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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

MILDRED O. WATSON, by and through her Successor-in-Interest, Lisa Watson; LISA WATSON, Individually,

Plaintiffs,

vs.

BEVERLY HILLS REHABILITATION CENTRE, LLC dba Beverly Hills Rehabilitation Centre; CEDARS SINAI MEDICAL CENTER and DOES 1 through 200, inclusive,

Defendants,

CASE NO.: 23STCV28540

Assigned to the Hon. Daniel M. Crowley
Department 71

FIRST AMENDED COMPLAINT FOR DAMAGES

1. **ELDER ABUSE** (Pursuant to *Welfare and Institutions Code* §§15600, et. seq.)
2. **NEGLIGENCE**
3. **VIOLATION OF RESIDENTS RIGHTS** (Pursuant to *Health and Safety Code* §1430(b)
4. **WRONGFUL DEATH**

DEMAND FOR JURY TRIAL

Action Filed: November 21, 2023
Trial Date: None Set

COME NOW Plaintiffs and allege upon information and belief as follows:

THE PARTIES

1. Plaintiff MILDRED O. WATSON (herein referred to as "WATSON"), is an individual who at all relevant times herein alleged was a resident of the County of Los Angeles, State of California. WATSON died on March 28, 2023, and brings this action by and through her Successor-in-Interest and surviving daughter, Lisa Watson. Upon information and belief, during all

relevant times, WATSON was under a continuous disability which caused the inability to clearly communicate, and as such, was insane within the meaning of California Code of Civil Procedure §352.

2. Plaintiff, LISA WATSON, is an individual who at all relevant times herein alleged was a resident of the State of California and is the daughter of Decedent WATSON. She brings this action as the Successor-in-Interest of WATSON pursuant to California *Welfare and Institutions Code* §15657.3(d), as defined in §377.11 of the California *Code of Civil Procedure*, and succeeds to the Decedent's interest in the instant proceeding in that as the Decedent's daughter, she is the beneficiary of the Decedent's estate. She is therefore authorized to act on behalf of the Decedent as her Successor-in-Interest and has complied with the filing requirements pursuant to California *Code of Civil Procedure* §377.32. She also brings the Wrongful Death cause of action on her own behalf.

3. Defendant, CEDARS-SINAI MEDICAL CENTER (herein referred to as "CEDARS") at all relevant times was in the business of providing care as a licensed general acute care hospital located at 8700 Beverly Boulevard, Los Angeles, CA 90048, and was subject to the requirements of federal and state law governing the operation of general acute hospitals operating in the State of California.

4. Defendant, BEVERLY HILLS REHABILITATION CENTRE, LLC dba Beverly Hills Rehabilitation Centre (herein referred to as "BHRC") at all relevant times was in the business of providing long-term custodial care as a licensed 24-hour skilled nursing facility located at 580 San Vicente Boulevard, Los Angeles, CA 90048, and was subject to the requirements of federal and state law governing the operation of skilled nursing facilities operating in the State of California.

5. Plaintiff is informed and believes and therefore alleges that at all relevant times to this complaint, DOES 1 through 200 were licensed and unlicensed individuals and/or entities, and employees of CEDARS and BRHC who rendered care and services to WATSON and whose conduct caused the injuries, and damages alleged herein. It is alleged that at all relevant times hereto, CEDARS and BRHC were aware of the unfitness of DOES 1 through 200 to perform their

necessary job duties and yet employed these persons and/or entities with a conscious disregard of the health, rights, and safety of WATSON.

6. Plaintiff is ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 200, and for that reason have sued those Defendants by such fictitious names. Plaintiffs will seek leave from the court to amend this Complaint to identify said Defendants when their identities are ascertained.

7. CEDARS, by and through its corporate officers, directors, and managing agents, presently unknown to Plaintiffs and according to proof at the time of trial, ratified the misconduct alleged herein in that they were aware of the understaffing of their hospitals, in both number and training, the relationship between understaffing and sub-standard provision of care to residents and patients of their hospitals, including WATSON, the unfitness of licensed and unlicensed nursing personnel employed at their hospitals, the rash and truth of lawsuits against their hospitals, and their customary practice of not adequately responding to correct deficiencies issued by the State of California's Department of Public Health. That notwithstanding this knowledge, these officers, directors, and/or managing agents meaningfully disregarded the issues even though they knew the understaffing could, would, and did lead to unnecessary injuries to the residents and patients of their hospitals, including WATSON

8. BRHC, by and through its corporate officers, directors, and managing agents, presently unknown to Plaintiffs and according to proof at the time of trial, ratified the misconduct alleged herein in that they were aware of the understaffing of their skilled nursing facilities, in both number and training, the relationship between understaffing and sub-standard provision of care to residents and patients of their skilled nursing facilities, including WATSON, the unfitness of licensed and unlicensed nursing personnel employed at their skilled nursing facilities, the rash and truth of lawsuits against their skilled nursing facilities, and their customary practice of not adequately responding to correct deficiencies issued by the State of California's Department of Public Health. That notwithstanding this knowledge, these officers, directors, and/or managing agents meaningfully disregarded the issues even though they knew the understaffing could, would, and did lead to unnecessary injuries to the residents and patients of their skilled nursing facilities,

including WATSON.

9. Upon information and belief, it is alleged that the misconduct of CEDARS and BRHC, which led to the injuries to WATSON as alleged herein, was the direct result and product of the financial and control policies and practices dictated by and forced upon their hospitals and skilled nursing facilities by and through the corporate officers, directors and others presently unknown and according to proof at the time of trial.

10. Based upon information and belief, DOES 1 through 200 were members of the "Governing Body" of CEDARS and BRHC responsible for the creation and implementation of policies and procedures for the operation of their hospitals and skilled nursing facilities and for supervising the administration of the same pursuant to 42 C.F.R. §483.75 and 22 C.C.R. §§70035. That these members, as executives, managing agents and/or owners of CEDARS and BRHC, were focused on unlawfully increasing the earnings in the operation of CEDARS's and BRHC's businesses as opposed to providing the legally mandated minimum care to be provided to elder and/or infirm residents in their hospitals and skilled nursing facilities, including WATSON. That the focus of these individuals on their own attainment of profit played a part in the underfunding of the hospitals and skilled nursing facilities which led to CEDARS and BRHC violating state and federal rules, laws and regulations and led to the injuries to WATSON as alleged herein.

11. CEDARS and BRHC were the knowing agents and/or alter-egos of one another, and each of their officers, directors, and managing agents directed, approved and/or ratified all of the acts and omissions of each other, and their agents and employees, thereby making each of them vicariously liable for the acts and omissions of their co-defendants, their agents and employees, as is more fully alleged herein. Moreover, through their managing agents, CEDARS and BRHC and each of them, approved, authorized, ratified and/or conspired to commit all of the acts and omissions alleged herein.

12. At all relevant times, CEDARS, BRHC and DOES 1 – 200, and each of their tortious acts and omissions as alleged herein, were done in concert with one another in furtherance of their common design and agreement to accomplish a particular result, namely decreasing costs and increasing revenues from the operation of their hospitals and skilled nursing facilities by

underfunding and understaffing with an insufficient number of care personnel, many of whom were not trained and qualified to care for the patients and residents. Moreover, CEDARS and BRHC aided and abetted each other in accomplishing the acts and omissions alleged herein. (Restatement (Second) of Torts § 876 (1979)).

13. Defendants, CEDARS, BRHC and DOES 1 through 200 are sometimes collectively referred to herein as "DEFENDANTS".

FIRST CAUSE OF ACTION

ELDER ABUSE

[Against All Defendants, and DOES 1-200]

14. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 13 of this Complaint as though set forth at length below.

15. At all relevant times, WATSON was over the age of 65 years who resides in this state and who had physical or mental limitations that restricted her ability to carry out normal activities or to protect her rights, including, but not limited to, physical or developmental disabilities, and who was admitted as an inpatient to a 24-hour health facility pursuant to 1250.3 of the Health and Safety Code, and thus, was a "elder adult" as that term is defined in the *Welfare and Institutions Code* § 15610.23.

16. That DEFENDANTS were to provide "care or services" to dependent adults and the elderly, including WATSON and were to be "care custodians" of WATSON and in a trust and fiduciary relationship with WATSON.

17. That the DEFENDANTS "neglected" WATSON as that term is defined in *Welfare and Institutions Code* §15610.57 in that the DEFENDANTS themselves, as well as their employees, failed to exercise the degree of care that reasonable persons in a like position would exercise by denying or withholding goods or services necessary to meet the basic needs of WATSON as is more fully alleged.

18. As a result of the DEFENDANTS' wrongdoing, WATSON suffered physical harm, pain and mental suffering. The DEFENDANTS had advance knowledge of the unfitness of their employees and employed them with a conscious disregard of the rights or safety of others,

"authorized or ratified the wrongful conduct," and the DEFENDANTS' conduct was "on the part of an officer, director, or managing agent of the corporation." (Civ. Code, § 3294, subd. (b).

FACTS RELEVANT TO ALL CAUSES OF ACTION

19. From April 2022 through March 2023, MILDRED O. WATSON was repeatedly admitted to and under the care, custody, and control of Defendants CEDARS and BHRC. During each admission she was fully dependent upon facility staff for repositioning, toileting, feeding, hydration, and skin care, and Defendants each accepted a substantial caretaking relationship with her within the meaning of Welfare & Institutions Code § 15610.57.

20. On April 11 2022, WATSON was admitted to CEDARS after suffering an acute ST-elevation myocardial infarction. She was profoundly weak, contracted in both upper extremities, and almost entirely immobile. Despite these risk factors, CEDARS failed to initiate or document any pressure-injury prevention program—including two-hour repositioning, heel off-loading, or use of a pressure-relieving surface—as required by 42 C.F.R. § 482.13(c)(3) and 22 C.C.R. §§ 70211, 70214, 70217. Nutrition assessments dated April 12 and April 18 confirmed intact skin and normal weight, showing that her integument could and should have been maintained

21. Within twenty-four hours of arrival at BHRC, staff documented and ordered treatment for a new sacrococcygeal pressure injury, marking the first appearance of skin breakdown. This early ulcer developed because neither CEDARS nor BHRC had provided adequate turning, hygiene, or nutritional support during or immediately following the April 2022 hospitalization.

22. On May 15 2022, WATSON was readmitted to CEDARS for dehydration and hypernatremia. On May 16 2022, a hospital dietitian documented a Stage II sacral pressure injury—the first hospital-acquired ulcer at CEDARS. A wound-care nurse was not consulted until after this finding, and contemporaneous records contain no documentation of consistent two-hour repositioning or skin assessments. CEDARS therefore allowed preventable pressure-injury formation in violation of its custodial duties.

23. WATSON was discharged again to BHRC on May 20 2022 with ongoing wound-

care needs. Over the following months her sacral ulcer deteriorated to Stage III before eventually healing by August 31 2022. The deterioration and later recurrence of the ulcer demonstrate that neither facility maintained the required staffing or monitoring to protect her from recurrent skin breakdown.

24. On December 12 2022, WATSON was transferred once more to CEDARS for profound weight loss and dehydration. She weighed only 73 pounds (BMI ≈ 14) and met criteria for severe malnutrition, yet nursing documentation noted only "scar tissue" at the sacrum. This hospitalization established her extreme vulnerability and CEDARS' ongoing duty to provide intensive custodial care, including nutrition, hydration, and skin protection.

25. CEDARS discharged her on December 21 2022 back to BHRC, where intake notes described a Stage II sacrococcygeal ulcer (1.5 × 2 cm)—indicating breakdown had begun or worsened during the CEDARS stay.

26. When WATSON was again brought to CEDARS on January 2 2023 with heart failure, the same wound rapidly deteriorated. Within six days, by January 8 2023, it had progressed to an unstageable Stage III–IV ulcer with slough and eschar, despite CEDARS' knowledge of her immobility and high risk. A specialty mattress was ordered only after two days, and wound-care consults and treatments were delayed until the injury had already reached full-thickness depth.

27. On January 8 2023, CEDARS discharged WATSON back to BHRC with an unstageable sacral ulcer measuring approximately 2.8 × 2.6 cm. The surrounding tissue was discolored and necrotic, establishing that she had suffered a hospital-acquired Stage III–IV pressure ulcer during that CEDARS admission.

28. While under BHRC's care between January 8 and February 25 2023, the wound expanded dramatically. On January 18 2023, Beverly Hills Wound Care Specialists documented a lesion probing to muscle—a Stage IV ulcer. By February 21 2023, the wound measured 7 × 6 × 1 cm, confirming unchecked progression despite repeated warnings of inadequate staffing and off-loading.

29. On February 25 2023, WATSON was again transported to CEDARS in septic shock. She was diagnosed with bacteremia and urinary-tract infection; cultures from her sacral

wound grew Proteus mirabilis and Enterococcus faecalis. A right-side ischial deep-tissue injury was also identified—another hospital-acquired wound.

30. Between February 28 and March 28 2023, CEDARS surgeons performed serial debridements of the sacral ulcer down to and including bone. Despite these interventions, the wound continued to enlarge, reaching 12.1 × 8.9 × 1.7 cm by March 28 2023. Infectious-disease consultants repeatedly attributed her sepsis to this massive Stage IV pressure ulcer.

31. On March 28 2023, WATSON died of overwhelming sepsis. The autopsy confirmed that she "likely died of sepsis with an infected sacral pressure injury as the likely source of infection."

32. The chronology above demonstrates a continuing pattern of reckless custodial neglect by both Defendants. CEDARS permitted preventable pressure injuries to develop and progress during its April 2022, May 2022, January 2023, and February–March 2023 hospitalizations, while BHRC allowed those same wounds to worsen through chronic understaffing and lack of basic hygiene and repositioning. These acts and omissions were ratified by Defendants' managing agents, who were aware of the staffing shortages, repeated state deficiencies, and systemic disregard for dependent-adult safety but consciously failed to implement corrective measures. Such conduct constitutes reckless neglect under Welfare & Institutions Code § 15657 and malice, oppression, and fraud under Civil Code § 3294(b).

ALLEGATIONS AGAINST CEDARS

33. While under the care, custody, and control of CEDARS, WATSON was a fully dependent elder who required ongoing custodial assistance with all activities of daily living, including repositioning, hygiene, feeding, hydration, and skin care. By admitting her as an inpatient, CEDARS undertook a substantial caretaking and custodial relationship within the meaning of Welfare and Institutions Code §15610.57 and owed her a continuing duty to provide for her basic needs and protect her from neglect.

34. During each of WATSON's hospitalizations at CEDARS—including those beginning April 11, 2022, May 15, 2022, December 12, 2022, January 2, 2023, and February 25, 2023—CEDARS repeatedly failed to provide the most elementary custodial care required to

prevent injury to a dependent adult. These omissions included:

(a) failure to turn and reposition her at least every two hours;

(b) failure to provide and maintain an appropriate pressure-reducing surface;

(c) failure to monitor and document skin integrity;

(d) failure to maintain adequate nutrition and hydration; and

(e) failure to timely notify her physician or family of changes in her condition, including evidence of skin breakdown and infection.

35. As a result of these systemic failures, WATSON developed hospital-acquired pressure injuries on multiple occasions at CEDARS. The first documented ulcer occurred during her May 2022 admission, when staff noted a *Stage II sacral pressure injury* that had not been present on admission. The most severe occurred during her January 2–8, 2023 admission, when her previously stable Stage II ulcer rapidly deteriorated to an unstageable Stage III–IV ulcer covered with slough and eschar. Despite clear risk factors and visible deterioration, CEDARS delayed ordering a specialty mattress and wound-care consultation until after the injury had reached full-thickness depth.

36. CEDARS' nursing and administrative staff repeatedly ignored visible signs of worsening pressure injuries, failed to ensure adequate turning schedules, and allowed WATSON to remain in soiled linens for extended periods. The neglect was aggravated by chronic understaffing and the lack of adequately trained personnel despite CEDARS' knowledge that such conditions placed elderly inpatients like WATSON at grave risk.

37. During WATSON's final admission beginning February 25, 2023, she arrived in septic shock from an infected Stage IV sacral ulcer and soon developed an additional right ischial deep-tissue pressure injury while under CEDARS' care. Her sacral wound required multiple debridements down to bone, ultimately measuring 12.1 × 8.9 × 1.7 cm, and cultures confirmed infection with *Proteus mirabilis* and *Enterococcus faecalis*. Infectious disease specialists repeatedly identified the infected ulcer as the source of her bacteremia and sepsis.

38. The above-described injuries were not the result of isolated medical judgment but of reckless custodial neglect—a systemic failure by CEDARS to provide the basic life-sustaining

services required to protect an immobile, dependent elder from preventable injury. The conduct alleged constitutes "neglect" under Welfare & Institutions Code §15610.57, encompassing the failure to assist in personal hygiene, to provide food, clothing, or shelter, or to protect from health and safety hazards.

39. The reckless nature of this neglect is further demonstrated by CEDARS' chronic understaffing and cost-driven policies. Upon information and belief, CEDARS' officers, directors, and managing agents had actual knowledge of persistent shortages of qualified nursing personnel, the facility's repeated state deficiencies for patient-care failures, and internal reports identifying delayed repositioning and missed wound-prevention interventions, yet deliberately failed to allocate resources to correct these conditions in order to maximize financial performance.

40. CEDARS' managing agents further ratified and concealed the neglect of WATSON by failing to discipline or retrain staff, and by intentionally omitting required reports of hospital-acquired wounds to the California Department of Public Health, in violation of Health & Safety Code §1279.1. Their conscious disregard for patient safety and regulatory compliance constitutes oppression, fraud, and malice within the meaning of Civil Code §3294(b).

41. At all relevant times, CEDARS was required by Title 22 of the California Code of Regulations, including §§70211, 70214, and 70217, to ensure that its nursing service was organized, staffed, equipped, and supplied to meet the needs of patients such as WATSON. CEDARS' failure to meet these mandatory requirements directly caused her pressure injuries, infections, and resulting sepsis.

42. In addition, under 42 C.F.R. §482.13(c)(3), CEDARS was obligated to ensure that each patient has the right to be free from all forms of abuse and neglect, and under 42 C.F.R. §482.28(b)(2) to meet each patient's nutritional needs in accordance with recognized dietary practices. CEDARS violated these federal standards by failing to maintain adequate nutrition, hydration, and hygiene for WATSON, thereby causing the deterioration of her health and the progression of her pressure wounds.

43. The pattern of neglect at CEDARS was systemic and repeated. Its nursing staff failed to adhere to basic preventive measures despite written care plans, high-risk designations, and

obvious visual evidence of deterioration. These failures were not inadvertent mistakes but knowing disregard of a high probability of harm to elderly, immobilized patient.

44. As a direct and proximate result of CEDARS' reckless neglect and the ratification of that neglect by its managing agents, WATSON suffered extreme and prolonged pain, infection, and loss of dignity. She ultimately died on March 28, 2023, from sepsis caused by an infected Stage IV sacral pressure injury, as confirmed by autopsy

45. Plaintiffs are therefore entitled to all remedies available under the Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst. Code §15600 et seq.), including compensatory damages for WATSON's pre-death pain and suffering, attorney's fees and costs under §15657(a), and punitive damages under Civil Code §3294(b) due to the reckless, oppressive, and malicious conduct of CEDARS' officers, directors, and managing agents.

ALLEGATIONS AGAINST BRHC

46. BRHC neglected to provide medical care for WATSON's physical and mental health needs by failing to take all the necessary steps to properly care for her pressure injuries. BRHC failed to adequately inform WATSON's physician of the nature and extent of her injuries, and failed to adequately and completely carry out doctor's orders for their treatment and failed to adequately and appropriately document WATSON's plan of care.

47. BRHC's neglect of WATSON was reckless, oppressive, and malicious. Specifically, the individuals who cared for WATSON knew that taking the necessary precautions to prevent her from incurring avoidable pressure injuries, was critical to her health, well-being, and prognosis. By failing to address WATSON's patient care issues, BRHC knew that it was highly probable that she would suffer pressure injuries and they knowingly disregarded that risk.

48. WATSON's injuries would not have occurred had BRHC simply adhered to applicable rules, laws and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility.

49. Minimum staffing of personnel at BRHC was dependent by law upon the acuity (need) level of the patients of BRHC. BRHC residents' acuity level during the residency of WATSON in BRHC was so high that the required "minimum" staffing ratios exceeded the

applicable numeric minimum requirement of *Health and Safety Code* §1276.5 pursuant to the provisions of Title 22 C.C.R. §§72515(b) and 72329. During the residency of WATSON at BRHC, BRHC did not meet these minimum staffing requirements based on its residents' acuity levels, including WATSON. The "understaffing" and "lack of training" plan was designed as a mechanism to reduce labor costs and predictably and foreseeably resulted in the abuse and neglect of many residents and most specifically, WATSON.

50. In addition to their direct liability for the abuse and neglect of WATSON, BRHC ratified the mistreatment of WATSON. Knowing of WATSON's pressure injuries, and knowing of her neglect, BRHC, through its managing agents, failed to terminate, discipline, reprimand, or otherwise repudiate the acts and omissions of any employee due to or based upon the care, treatment, monitoring or supervision, or lack thereof, rendered to WATSON at BRHC.

51. While WATSON was in the care and custody of DEFENDANTS, DEFENDANTS recklessly neglected WATSON by breaching their duties of care owed to WATSON in failing to provide WATSON with the care and treatment to which she was entitled as an elder/dependent adult citizen of California. These failures included, but are not limited to: failing to prevent the development of infections and failing to report her change of condition and providing timely care, failing to develop and implement care plans, failing to assist with personal hygiene resulting in skin breakdown to WATSON's body and failing to provide staff with the knowledge, skills and competencies to care for residents with skin breakdown, and failing to prevent WATSON from experiencing pain and suffering.

52. The injuries suffered by WATSON were the result of the DEFENDANTS' illegal and reckless plan and effort to cut costs in the operation of their facilities and in other ways as alleged, to usurp the sole legal responsibility of the facility Administrator and governing body in the planning and operation of the facilities, and thereby in the undertaking assumed all of the responsibilities of the facilities, including the duty of due care and compliance with all legal standards applicable to general acute care hospitals and skilled nursing facilities. In doing so, the DEFENDANTS knew or should have known that their staff would be unable to comply with the standards for care set forth above, and other legal standards, all at the expense of their residents

such as WATSON. Integral to this plan was the practice and pattern of staffing with an insufficient number of service personnel, many of whom were not properly trained or qualified to care for the elders and/or dependent adults, whose lives were entrusted to them. The "understaffing" and "lack of training" plan was designed as a mechanism to reduce labor costs and predictably and foreseeably resulted in the abuse and neglect of many residents and patients and most specifically, WATSON.

53. At all times herein mentioned, the DEFENDANTS had actual and/or constructive knowledge of the unlawful conduct and business practices alleged herein, yet represented to the general public and WATSON that their facilities would provide care that met all applicable legal standards. Moreover, such unlawful business practices were mandated, directed, authorized, and/or personally ratified by the officers, directors and/or managing agents of the DEFENDANTS as set forth in paragraphs 7 and 8 and other management personnel whose names are presently unknown to WATSON and according to proof at the time of trial.

54. The DEFENDANTS, by and through the corporate officers, directors and managing agents set forth in paragraph 7 and 8 and other corporate officers and directors presently unknown to WATSON and according to proof at the time of trial, authorized and ratified the conduct of their co-defendants at the facility in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing, in both the number and training, the relationship between understaffing and sub-standard provision of care to the residents, including WATSON, and the DEFENDANTS practice of being issued deficiencies by the State of California's Department of Public Health. Furthermore, the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraphs 7 and 8 and others presently unknown to WATSON and according to proof at the time of trial, ratified the conduct of themselves and their co-defendants in that they were aware that such understaffing and deficiencies would lead to injury to the residents, including WATSON and insufficiency of financial budgets to lawfully operate their facilities. This ratification by the DEFENDANTS themselves is that ratification of the customary practice and usual performance of the facility as set forth in *Schanafelt v. Seaboard Finance Company*, (1951) 108 Cal.App.2d 420, 423-424.

55. Upon information and belief, the DEFENDANTS enacted, established, and implemented the financial plan and scheme which led to their facilities being understaffed, in both number and training, by way of imposition of financial limitations on their facilities in matters such as, and without limiting the generality of the foregoing, the setting of financial budgets which clearly did not allow for sufficient resources to be provided to WATSON. These choices and decisions were, and are, at the express direction of the management personnel including the corporate officers and directors enumerated in paragraphs 6 and 7 and others presently unknown to WATSON and according to proof at the time of trial, having power to bind as set forth in *McInerney v. United Railroads of San Francisco*, (1920) 50 Cal.App.538, 549; *Bertero v. National General Corporation* (1974) 13 Cal. 3d 43, 67.

56. The Corporate authorization and enactment of the DEFENDANTS, alleged in the preceding paragraphs, constituted the permission and consent of the facilities' misconduct by the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraphs 7 and 8 and others presently unknown to WATSON and according to proof at the time of trial, who had within their power the ability and discretion to mandate that they employ adequate staff to meet the needs of their patients, including WATSON, as required by applicable rules, laws and regulations governing the operation of skilled nursing facilities and general acute care hospitals in the State of California. The conduct constitutes ratification of the facility's misconduct by DEFENDANTS, which led to injury to WATSON as set forth in *O'Hara v. Western Seven Trees Corp*., (1977) 75 Cal.App.3d. 798, 11806 and *Kisesky v. Carpenters Trust for So. Cal* (1983) 144 Cal.App.3d 222, 235.

57. Plaintiffs have reason to believe that the focus and intent to carry out the above strategies to increase revenues and profit margins and to decrease costs caused widespread neglect of patients, including WATSON.

58. Due to the DEFENDANTS' direct conduct, as well as their practice of aiding and abetting the wrongful acts and omissions alleged herein, WATSON suffered infections and skin breakdown. These injuries were not the product of isolated failures but rather the result of prolonged neglect and abuse that arose out of four (4) calculated business practices by

DEFENDANTS: (1) understaffing; (2) relentless marketing and sales practices to increase resident and patient census despite knowledge of ongoing care deprivation; (3) ongoing practice of utilizing unqualified and untrained employees who, by law, were forbidden by law to administer nursing care to residents; and (4) ongoing practice of recruiting heavier care residents for which the facilities received higher reimbursements, despite the dangerous levels of staff who were incapable of meeting the needs of the existing resident population.

59. The injuries suffered by WATSON and the misconduct by the DEFENDANTS, and each of them, as alleged herein, resulted from the facilities' failure to provide basic custodial care to WATSON.

60. Thus, the specified acts of neglect alleged herein constitute neglect of "custodial" duties, not "professional" duties. No professional license is required to ensure that WATSON was cleaned, supervised, monitored, and provided with preventative measures, provided with proper nutrition, provided with proper hydration or otherwise not neglected. No professional license is required to ensure that DEFENDANTS' facilities not be underfunded or inadequately staffed. In sum, the acts and omissions alleged herein are acts or omissions related to "custodial" services, not "professional" services.

61. The violations of state and federal laws and regulations as specifically set forth herein as alleged against DEFENDANTS are not meant to limit the generality of the allegations contained herein, but are merely illustrative of the depth of the DEFENDANTS' malicious, oppressive, fraudulent and/or reckless conduct.

62. The state and federal regulations set forth hereinabove set the standard of care in the nursing home industry and help define the care duty to patients, and said regulations are appropriate in determining whether the facility's conduct amounted to physical abuse, neglect, recklessness, oppression, or malice. (*Norman v. Life Care Centers of America, Inc*. (2003) 107 Cal.App.4th 1233, and *Gregory v. Beverly Enterprises* (2000) 80 Cal.App. 4th 514).

63. As a direct result of the DEFENDANTS' conduct as alleged herein, DEFENDANTS allowed WATSON to suffer pain, indignity, humiliation, and injury, which were entirely preventable had DEFENDANTS provided enough sufficiently trained staff at their facilities to

provide WATSON with the amount of care, monitoring, and supervision that state and federal regulations required.

64. As a direct result of the DEFENDANTS' conduct as alleged herein, DEFENDANTS allowed WATSON to suffer pain, indignity, humiliation, and injury, which were entirely preventable had DEFENDANTS provided enough sufficiently trained staff at their facilities to provide WATSON with supervision, or lack thereof, rendered to WATSON.

65. WATSON suffered pain and suffering as a result of the DEFENDANTS' abuse and neglect as alleged herein. DEFENDANTS are responsible for that pain and suffering as well as all subsequent damages and expenses that were incurred in treating WATSON for the injuries she suffered at the hands of DEFENDANTS.

SECOND CAUSE OF ACTION

NEGLIGENCE

[Against All Defendants and DOES 1-200]

66. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 65 above as though set forth below.

67. CEDARS and BRHC owed statutory, regulatory, and common law duties of care to WATSON.

68. CEDARS and BRHC breached their statutory, regulatory, and common law duties of care to WATSON as more fully alleged above.

69. As the proximate result of CEDARS's and BRHC's breach of their statutory, regulatory, and common law duties of care to WATSON as more fully alleged above, WATSON suffered injuries in an amount and manner more specifically alleged above and according to proof at the time of trial.

THIRD CAUSE OF ACTION

VIOLATION OF RESIDENTS RIGHTS

[Against BRHC and DOES 1-100]

70. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 69 above as though set forth below.

71. *Health and Safety Code* §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 Patients' Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations [which incorporates *Health and Safety Code* §1599.1], or any other right provided for by federal or state law or regulation."

72. At all relevant times, BEVERLY HILLS REHABILITATION CENTRE, LLC was the licensee of the skilled nursing facility known as BEVERLY HILLS REHABILITATION CENTRE.

73. For the reasons set forth above and incorporated herein by reference, and for further reasons as will be presented at trial, BRHC failed to treat WATSON with respect, consideration, and full recognition of dignity in care of her personal needs as required by the Patient's Bill of Rights and other rights provided by federal or state law or regulation. BRHC violated these rights of WATSON, including, but not limited to:

a. Title 22 C.C.R. §72527(a)(3), which mandates that a resident shall be fully informed by a physician of her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services;

b. Title 22 C.C.R. §72527(a)(12), which mandates that a resident shall be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs;

c. Title 22 C.C.R. §72527(a)(25), which incorporates by reference the rights enumerated in *Health and Safety Code* §1599.1, which mandates that the "facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility." (*Health and Safety Code* §1599.1(a)); BRHC violated this statute by not providing sufficient staff in quantity and quality.

d. Title 22 C.C.R. §72527(a)(25), which incorporates by reference the rights enumerated in *Health and Safety Code* §1599.1, which mandates that "each resident shall show

evidence of good personal hygiene, and be given care to prevent bedsores." (*Health and Safety Code* §1599.1(b)); BRHC violated this statute by not providing WATSON with sufficient hygiene care to prevent the development of pressure injuries.

e. Title 22 C.C.R. §72527(a)(25), which incorporates by reference the rights enumerated in *Health and Safety Code* §1599.1, which mandates that the "facility shall be clean, sanitary, and in good repair at all times." (*Health and Safety Code* §1599.1(e)); BRHC violated this statute by not keeping its facility in good repair at all times.

f. Title 22 C.C.R. §72315, which mandates that a skilled nursing facility, such as BRHC, provide each patient with good nutrition and with necessary fluids for hydration; BRHC violated this statute by not providing WATSON with good nutrition and necessary fluids for hydration.

g. Title 22 C.C.R. §72315, which mandates that a skilled nursing facility provide each patient with care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include: 1) changing position of fast and chairfast patients with preventive skin care in accordance with the needs of the patient; (2) encouraging, assisting and training in self-care and activities of daily living; (3) maintaining proper body alignment and joint movement to prevent contractures and deformities; (4) using pressure-reducing devices where indicated; (5) providing care to maintain clean, dry skin free from feces and urine; (6) changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine; and (7) carrying out of physician's orders for treatment of decubitus injuries. The facility shall notify the physician, when a pressure injury first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b). BRHC violated this statute by failing to prevent WATSON from developing pressure injuries. ulcer all in violation of 42 CFR 483.25 (c) and 22 *California Code of Regulations* 72315(f).

74. While a resident of BRHC, WATSON's rights were repeatedly violated. WATSON developed and suffered from pressure injuries and infections. These injuries would not have occurred had BRHC simply adhered to the applicable rules, laws, and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility.

75. One of the purposes of *Health and Safety Code* §1430(b) is to protect against the type of injuries that WATSON sustained.

76. WATSON is a member of a group of persons that *Health and Safety Code* §1430(b) is intended to protect.

77. Among other remedies, *Health and Safety Code* §1430(b) authorizes the recovery of damages up to $500.00 per violation and mandatory attorneys' fees and costs. These remedies are cumulative to any other remedies provided by law.

FOURTH CAUSE OF ACTION

WRONGFUL DEATH

[Against all Defendants and DOES 1 – 200]

78. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 77 above as though set forth below:

79. LISA WATSON is the surviving heir of Decedent WATSON.

80. CEDARS and BHRC owed statutory and common law duties to WATSON as more fully set forth above.

81. CEDARS and BHRC failed to meet their statutory and common law duties to WATSON as more fully set forth above.

82. As a proximate result of negligence and "neglect" as that term is defined in *Welfare & Institutions Code* §15610.57 as more particularly alleged above perpetrated by CEDARS and BHRC and each of them. WATSON died on March 28, 2023.

83. Prior to the death of WATSON, LISA WATSON enjoyed the love, society, comfort and attention of WATSON.

84. As a proximate result of the negligent acts (both negligence and neglect as that term is defined in *Welfare & Institutions Code* §15610.57) of CEDARS and BHRC, LISA WATSON has sustained the loss of the society, comfort, attention, and love of WATSON in a sum according to proof at the time of trial and within the jurisdictional limits of this Court.

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 attorney's fees and costs pursuant to *Welfare and Institutions Code* §15657(a) (As to the First Cause of Action only);

4. For exemplary and punitive damages pursuant to *Civil Code* §3294 (As to the First Cause of Action only);

5. For attorney's fees and costs pursuant to *Health and Safety Code* §1430(b) (As to the Third Cause of Action only);

6. For costs of suit; and

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

DATED: October 24, 2025

PECK LAW GROUP, APC

By: 

Adam J. Peck, Esq.
Attorneys for Plaintiffs

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the action; my business address is 6454 Van Nuys Boulevard, Suite 150, Van Nuys, California 91401.

On October 24, 2025, I served the foregoing document described as set forth below on the interested parties in this action, addressed as follows:

Document Served: **FIRST AMENDED COMPLAINT FOR DAMAGES**

Person(s) Served: See Attached SERVICE / MAILING LIST

XX (ELECTRONIC TRANSMISSION) Only by e-mailing the document(s) to the person(s) below. This is permissible pursuant to Code of Civil Procedure §1010.6(e)(1). Therefore, the document(s) referenced above is/are served only by using electronic mail.

XX (STATE) I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

____ (FEDERAL) I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

EXECUTED at Van Nuys, California on October 24, 2025

Declarant, Leslie Koller

SERVICE / MAILING LIST

Mildred O. Watson, et al. v. Beverly Hills Rehabilitation Centre, LLC, et al.
LASC Case No. 23STCC28540

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