has no fall history.

22 22. On or about September 11, 2019, 86 year old DECEDENT, who suffered from
23 anemia and required blood transfusions, was admitted to the HOSPITAL with a 102 fever.
24 DECEDENT was wrongfully found in the Emergency Department to once again not have a history
25 of falls and that he was a low fall risk.

26 23. Due to DECEDENT’S weakened state, age and required assistive device,
27 DECEDENT was a high fall risk and his room was marked accordingly. However, the DECEDENT
28 suffered a fall in his room on or about September 13, 2019. HOSPITAL staff stated DECEDENT

1 would be taken for a CT scan. DECEDENT was diagnosed with a fractured pelvis in two places and
2 placed on an IV morphine drip for severe pain.

3 24. On the day the fall occurred, Mrs. Kohut inquired as to whether there were guard
4 rails put in place for DECEDENT due to his known fall risk. A staff member explained that in order
5 for guard rails to be put in place, a doctor would need to order guard rails to be put up.

6 25. At approximately 5:45 p.m. on September 13, 2019, DECEDENT suffered a fall in
7 the HOSPITAL, resulting in complaints of pain to his left elbow and pelvis.

8 26. A CT scan performed revealed that DECEDENT sustained comminuted left superior
9 and inferior pubic rami fractures.

10 27. On or about September 16, 2019, DECEDENT was transferred to the skilled nursing
11 facility for rehabilitation due to his fractured pelvis.

12 28. Thereafter, due to immobility caused by the fall and fracture, DECEDENT
13 developed a Stage II pressure injury on his coccyx.

14 29. Upon DECEDENT'S admission to the HOSPITAL, DEFENDANTS were well
15 aware, through assessment information, family information, as well as physician notes and orders
16 provided to the HOSPITAL, that DECEDENT suffered from anemia requiring blood transfusions,
17 a medical history of sepsis, a weakened immune system, and required an assistive device to
18 ambulate. DECEDENT was a high risk to suffer falls, and therefore required special care and
19 assistance including 24-hour supervision and monitoring, assistance and monitoring with
20 ambulation and transferring, the provision of safety and assistance devices to prevent accidents,
21 assistance and monitoring with other activities of daily living, and the implementation of
22 interventions to prevent further falls. That notwithstanding this knowledge, and notwithstanding a
23 full knowledge that the failure to create and implement proper care plans to prevent DECEDENT
24 from suffering further falls created a high probability that DECEDENT would suffer further falls
25 and resulting injury, DEFENDANTS knowingly disregarded this risk and failed to adequately
26 assess, generate and implement an adequate plan of care for DECEDENT and to implement
27 adequate preventive measures for falling. That in so doing, DEFENDANTS failed to meet
28 DECEDENT'S needs and failed to comply with the rules, laws and regulations governing their

1 HOSPITAL. Moreover, DEFENDANTS knowingly exposed DECEDENT to extreme health and
2 safety hazards.

3 30. The DEFENDANTS were well aware that if they failed to provide DECEDENT with
4 the aforementioned care, supervision, and monitoring, there was a high probability that
5 DECEDENT would suffer injury. That DEFENDANTS consciously disregarded this risk and failed
6 to provide DECEDENT with the aforementioned required care, leading directly to DECEDENT'S
7 injuries and death.

8 31. General acute care hospitals such as the HOSPITAL are to not only conduct
9 assessments of high fall risk patients such as DECEDENT, but also are to update the assessments
10 as frequently as necessary to determine the specific interventions that should be put in place to
11 prevent a patient such as DECEDENT from suffering any falls. These interventions include such
12 innocuous interventions as lap buddies, a device to prevent one from falling out of a wheelchair, to
13 hip guards. The HOSPITAL did not provide any such services or interventions to DECEDENT
14 notwithstanding that DECEDENT required such services.

15 32. The DEFENDANTS were aware, upon admission and during the residency of
16 DECEDENT, that DECEDENT required a higher level of care and care interventions to prevent
17 injury to DECEDENT than the HOSPITAL could, or would, provide. And yet so as to unlawfully
18 promote profits the DEFENDANTS admitted and retained DECEDENT as a patient of the
19 HOSPITAL even though the DEFENDANTS were fully aware that in so doing they exposed
20 DECEDENT to extreme health and safety hazards. In so doing the DEFENDANTS recklessly failed
21 to provide to DECEDENT required medical and custodial care thereby causing injury and death.

22 33. That the HOSPITAL knew prior to the admission of the DECEDENT that when the
23 HOSPITAL failed to provide the required care set forth above, that there was a high probability that
24 patients such as DECEDENT would suffer serious injury. That the HOSPITAL consciously
25 disregarded this risk and failed to provide DECEDENT with the aforementioned required care,
26 leading directly to DECEDENT'S injuries and death.

27 34. On March 31, 2020, DECEDENT passed away. He spent the remainder of his life
28 enduring otherwise unnecessary medical treatments due to the entirely avoidable injuries alleged

1 herein. Despite DECEDENT’S infirm health upon and through his admission at the HOSPITAL,
2 the substandard care provided by the HOSPITAL greatly impacted the quality of DECEDENT’S
3 life. The abuse and neglect caused unnecessary and prolonged pain and suffering for both
4 DECEDENT and his family.

5 **FIRST CAUSE OF ACTION**
6 **WRONGFUL DEATH**

7 **[By PLAINTIFF, JEAN KOHUT, Against All Defendants.]**

8 35. JEAN KOHUT hereby incorporates the allegations asserted in paragraphs 1 through
9 34 above as though set forth below.

10 36. JEAN KOHUT is the sole surviving heir of DECEDENT.

11 37. That DEFENDANTS owed duties to DECEDENT as more fully set forth above and
12 pursuant to the Elder Abuse and Dependent Adult Civil Protection Act.

13 38. That DEFENDANTS failed to meet their duties to DECEDENT pursuant to the
14 Elder Abuse and Dependent Adult Civil Protection Act as more fully set forth above.

15 39. As a proximate result of the “neglect” (as that term is defined in *Welfare and*
16 *Institutions Code* §15610.57) as more particularly alleged above perpetrated by all of the
17 Defendants, and each of them, DECEDENT died on March 31, 2020.

18 40. Prior to the death of DECEDENT, JEAN KOHUT enjoyed the love, society, comfort
19 and attention of DECEDENT.

20 41. As a proximate result of the acts of all of the Defendants as alleged herein, JEAN
21 KOHUT sustained loss of the society, comfort, attention and love of DECEDENT in a sum
22 according to proof at trial and within the jurisdictional limits of this Court.

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WHEREFORE, Plaintiffs pray for judgment and damages as follows:

1. For general damages according to proof;
2. For special damages according to proof;
3. For punitive and exemplary damages;
4. For attorneys' fees and costs as allowed by law according to proof at the time of trial;
5. For costs of suit; and

For such other and further relief as the Court deems just and proper.

DATED: October 12, 2020

GARCIA & ARTIGLIERE

By: *Stephen M. Garcia*
Stephen M. Garcia
Attorneys for Plaintiff