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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES – CENTRAL DISTRICT

MARY VIRGINIA SCHULLER, by and through her Successor-in-Interest, Jewel Dunn Schuller, JEWEL DUNN SCHULLER, individually, and JOHN SCHULLER, individually,

Plaintiffs,

vs.

B.V. GENERAL, INC. dba BUENA VENTURA POST ACUTE CARE CENTER; HEALTHCARE MANAGEMENT SERVICES, LLC; and DOES 1 through 250, inclusive,

Defendants.

JILL SCHULLER, an individual, JENNIFER HARRIS, an individual, and JOY PRUDHOLME, and individual,

Nominal Defendants.

CASE NO.: BC575543

COMPLAINT FOR DAMAGES AND INJUNTIVE RELIEF

1. **ELDER ABUSE/NEGLECT** (Pursuant to *Welfare and Institutions Code* §§15600, et. seq.)
2. **NEGLIGENCE**
3. **NEGLIGENT HIRING, SUPERVISION, & RETENTION (CACI 426)**
4. **VIOLATION OF RESIDENTS RIGHTS** (Pursuant to *Health and Safety Code* §1430(b))
5. **NEGLIGENT INFLICTION OF EMOTIOAN DISTRESS (CACI 1621)**
6. **WRONGFUL DEATH**

DEMAND FOR JURY TRIAL

03/13/2015

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COMES NOW Plaintiffs and alleges upon information and belief as follows:

THE PARTIES

1. Plaintiff MARY VIRGINIA SCHULLER (herein referred to as "SCHULLER"), deceased, is an individual who at all relevant times herein alleged was a resident of the County of Los Angeles, State of California. SCHULLER died on July 7, 2014 and brings this action by and through her Successor-in-Interest, Jewel Dunn Schuller. Upon information and belief, during all relevant times, SCHULLER 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 JEWEL DUNN SCHULLER is an individual who at all relevant times herein alleged was a resident of the County of Los Angeles, State of California and is the natural born daughter of decedent SCHULLER. She brings this action as the SCHULLER's Successor-in-Interest pursuant to *Welfare and Institutions Code* §15657.3(d), as defined in section 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 natural born 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 *Code of Civil Procedure* section 377.32. She also brings the Wrongful Death cause of action individually on her own behalf.

3. Plaintiff JOHN SCHULLER is an individual who at all relevant times herein alleged was a resident of the County of Los Angeles, State of California and is the natural born son and surviving lawful heir of decedent SCHULLER. He brings the Wrongful Death cause action individually on his own behalf.

4. Plaintiff JILL SCHULLER is an individual who at all relevant times herein alleged was a resident of the County of San Bernardino, State of California and is the natural born daughter and surviving lawful heir of decedent SCHULLER and is therefore, named herein as an indispensable party pursuant to California *Code of Civil Procedure* §382.

5. Plaintiff JENNIFER HARRIS is an individual who at all relevant times herein alleged was a resident of the State of New York and is the natural born daughter and surviving

lawful heir of decedent SCHULLER and is therefore, named herein as an indispensable party pursuant to California *Code of Civil Procedure* §382.

6. Plaintiff JOY PRUDHOLME is an individual who at all relevant times herein alleged was a resident of the County of Los Angeles, State of California and is the natural born daughter and surviving lawful heir of decedent SCHULLER and is therefore, named herein as an indispensable party pursuant to California *Code of Civil Procedure* §382.

7. Defendants B.V. GENERAL, INC. dba BUENA VENTURA POST ACUTE CARE CENTER and DOES 1 through 50, (herein referred to as "FACILITY") were at all relevant times in the business of providing long-term custodial care as a licensed 24-hour skilled nursing facility located at 1016 South Record Ave., Los Angeles, California 90023 and were subject to the requirements of federal and state law governing the operation of skilled nursing facilities in the State of California.

8. Defendants HEALTHCARE MANAGEMENT SERVICES, LLC, and DOES 51 through 100 (herein referred to as the "MANAGEMENT DEFENDANTS") were at all relevant times the FACILITY's owner, operators, parent company, and/or management company of the FACILITY and actively participated and controlled the business of the FACILITY and thus provided long-term professional and custodial care as 24-hour skilled nursing facility (hereinafter the FACILITY and the MANAGEMENT DEFENDANTS are collectively sometimes jointly referred to as "DEFENDANTS").

9. Plaintiff is informed and believes and therefore alleges that at all relevant times to this complaint, DOES 101 through 250 were licensed and unlicensed individuals and/or entities, and employees of the DEFENDANTS rendering care and services to SCHULLER and whose conduct caused the injuries, and damages alleged herein. It is alleged that at all relevant times hereto, Defendants were aware of the unfitness of DOES 101 through 250 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 SCHULLER.

10. Plaintiffs are ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 250, 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.

DIRECT AND VICARIOUS LIABILITY OF MANAGEMENT DEFENDANTS

11. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 10 of this Complaint as though set forth at length below.

12. The liability of the MANAGEMENT DEFENDANTS for the abuse of SCHULLER as alleged herein arises in part from their own direct misconduct as alleged herein as well as for the misconduct of others all according to proof at the time of trial.

13. The DEFENDANTS, by and through its corporate officers, directors, and managing agents, including Edward Keh - Owner, Lawrence Keh - Owner, Martha Keh - Owner, Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, and other presently unknown to Plaintiffs and according to proof at the time of trial, ratified the conduct of their co-defendants and the FACILITY in that they were aware of the understaffing of the FACILITY, in both number and training, the relationship between understaffing and sub-standard provision of care to residents of the FACILITY, including SCHULLER, the unfitness of licensed and unlicensed nursing personnel employed at the FACILITY, the rash and truth of lawsuits against its skilled nursing facilities including the FACILITY, and FACILITY'S 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 of the FACILITY, including SCHULLER.

14. Upon information and belief, it is alleged that the misconduct of the DEFENDANTS, which led to the injuries to SCHULLER as alleged herein, was the direct result and product of the financial and control policies and practices dictated by and forced upon the FACILITY by the MANAGEMENT DEFENDANTS by and through the corporate officers and directors enumerated in paragraph 10 of the complaint and others presently unknown and according to proof at time of trial.

15. Based upon information and belief, DOES 101 through 110 were members of the "Governing Body" of the FACILITY responsible for the creation and implementation of policies and procedures for the operation of the FACILITY and for supervising the administration of the FACILITY pursuant to 42 C.F.R. §483.75. That these members, as executives, managing agents and/or owners of the FACILITY, were focused on unlawfully increasing the earnings in the operation of DEFENDANTS' businesses as opposed to providing the legally mandated minimum care to be provided to elder and/or infirm residents in their skilled nursing facilities, including SCHULLER. That the focus of these individuals on their own attainment of profit played a part in the underfunding of the FACILITY which led to the FACILITY violating state and federal rules, laws and regulations and led to the injuries and to SCHULLER as alleged herein.

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

17. The DEFENDANTS 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 and the FACILITY, their agents and employees, as is more fully alleged herein. Moreover, through their managing agents, the FACILITY and each of them, agreed, approved, authorized, ratified and/or conspired to commit all of the acts and omissions alleged herein.

18. Plaintiffs further allege that at all times relevant hereto there was a such a unity of interest and ownership between DEFENDANTS such that the individual distinctions between them had ceased and that the facts as alleged herein are such that an adherence to the fiction of the separate existence of DEFENDANTS would, under the particular circumstances alleged herein, sanction a fraud and/or promote injustice. In particular, there is a sufficient unity of interest and ownership between the FACILITY and the MANAGEMENT DEFENDANTS, and each of them, such that the acts of one are for the benefit of and can be imputed to the acts of others. Without limitation, the unity of interest and relationship between these defendants is evidenced by: (a) MANAGEMENT DEFENDANTS either make or approve key decisions concerning the

FACILITY'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 benefit of the MANAGEMENT DEFENDANTS; (b) communications by the MANAGEMENT DEFENDANTS with the Department of Public Health with respect to licensing issues affecting the FACILITY, which communications, on information and belief, were undertaken at the direction and/or benefit of the MANAGEMENT DEFENDANTS; and (c) overlapping officers, directors, and employees between these DEFENDANTS and between them and other California skilled nursing facilities owned and or operated by the MANAGEMENT DEFENDANTS.

19. Furthermore, on information and belief, there would be an inequitable and unjust result if the FACILITY were treated as a separate entity from the MANAGEMENT DEFENDANTS, given that the latter defendants have diverted away funds obtained from the operation of the FACILITY to itself, thereby treating the FACILITY as a mere shell or sham and rendering it incapable of either meeting its high staffing needs or satisfying a judgment.

20. On information and belief, at all times herein mentioned, DEFENDANTS, and each of them, was 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. In particular, the FACILITY and the MANAGEMENT DEFENDANTS entered into a joint venture in which they had a joint interest in a common business- namely increasing their profits from the operation of the FACILITY while sacrificing staffing levels and thereby the health and safety of residents such as Plaintiff- with an understanding that profits and losses would be shared and with a right to joint control.

21. At all relevant times, the DEFENDANTS 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 the FACILITY by underfunding and understaffing the FACILITY with an insufficient number of care personnel, many of whom were not trained and qualified to care for the residents at the FACILITY. Moreover, the DEFENDANTS aided and abetted each

other in accomplishing the acts and omissions alleged herein. (Restatement (Second) of Torts § 876 (1979)).

22. At all relevant times, the MANAGEMENT DEFENDANTS and each of them, through their managers, directors, officers and other agents directly oversaw, managed and/or controlled all aspects of the operation and management of the FACILITY, including, but not limited to, budgeting, staffing, staff training, creating and implementing policies and procedures, accounts payable, accounts receivable, general accounting, cash management, pricing, reimbursement, capitalization, and profit and loss margins.

23. Plaintiffs are informed and believe and thereon allege that as the management company, owner, and operator of the FACILITY, MANAGEMENT DEFENDANTS contracted with the FACILITY to operate and manage the FACILITY.

24. Plaintiffs are informed and believe and thereon allege that MANAGEMENT DEFENDANTS had full management responsibility for the operation of the FACILITY which included, but was not limited to, the following:

a. Managing the operation of the FACILITY to ensure that the standards of patient care are maintained at least at prescribed levels of care;

b. Complying with all statutes and rules and regulations of governmental authorities applicable to the operation of the FACILITY;

c. Providing supervision for and direction to the Administrator of the FACILITY;

d. Establishing staffing schedules and personnel policies and procedures;

e. Hiring and firing all persons employed at the FACILITY;

f. Providing training to the staff, and;

g. Budgeting and accounting.

25. The MANAGEMENT DEFENDANTS were also given the authority and duty to manage the operation of the FACILITY on a day-to-day basis. The MANAGEMENT DEFENDANTS authority and duties under an agreement included but were not limited to, managing the operation of the FACILITY to ensure that the standards of the patient care were

maintained at least at prescribed levels of care, which operation shall include but not be limited to the following skilled nursing functions: dietary, nursing care, recreation and activities, maintenance of plant, housekeeping, laundry, administration, physical therapy, and occupational therapy.

26. The MANAGEMENT DEFENDANTS also established staffing schedules and personnel policies, including hiring and discharging all persons employed at the FACILITY including the highest levels of management at the facility. The MANAGEMENT DEFENDANTS also had the duty to provide all necessary training and continuing education to maintain the quality of the services provided at the FACILITY.

27. While SCHULLER was a resident at the FACILITY, pursuant to an agreement between DEFENDANTS, the MANAGEMENT DEFENDANTS directly controlled her care, which had the most direct and immediate impact on her health and safety. As alleged in more detail below, the MANAGEMENT DEFENDANTS and the nursing staff it hired, trained, supervised, and disciplined, withheld medical care from SCHULLER and failed to safeguard her health and safety resulting in a myriad of injuries, including death. The MANAGEMENT DEFENDANTS are responsible as a joint tortfeasor for the injuries sustained by SCHULLER while she was a resident at the FACILITY due to its intimate involvement with the day-to-day operation of the FACILITY for both the clinical and business disciplines.

28. The MANAGEMENT DEFENDANTS had full management responsibility for the operation of the FACILITY. The MANAGEMENT DEFENDANTS contracted with the FACILITY and agreed to assume and discharge all responsibilities related to the FACILITY and the License, which accrued during the management period in connection with properly operating and managing the facility in accordance with regulations and standards required of a facility so licensed. The breadth and scope of the MANAGEMENT DEFENDANTS' role in the operation of the FACILITY makes it a joint tortfeasor. Again, the MANAGEMENT DEFENDANTS had the following duties during SCHULLER's admission at the FACILITY: managing the operation of the FACILITY to ensure that the standards of patient care are maintained at least at prescribed levels of care; complying with all statutes and rules and regulations of governmental authorities

applicable to the operation of the FACILITY providing supervision for and direction to the Administrator of FACILITY; establishing staffing schedules and personnel policies and procedures; hiring and firing all persons employed at the FACILITY; providing training to the staff; budgeting and accounting; being in charge of the day-to-day operation, patient care and maintenance of the FACILITY. Accordingly, all the acts and omissions by the FACILITY nursing staff and management team are directly attributable to the MANAGEMENT DEFENDANTS.

FIRST CAUSE OF ACTION

ELDER ABUSE/NEGLECT

[By MARY VIRGINIA SCHULLER, by and through her Successor-in-Interest, Jewel Dunn Schuller, Against All Defendants and DOES 1-250]

29. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 28 of this Complaint as though set forth at length below.

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

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

32. That the DEFENDANTS "neglected" SCHULLER 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 SCHULLER as is more fully alleged herein.

33. As a result of the DEFENDANTS' wrongdoing, SCHULLER suffered physical harm, pain or mental suffering, and death.

34. The DEFENDANTS had advance knowledge of the unfitness of their employees and employed him or her 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).)

35. As alleged in more detail herein, while a resident at the FACILITY, the FACILITY failed to provide SCHULLER with basic medical care that she was entitled to as an elderly citizen of the State of California, including, but not limited to, the following: (1) Failed to provide Basic Life Support (BLS) to SCHULLER when she was found unresponsive on June 28, 2014; (2) Failed to provide adequate and appropriate assessment of SCHULLER's medical status; (3) Failed to provide timely medical treatment to SCHULLER; (4) Failed to identify and provide SCHULLER's resuscitation code status to FACILITY staff; and (5) Failed to initiate cardio-pulmonary resuscitation (CPR) – an emergency procedure performed in an effort to manually preserve intact brain function until further measures were taken to restore spontaneous blood circulation and breathing) immediately after the licensed staff realized SCHULLER was not breathing. All of these failures caused or contributed to her untimely death on July 7, 2014. SCHULLER's injuries would not have occurred had the DEFENDANTS simply adhered to applicable rules, laws and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility. In doing the acts alleged herein the DEFENDANTS routinely and systematically failed to provide SCHULLER with the medical and custodial care that she required.

36. On or around June 21, 2014, SCHULLER was admitted to the FACILITY for treatment and rehabilitation. Prior to admission, the FACILITY's Director of Marketing, Business Development, Adrienne Nussbaum, told SCHULLER's daughter Jewel that the FACILITY was a "five-star facility" and provides "excellent care." In reliance on this misrepresentation, Jewel admitted her mother to the FACILITY.

37. Upon admission, the FACILITY knew that SCHULLER was suffering from the following medical conditions: Hypertension, Muscular atrophy, Dysphagia, Altered Mental Status, Dementia, Alzheimer's disease, Cardiac Arrhythmia, Cardiac Pacemaker, Atrioventricular Block, Glaucoma, and Cerebrovascular accident with right sided hemiparesis (weakness on one side of the body).

38. The FACILITY also knew SCHULLER required total assistance with all aspects of daily living, including personal hygiene and toileting. The FACILITY was aware that SCHULLER was "totally dependent on the staff for bed mobility" due to her right sided

hemiparesis and in fact, were put on express notice by SCHULLER's daughter, Jewel when she told the FACILITY's Director of Nursing that she was concerned about her mother's ability to re-position herself in her bed. The Minimum Data Set (MDS), which is a standardized assessment and care planning tool utilized by nursing homes, also indicated that SCHULLER needed "extensive assist" from staff for "bed mobility."

39. On June 25, 2014, Jewel arrived at the FACILITY to visit her mother and found her lying in bed covered in her own feces and urine. Jewel complained to the FACILITY's administrator, Louie Jr. Rios and was promised that this would never happen again.

40. Nevertheless, on June 27, 2014, Jewel went to the FACILITY to visit her mother and yet again found her in a filthy condition, covered in her own feces and urine. Jewel immediately requested a meeting wherein the FACILITY's managing agent and Director of Nursing attended and promised Jewel that she will never see her mother like that again.

41. On June 28, 2014, at 6:45 p.m., SCHULLER's daughter Jewel went to the FACILITY to visit her mother. Upon entering her mother's room, she saw a female nurse employee of the FACILITY in the room leaning over her mother's head of bed. The bed was in a lowered-position and the lights were off. Jewel approached her mother and as she got closer to her, she noticed that SCHULLER's face was pressed down in her pillow and it appeared that she was not breathing. As Jewel became visibly upset and began yelling and screaming for help, the female nurse in the room did nothing. In conscious disregard of the health and safety of SCHULLER, the female nurse did not check SCHULLER's vital signs. In fact, she did not even bother to check to see if SCHULLER was breathing even though she did not see SCHULLER's chest rising.

42. At about 6:50 p.m., 911 was called and paramedics arrived at approximately 6:55 - 7:00 p.m. wherein CPR was finally initiated approximately 10-15 minutes after SCHULLER was found unresponsive. SCHULLER was emergently transported to White Memorial Medical Center.

43. On July 1, 2014, the Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS"), a federal governmental agency, conducted an unannounced visit to the FACILITY to investigate the June 28, 2014 incident. To be part of the

Medicare and Medicaid programs, nursing homes, such as the FACILITY, must meet certain requirements set by the United States Congress. CMS has entered into an agreement with state governments to do health and fire safety inspections of these nursing homes and investigate complaints about nursing home care. Substantiated allegations for violations of Federal and/or State laws or regulations receive deficiencies that cite the violations of noncompliance.

44. As a result of the inspection and investigation, CMS concluded that the FACILITY violated Title 42 C.F.R. §483.25, which provides that each resident of a nursing home, such as SCHULLER, must receive and the FACILITY must provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

45. CMS concluded that FACILITY failed to initiate cardio-pulmonary resuscitation (CPR) – an emergency procedure performed in an effort to manually preserve intact brain function until further measures were taken to restore spontaneous blood circulation and breathing) immediately after the licensed staff realized SCHULLER was not breathing on June 28, 2014, in accordance with the Physician Orders for Life-Sustaining Treatment (POLST – a form created for specific medical orders to be honored by health care workers during a medical crisis).[1]

46. CMS also concluded that the FACILITY failed to follow its own internal policy and procedure titled "Cardiopulmonary Resuscitation and Basic Life Support," which provided that residents, such as SCHULLER, must be checked for a pulse and respirations and in the event they are absent, an attempt must be made to arouse the resident, activate the emergency response team, initiate CPR, and call a code as designated by facility protocol. The policy and procedure also mandated that the FACILITY staff open the resident's airway, check breathing, administer rescue breaths, check for pulse, and give chest compressions.

47. CMS also concluded that the FACILITY failed to follow the American Heart Association Adult Basic Life Support for Healthcare Providers manual which provides that when a

[1] The POLST dated June 25, 2014 indicated that SCHULLER was a "FULL CODE" meaning CPR was to be initiated in case of an emergency.

resident in a nursing home, such as SCHULLER, is unresponsive with no breathing or no normal breathing, the first thing to do is to active the emergency response system. The second step is to check the pulse rate and if definite pulse rate and if there is no pulse, begin cycle of 30 compressions to 2 breaths and ensure chest rises that would indicate that the resident is receiving the oxygen. The manual also indicated that a bag-mask device is the most common method of delivering rescue breaths versus only administering oxygen through a regular mask.

48. CMS's investigation specifically revealed that the FACILITY failed in providing basic medical care in numerous ways, such as by not opening SCHULLER's airway, assessing for breathing, providing rescue breathing promptly using a bag-mask device, rechecking pulse every 2 minutes, and providing CPR when there was no pulse. As such, CMS concluded that failing to initiate CPR immediately after the licensed staff of the FACILITY realized SCHULLER was not breathing resulted in the lack of oxygen to SCHULLER thereby causing her permanent brain damage. CMS also concluded that the FACILITY would leave SCHULLER unattended in her own feces and urine for extended periods of time. CMS therefore issued the FACILITY a "G" deficiency.[2]

49. On July 7, 2014, SCHULLER passed away. The Los Angeles County Coroner's office determined that SCHULLER did not pass away due to natural causes, but rather, due to the "accident" on June 28, 2014 wherein the immediate cause of death was "suffocation" which caused SCHULLER to have no neurological activity due to anoxic brain injury.[3] The Coroner listed on the Death Certificate that SCHULLER was "positioned face down in [her] pillow."

50. DEFENDANTS knew that due to SCHULLER's physical condition, she was unable to provide for her own basic needs and was dependent on them for bed mobility. Nevertheless, not only was said care and services withheld from SCHULLER but she was not even provided with the minimum care mandated by federal and/or state nursing home laws even though

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[2] For isolated incidents, deficiencies range in severity from least to worst as follows: A, D, G, J. Thus, "G" deficiency is the second-worst deficiency a facility can be issued for "isolated" incidents, "J" being the worst deficiency.

[3] Anoxic brain damage is injury to the brain due to a lack of oxygen.

DEFENDANTS knew it was substantially certain that SCHULLER would suffer injury due to the failure to provide the care and services she needed and which was mandated by law. Moreover, the complete denial of medical care and nature DEFENDANTS' failure to provide such services and care demonstrates that DEFENDANTS acted with conscious disregard of the high probability that SCHULLER would suffer injury as a result of their failure to provide the care and services she needed which was mandated by law.

51. DEFENDANTS neglected to provide medical care for SCHULLER's physical and mental health needs by failing to take all the necessary steps to properly care for her. DEFENDANTS' neglect of SCHULLER was reckless, oppressive, and malicious. Specifically, the individuals who cared for SCHULLER knew that taking the necessary precautions to prevent her from suffering the injuries herein. By failing to address SCHULLER's patient care issues, DEFENDANTS knew that it was highly probable that she would suffer injury.

52. SCHULLER'S injuries would not have occurred had the DEFENDANTS simply adhered to applicable rules, laws and regulations, as well as the acceptable standards of practice governing the operation of a skilled nursing facility.

53. Additionally, in violation of Title 42 C.F.R. 483.20, the FACILITY failed to conduct initially and periodically comprehensive accurate, standardized, and reproducible assessments of each resident's functional capacity. The FACILITY also violated Title 42 C.F.R. Section 483.25 by failing to provide qualified nursing care to SCHULLER after she was found unresponsive on June 28, 2014.

54. That as a direct result of the chronic understaffing at DEFENDANTS' facilities in both number and training, DEFENDANTS failed to provide SCHULLER with proper care and failed to timely react to SCHULLER 's emergent conditions. SCHULLER suffered these injuries because the DEFENDANTS' staff simply did not have adequate time or the inclination to provide her with the required care and to document and address her emergent conditions. These injures were entirely preventable had there been sufficient staff on duty, in both number and competency, to actually implement the protections required by the DEFENDANTS' own Plan of Care and Physician Orders and assessments for SCHULLER . Unfortunately, there was not sufficient staff

on duty at the DEFENDANTS's facilities to implement the protections called for in SCHULLER's Plan of Care and Physician Orders and assessments for SCHULLER and she suffered the painful and preventable injuries alleged herein.

55. DEFENDANTS also failed to implement additional interventions to ensure that SCHULLER, who was noted to have right sided weakness and dementia, would not be positioned in her bed in a manner that would risk substantial injury.

56. That SCHULLER's unresponsive condition on June 28, 2014 went unnoticed and untreated by the FACILITY staff simply because they did not have adequate staff, or adequately trained and supervised staff, and because staff was unfit to provide nursing care to elderly and dependent residents.

57. Accordingly, decisions by the DEFENDANTS as to staffing and census were made irrespective of patient and resident population needs within the FACILITY, but rather, were determined by the financial needs of the company.

58. Minimum staffing of personnel at the FACILITY was dependent by law upon the acuity (need) level of the patients of the FACILITY. The FACILITY residents' acuity level during the residency of SCHULLER in FACILITY 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), 72329 and 42 C.F.R. §482.30. During the residency of SCHULLER in the FACILITY, FACILITY did not meet these minimum staffing requirements based on its residents' acuity levels, including SCHULLER.

59. DEFENDANTS represented to the general public and to SCHULLER and/or her family members, that DEFENDANTS were sufficiently staffed so as to be able to meet the needs of SCHULLER and that DEFENDANTS operated in compliance with all applicable rules, laws and regulations governing the operation of and skilled nursing facilities in the State of California. These representations were, and are, false.

60. In the operation of DEFENDANTS' facilities, DEFENDANTS and each of them, held themselves out to the general public via websites, brochures, admission agreements and other mechanisms presently unknown to Plaintiffs and according to proof at time of trial, to SCHULLER

and others similarly situated, that their skilled nursing facilities provided services which were in compliance with all applicable federal and state laws, rules and regulations governing the operation of a skilled nursing facility in the State of California. In the operation of DEFENDANTS' facilities, DEFENDANTS held itself out to SCHULLER and/or her family members that DEFENDANTS would be able to meet the needs of SCHULLER . These representations of the nature and quality of the nature of services to be provided were, in fact, false.

61. The DEFENDANTS owed a duty to SCHULLER , to provide her with the necessary custodial and professional care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, as required by 22 C.C.R. §72515(b). The FACILITY failed to meet this duty to SCHULLER thereby causing her injury.

62. The FACILITY owed a duty to SCHULLER to respect her right to be free from mental and physical abuse, which right is protected by 22 C.C.R. §72527(a)(9). The FACILITY failed to meet this duty to SCHULLER thereby causing her injury.

63. The FACILITY owed a duty to SCHULLER to notify a physician of any sudden and marked adverse change in signs, symptoms, or behavior exhibited by a patient, which right is protected by 22 C.C.R. §72311(3)(b). The FACILITY failed to meet this duty to SCHULLER thereby causing her injury.

64. The FACILITY owed a duty to SCHULLER to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity pursuant to 42 C.F.R. §483.20. The FACILITY failed to meet this duty to SCHULLER thereby causing her injury.

65. The DEFENDANTS owed a duty to SCHULLER to, and represented they would, provide services consistent with 42 U.S.C. § 1396r(b)(4)(C), to provide custodial and professional services to SCHULLER with sufficient budget and sufficient staffing to meet the needs of SCHULLER . The DEFENDANTS failed to meet this duty to SCHULLER thereby causing her injury.

66. The FACILITY owed a duty to, and represented they would, provide services to SCHULLER pursuant to 42 C.F.R. §483.30 and 22 C.C.R. §72329 to have sufficient number of personnel on duty at the facilities on a 24-hour basis to provide appropriate custodial and professional services to SCHULLER in accordance with SCHULLER resident care plans. The FACILITY did not provide these legally required services. The FACILITY failed to meet this duty to SCHULLER thereby causing her injury.

67. Title 22 C.C.R. §72311 and 42 C.F.R. §483.20 mandates that a skilled nursing facility, such as the FACILITY, shall provide, and the FACILITY promised to provide SCHULLER with, nursing service which shall include an individual, written plan of care which indicates the care to be given, and the objectives to be accomplished and which shall be updated as frequently as necessary, including when a resident undergoes a change in condition. The FACILITY represented that they would provide services consistent with the regulations yet failed to do so causing injury to SCHULLER.

68. Title 22 C.C.R. §72517 mandates that a skilled nursing facility, such as the FACILITY, have an ongoing education program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel which shall include: the prevention and control of infections, and preservation of resident dignity. The FACILITY represented that they would provide services consistent with the regulations yet failed to do so causing injury to SCHULLER.

69. Title 42 C.F.R. §483.13 mandates that a skilled nursing facility, such as the FACILITY, shall report "all alleged violations of involving mistreatment, neglect, or abuse, including injuries of an unknown source" to the administrator of the skilled nursing facility. In addition, a skilled nursing facility must have evidence that all alleged violations are thoroughly investigated and the results of all investigations must be reported to the administrator and to state officials and the department of public health. The FACILITY represented that they would provide services consistent with the regulations yet failed to do so causing injury to SCHULLER.

70. While SCHULLER was in the care and custody of DEFENDANTS, DEFENDANTS recklessly neglected SCHULLER by breaching their duties of care owed to

SCHULLER in failing to provide SCHULLER with the care and treatment to which she was entitled as a dependent citizen of California.

71. The injuries suffered by SCHULLER 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 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 SCHULLER. 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 "under staffing" and "lack of training" plan was designed as a mechanism as to reduce labor costs and predictably and foreseeably resulted in the abuse and neglect of many residents and patients and most specifically, SCHULLER.

72. 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 SCHULLER 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 paragraph 13 and other management personnel whose names are presently unknown to the SCHULLER and according to proof at time of trial.

73. The DEFENDANTS, by and through the corporate officers, directors and managing agents set forth in paragraph 13 and other corporate officers and directors presently unknown to SCHULLER and according to proof at time of trial, authorized and ratified the conduct of their co-defendants the FACILITY in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing, in both number and training, the relationship between understaffing and sub-standard provision of care to the residents, including SCHULLER , and the

DEFENDANTS practice of being issued deficiencies by the State of California's Department of Public Health in the State of California. Furthermore, the DEFENDANTS, by and through the corporate officers and directors enumerated in paragraph 13 and others presently unknown to SCHULLER and according to proof at 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 SCHULLER and insufficiency of financial budgets to lawfully operate their facilities. This ratification by the DEFENDANTS itself, is that ratification of the customary practice and usual performance of the FACILITY as set forth in *Schnafel v. Seaboard Finance Company,* (1951) 108 Cal.App.2d 420, 423-424.

74. 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 SCHULLER. These choices and decisions were, and are, at the express direction of the management personnel including the corporate officers and directors enumerated in paragraph 13 and others presently unknown to SCHULLER and according to proof at 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.

75. 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 paragraph 13 and others presently unknown to SCHULLER and according to proof at 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 SCHULLER , as required by applicable rules, laws and regulations governing the operation of skilled nursing facilities in the State of California. The conduct constitutes ratification of the facilities'' misconduct by DEFFENDANTS, which led to injury to SCHULLER 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.

76. 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 SCHULLER.

77. Due to the DEFENDANTS' direct conduct, as well as their practice of aiding and abetting the wrongful acts and omissions alleged herein, SCHULLER suffered injuries alleged herein. 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 nursing home received higher reimbursements, despite the dangerous levels of staff who were incapable of meeting the needs of the existing resident population.

78. The injuries suffered by SCHULLER and the misconduct by the DEFENDANTS, and each of them, as alleged herein, resulted from the FACILITY'S failure to provide basic custodial care to SCHULLER.

79. Thus, the specified acts of neglect alleged herein constitute neglect of "custodial" duties, not "professional" duties. No professional license is required to ensure that SCHULLER 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.

80. 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.

81. 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 facilities 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).

82. As a direct result of the DEFENDANTS conduct as alleged herein, DEFENDANTS allowed SCHULLER to suffer pain, indignity, humiliation, and injury, which were entirely preventable had DEFENDANTS provided enough sufficiently trained staff at their facilities to provide SCHULLER with the amount of care, monitoring, and supervision that state and federal regulations required.

83. In addition to their direct liability for the abuse and neglect of SCHULLER, the DEFENDANTS ratified the mistreatment of SCHULLER. Knowing of SCHULLER 'S injuries, and knowing of her neglect, DEFENDANTS 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 SCHULLER .

84. SCHULLER 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 SCHULLER for the injuries he suffered at the hands of DEFENDANTS.

SECOND CAUSE OF ACTION

NEGLIGENCE

[Against All Defendants and DOES 1-250]

85. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 84 above as though set forth below.

86. The DEFENDANTS owed statutory, regulatory, and common law duties of care to SCHULLER.

87. The DEFENDANTS breached their statutory, regulatory, and common law duties of care to SCHULLER as more fully alleged above.

88. As the proximate result of the DEFENDANTS breach of their statutory, regulatory, and common law duties of care to SCHULLER as more fully alleged above, SCHULLER suffered injuries in an amount and manner more specifically alleged above and according to proof at time of trial.

THIRD CAUSE OF ACTION

NEGLIGENT HIRING, SUPERVISION, and RETENTION (CACI 426)

[Against all Defendants and DOES 1-250]

89. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 88 as though set forth below.

90. As the direct result of said breaches by the DEFENDANTS, SCHULLER suffered injury in an amount and manner more specifically alleged above and according to proof at time of trial.

91. That the DEFENDANTS negligently hired, supervised and/or retained employees Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and other presently unknown to SCHULLER but will be sought via discovery.

92. That in fact Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to SCHULLER but will be sought via discovery, were unfit to perform their job duties and the DEFENDANTS knew, or should have known, that that they were unfit and that this unfitness created a risk to elder and infirm residents such as SCHULLER .

93. This knowledge on the part of the DEFENDANTS was, or should have been, acquired by the DEFENDANTS through various mechanisms including the pre-employment interview process, reference checks, probationary period job performance evaluations, other periodic job performance evaluations and/or disciplinary processes.

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94. The DEFENDANTS failed to properly and completely conduct a comprehensive pre-employment interview process and reference checks as to Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to SCHULLER but will be sought via discovery. Had the DEFENDANTS done so they would have discerned that these persons were unfit to perform their job duties in a licensed skilled nursing facility in California.

95. The DEFENDANTS failed to properly and completely conduct, and thereafter ignored the content of, probationary period job performance evaluations, other periodic job performance evaluations and/or disciplinary processes as to Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to SCHULLER but will be sought via discovery, and had the DEFENDANTS done so they would have discerned that these persons were unfit to perform their job duties in a licensed skilled nursing facility in California.

96. That as the result of the unfitness of Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to SCHULLER but will be sought via discovery, SCHULLER was injured in an amount and manner to be proven at time of trial.

97. That the DEFENDANTS negligence in hiring, supervising and/or retaining Vincent Hambright – Officer/Director, Rachelle Siron, Upar Choomoo, Louie Jr. Rios - Administrator, Xochitl Guzman - Director of Nursing, many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to SCHULLER but will be sought via discovery, caused SCHULLER injury in an amount and manner to be proven at time of trial.

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FOURTH CAUSE OF ACTION

VIOLATION OF RESIDENTS RIGHTS

[Against All Defendants and DOES 1-50]

98. Plaintiff hereby incorporates the allegations asserted in paragraphs 1 through 97 above as though set forth below.

99. *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."

100. At all relevant times, B.V. GENERAL, INC. was the licensee of skilled nursing facility known BUENA VENTURA POST ACUTE CARE CENTER.

101. For the reasons set forth above and incorporated herein by reference, and for further reasons as will be presented at trial, the FACILITY failed to treat SCHULLER 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. The FACILITY violated these rights of SCHULLER , including, but not limited to:

a. 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;

b. 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));

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 "each resident

shall show evidence of good personal hygiene, and be given care to prevent bedsores." (*Health and Safety Code* §1599.1(b));

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 the "facility shall be clean, sanitary, and in good repair at all times.." (*Health and Safety Code* §1599.1(e));

e. Title 22 C.C.R. §72517, which mandates that a skilled nursing facility, such as the FACILITY, have an ongoing education program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel which shall include: the prevention and control of infections, accident prevention and safety measures, and preservation of resident dignity;

f. Title 42 C.F.R. §483.25, which mandates that a skilled nursing facility, such as the FACILITY, must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care;

g. Title 42 C.F.R. §§483.20which provide that the a skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of its resident's functional capacity and maintain completed assessments of residents in their active medical record and use the results of the assessments to develop, review, and revise resident's comprehensive plan of care; develop a comprehensive care plan for residents that included measurable objectives and timetables to meet her medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment; and provide residents with services that met professional standard of quality.

h. Title 42 C.F.R. §483.25(h)(1) which provides that a skilled nursing facility must ensure that a resident has an environment free of accident hazards.

102. While a resident of the FACILITY, SCHULLER'S rights were repeatedly violated. These injuries would not have occurred had the FACILITY 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.

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

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

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

106. In addition, California *Health and Safety Code* § 1430(b) provides that DEFENDANTS "may be enjoined from permitting the violation to continue." Defendants have acted and continue to act in violation of the aforementioned basic rights of their residents. DEFENDANTS' residents will continue to suffer injuries as a result of these violations unless the Court takes injunctive action. Therefore, Plaintiff requests injunctive relief, including requiring DEFENDANTS to draft policies and procedures relating to their violations of Plaintiff's rights; annual in-service training of DEFENDANTS' staff on the subjects of the violations; a third party auditor to be paid at DEFENDANTS' expense to perform audits, review policies, procedures, and to perform annual audits to ensure the proper enforcement of these policies and procedures.

FIFTH CAUSE OF ACTION

NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

[Against all Defendants and DOES 1-250]

107. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 106 above as though set forth below.

108. JEWEL DUNN SCHULLER, individually, is the natural born daughter of SCHULLER.

109. At all relevant times, plaintiff JEWEL DUNN SCHULLER was present to personally observe the instances of neglect and the resulting injuries suffered by her mother. She

specifically witnessed the lack of care being provided to her mother first-hand as she observed her mother covered in her own feces and urine on many occasions. She was also present on June 28, 2014 when she observed that her mother's face was pressed down in the pillow wherein the FACILITY staff failed to initiate CPR, check SCHULLER's vital signs, or check to see if she was breathing, which ultimately led to SCHULLER's untimely death. As such, JEWEL DUNN SCHULLER was present and aware that her mother was suffering.

110. As a result of personally witnessing the aforementioned neglect, JEWEL DUNN SCHULLER has suffered serious emotional distress.

111. That, the FACILITY's aforementioned conduct was a substantial factor in causing JEWEL DUNN SCHULLER serious emotional distress.

SIXTH CAUSE OF ACTION

WRONGFUL DEATH

[Against all Defendants and DOES 1-250]

112. Plaintiffs hereby incorporate the allegations asserted in paragraphs 1 through 111 above as though set forth below.

113. JEWEL DUNN SCHULLER, individually, JOHN SCHULLER, individually, and the nominal defendants are the surviving heirs of decedent SCHULLER.

114. DEFENDANTS owned statutory and common law duties to SCHULLER as more fully set forth above.

115. That the DEFENDANTS failed to meet their statutory and common law duties to SCHULLER as more fully set forth above.

116. 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 all of the DEFENDANTS, and each of them, SCHULLER died on July 7, 2014. Specifically, as a proximate result of the conduct of DEFENDANTS as alleged herein, SCHULLER's airway was not opened and no CPR was initiated upon discovering her unresponsive on June 28, 2014 which caused her death as confirmed by the Los Angeles County Coroner who labeled her death due to

an "accident" as a result of "suffocation."

117. Prior to the death of SCHULLER, JEWEL DUNN SCHULLER, individually, JOHN SCHULLER, individually, and the nominal defendants enjoyed the love, society, comfort, and attention of SCHULLER.

118. As a proximate result of the negligent acts (both negligence and neglect as that term is defined in *Welfare & Institutions Code* §15610.57) of all of the DEFENDANTS as alleged herein, JEWEL DUNN SCHULLER, individually, JOHN SCHULLER, individually, and the nominal defendants have sustained loss of the society, comfort, attention, and love of SCHULLER in a sum according to proof at 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 Fourth Cause of Action only);
6. Injunctive relief;
7. For costs of suit; and
8. For such other and further relief as the Court deems just and proper.

DATED: March 12 2015

GHARIBIAN LAW, APC / KEOSIAN | BERBERIAN LLP

By: _____

Art Gharibian, Esq.
Richard Berberian, Esq.
Attorneys for Plaintiffs

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
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FOR COURT USE ONLY

FILED
Superior Court of California
County of Los Angeles

MAR 13 2015

Sherri R. Carter, Executive Officer/Clerk
By Myrna Beltran Deputy
Myrna Beltran

SUPERIOR COURT OF CALIFORNIA, COUNTY OF Los Angeles
STREET ADDRESS: 111 North Hill Street
MAILING ADDRESS: 111 North Hill Street
CITY AND ZIP CODE: Los Angeles, 90012
BRANCH NAME: Central District

CASE NAME:
Schuller, et. al. vs. Buena Ventura Post Acute Care Center

CIVIL CASE COVER SHEET	Complex Case Designation	CASE NUMBER:
☑ Unlimited (Amount demanded exceeds $25,000) ☐ Limited (Amount demanded is $25,000 or less)	☐ Counter ☐ Joinder Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)	BC575543 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)*: One
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.)*

Date: March 13, 2015
Art Gharibian, Esq.
(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.

Form Adopted for Mandatory Use
Judicial Council of California
CM-010 [Rev. July 1, 2007]

CIVIL CASE COVER SHEET

Cal. Rules of Court, rules 2.30, 3.220, 3.400–3.403, 3.740;
Cal. Standards of Judicial Administration, std. 3.10
www.courtinfo.ca.gov

INSTRUCTIONS ON HOW TO COMPLETE THE COVER SHEET

To Plaintiffs and Others Filing First Papers. If you are filing a first paper (for example, a complaint) in a civil case, you **must** complete and file, along with your first paper, the *Civil Case Cover Sheet* contained on page 1. This information will be used to compile statistics about the types and numbers of cases filed. You must complete items 1 through 6 on the sheet. In item 1, you must check **one** box for the case type that best describes the case. If the case fits both a general and a more specific type of case listed in item 1, check the more specific one. If the case has multiple causes of action, check the box that best indicates the **primary** cause of action. To assist you in completing the sheet, examples of the cases that belong under each case type in item 1 are provided below. A cover sheet must be filed only with your initial paper. Failure to file a cover sheet with the first paper filed in a civil case may subject a party, its counsel, or both to sanctions under rules 2.30 and 3.220 of the California Rules of Court.

To Parties in Rule 3.740 Collections Cases. A "collections case" under rule 3.740 is defined as an action for recovery of money owed in a sum stated to be certain that is not more than $25,000, exclusive of interest and attorney's fees, arising from a transaction in which property, services, or money was acquired on credit. A collections case does not include an action seeking the following: (1) tort damages, (2) punitive damages, (3) recovery of real property, (4) recovery of personal property, or (5) a prejudgment writ of attachment. The identification of a case as a rule 3.740 collections case on this form means that it will be exempt from the general time-for-service requirements and case management rules, unless a defendant files a responsive pleading. A rule 3.740 collections case will be subject to the requirements for service and obtaining a judgment in rule 3.740.

To Parties in Complex Cases. In complex cases only, parties must also use the *Civil Case Cover Sheet* to designate whether the case is complex. If a plaintiff believes the case is complex under rule 3.400 of the California Rules of Court, this must be indicated by completing the appropriate boxes in items 1 and 2. If a plaintiff designates a case as complex, the cover sheet must be served with the complaint on all parties to the action. A defendant may file and serve no later than the time of its first appearance a joinder in the plaintiff's designation, a counter-designation that the case is not complex, or, if the plaintiff has made no designation, a designation that the case is complex.

CASE TYPES AND EXAMPLES

Auto Tort
- Auto (22)–Personal Injury/Property Damage/Wrongful Death
- Uninsured Motorist (46) *(if the case involves an uninsured motorist claim subject to arbitration, check this item instead of Auto)*

Other PI/PD/WD (Personal Injury/ Property Damage/Wrongful Death) Tort
- Asbestos (04)
  - Asbestos Property Damage
  - Asbestos Personal Injury/ Wrongful Death
- Product Liability *(not asbestos or toxic/environmental)* (24)
- Medical Malpractice (45)
  - Medical Malpractice–Physicians & Surgeons
  - Other Professional Health Care Malpractice
- Other PI/PD/WD (23)
  - Premises Liability (e.g., slip and fall)
  - Intentional Bodily Injury/PD/WD (e.g., assault, vandalism)
  - Intentional Infliction of Emotional Distress
  - Negligent Infliction of Emotional Distress
  - Other PI/PD/WD

Non-PI/PD/WD (Other) Tort
- Business Tort/Unfair Business Practice (07)
- Civil Rights (e.g., discrimination, false arrest) *(not civil harassment)* (08)
- Defamation (e.g., slander, libel) (13)
- Fraud (16)
- Intellectual Property (19)
- Professional Negligence (25)
  - Legal Malpractice
  - Other Professional Malpractice *(not medical or legal)*
- Other Non-PI/PD/WD Tort (35)

Employment
- Wrongful Termination (36)
- Other Employment (15)

Contract
- Breach of Contract/Warranty (06)
  - Breach of Rental/Lease Contract *(not unlawful detainer or wrongful eviction)*
  - Contract/Warranty Breach–Seller Plaintiff *(not fraud or negligence)*
  - Negligent Breach of Contract/ Warranty
  - Other Breach of Contract/Warranty
- Collections (e.g., money owed, open book accounts) (09)
  - Collection Case–Seller Plaintiff
  - Other Promissory Note/Collections Case
- Insurance Coverage *(not provisionally complex)* (18)
  - Auto Subrogation
  - Other Coverage
- Other Contract (37)
  - Contractual Fraud
  - Other Contract Dispute

Real Property
- Eminent Domain/Inverse Condemnation (14)
- Wrongful Eviction (33)
- Other Real Property (e.g., quiet title) (26)
  - Writ of Possession of Real Property
  - Mortgage Foreclosure
  - Quiet Title
  - Other Real Property *(not eminent domain, landlord/tenant, or foreclosure)*

Unlawful Detainer
- Commercial (31)
- Residential (32)
- Drugs (38) *(if the case involves illegal drugs, check this item; otherwise, report as Commercial or Residential)*

Judicial Review
- Asset Forfeiture (05)
- Petition Re: Arbitration Award (11)
- Writ of Mandate (02)
  - Writ–Administrative Mandamus
  - Writ–Mandamus on Limited Court Case Matter
  - Writ–Other Limited Court Case Review
- Other Judicial Review (39)
  - Review of Health Officer Order
  - Notice of Appeal–Labor Commissioner Appeals

Provisionally Complex Civil Litigation (Cal. Rules of Court Rules 3.400–3.403)
- Antitrust/Trade Regulation (03)
- Construction Defect (10)
- Claims Involving Mass Tort (40)
- Securities Litigation (28)
- Environmental/Toxic Tort (30)
- Insurance Coverage Claims *(arising from provisionally complex case type listed above)* (41)

Enforcement of Judgment
- Enforcement of Judgment (20)
  - Abstract of Judgment (Out of County)
  - Confession of Judgment *(non-domestic relations)*
  - Sister State Judgment
  - Administrative Agency Award *(not unpaid taxes)*
  - Petition/Certification of Entry of Judgment on Unpaid Taxes
  - Other Enforcement of Judgment Case

Miscellaneous Civil Complaint
- RICO (27)
- Other Complaint *(not specified above)* (42)
  - Declaratory Relief Only
  - Injunctive Relief Only *(non-harassment)*
  - Mechanics Lien
  - Other Commercial Complaint Case *(non-tort/non-complex)*
  - Other Civil Complaint *(non-tort/non-complex)*

Miscellaneous Civil Petition
- Partnership and Corporate Governance (21)
- Other Petition *(not specified above)* (43)
  - Civil Harassment
  - Workplace Violence
  - Elder/Dependent Adult Abuse
  - Election Contest
  - Petition for Name Change
  - Petition for Relief From Late Claim
  - Other Civil Petition

SHORT TITLE:	CASE NUMBER
Schuller, et. al. vs. Buena Ventura Post Acute Care Center	BC575543

CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION (CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)

This form is required pursuant to Local Rule 2.0 in all new civil case filings in the Los Angeles Superior Court.

Item I. Check the types of hearing and fill in the estimated length of hearing expected for this case:

JURY TRIAL? ☑ YES CLASS ACTION? ☐ YES LIMITED CASE? ☐ YES TIME ESTIMATED FOR TRIAL 7-10 ☐ HOURS/ ☑ DAYS

Item II. Indicate the correct district and courthouse location (4 steps – If you checked "Limited Case", skip to Item III, Pg. 4):

Step 1: After first completing the Civil Case Cover Sheet form, find the main Civil Case Cover Sheet heading for your case in the left margin below, and, to the right in Column **A**, the Civil Case Cover Sheet case type you selected.

Step 2: Check **one** Superior Court type of action in Column **B** below which best describes the nature of this case.

Step 3: In Column **C**, circle the reason for the court location choice that applies to the type of action you have checked. For any exception to the court location, see Local Rule 2.0.

Applicable Reasons for Choosing Courthouse Location (see Column C below)

1. Class actions must be filed in the Stanley Mosk Courthouse, central district.
2. May be filed in central (other county, or no bodily injury/property damage).
3. Location where cause of action arose.
4. Location where bodily injury, death or damage occurred.
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside.
10. Location of Labor Commissioner Office

Step 4: Fill in the information requested on page 4 in Item III; complete Item IV. Sign the declaration.

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Auto Tort	Auto (22)	☐ A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1., 2., 4.
	Uninsured Motorist (46)	☐ A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1., 2., 4.
Other Personal Injury/ Property Damage/ Wrongful Death Tort	Asbestos (04)	☐ A6070 Asbestos Property Damage ☐ A7221 Asbestos - Personal Injury/Wrongful Death	2. 2.
	Product Liability (24)	☐ A7260 Product Liability (not asbestos or toxic/environmental)	1., 2., 3., 4., 8.
	Medical Malpractice (45)	☐ A7210 Medical Malpractice - Physicians & Surgeons ☐ A7240 Other Professional Health Care Malpractice	1., 4. 1., 4.
	Other Personal Injury Property Damage Wrongful Death (23)	☐ A7250 Premises Liability (e.g., slip and fall) ☐ A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.) ☐ A7270 Intentional Infliction of Emotional Distress ☐ A7220 Other Personal Injury/Property Damage/Wrongful Death	1., 4. 1., 4. 1., 3. 1., 4.

SHORT TITLE: Schuller, et. al. vs. Buena Ventura Post Acute Care Center	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Non-Personal Injury/ Property Damage/ Wrongful Death Tort	Business Tort (07)	☐ A6029 Other Commercial/Business Tort (not fraud/breach of contract)	1., 3.
	Civil Rights (08)	☐ A6005 Civil Rights/Discrimination	1., 2., 3.
	Defamation (13)	☐ A6010 Defamation (slander/libel)	1., 2., 3.
	Fraud (16)	☐ A6013 Fraud (no contract)	1., 2., 3.
	Professional Negligence (25)	☐ A6017 Legal Malpractice ☐ A6050 Other Professional Malpractice (not medical or legal)	1., 2., 3. 1., 2., 3.
	Other (35)	☐ A6025 Other Non-Personal Injury/Property Damage tort	2.,3.
Employment	Wrongful Termination (36)	☐ A6037 Wrongful Termination	1., 2., 3.
	Other Employment (15)	☐ A6024 Other Employment Complaint Case ☐ A6109 Labor Commissioner Appeals	1., 2., 3. 10.
Contract	Breach of Contract/ Warranty (06) (not insurance)	☐ A6004 Breach of Rental/Lease Contract (not unlawful detainer or wrongful eviction) ☐ A6008 Contract/Warranty Breach -Seller Plaintiff (no fraud/negligence) ☐ A6019 Negligent Breach of Contract/Warranty (no fraud) ☐ A6028 Other Breach of Contract/Warranty (not fraud or negligence)	2., 5. 2., 5. 1., 2., 5. 1., 2., 5.
	Collections (09)	☐ A6002 Collections Case-Seller Plaintiff ☐ A6012 Other Promissory Note/Collections Case	2., 5., 6. 2., 5.
	Insurance Coverage (18)	☐ A6015 Insurance Coverage (not complex)	1., 2., 5., 8.
	Other Contract (37)	☐ A6009 Contractual Fraud ☐ A6031 Tortious Interference ☐ A6027 Other Contract Dispute(not breach/insurance/fraud/negligence)	1., 2., 3., 5. 1., 2., 3., 5. 1., 2., 3., 8.
Real Property	Eminent Domain/Inverse Condemnation (14)	☐ A7300 Eminent Domain/Condemnation Number of parcels_____	2.
	Wrongful Eviction (33)	☐ A6023 Wrongful Eviction Case	2., 6.
	Other Real Property (26)	☐ A6018 Mortgage Foreclosure ☐ A6032 Quiet Title ☐ A6060 Other Real Property (not eminent domain, landlord/tenant, foreclosure)	2., 6. 2., 6. 2., 6.
Unlawful Detainer	Unlawful Detainer-Commercial (31)	☐ A6021 Unlawful Detainer-Commercial (not drugs or wrongful eviction)	2., 6.
	Unlawful Detainer-Residential (32)	☐ A6020 Unlawful Detainer-Residential (not drugs or wrongful eviction)	2., 6.
	Unlawful Detainer-Post-Foreclosure (34)	☐ A6020F Unlawful Detainer-Post-Foreclosure	2., 6.
	Unlawful Detainer-Drugs (38)	☐ A6022 Unlawful Detainer-Drugs	2., 6.

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	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Judicial Review	Asset Forfeiture (05)	☐ A6108 Asset Forfeiture Case	2., 6.
	Petition re Arbitration (11)	☐ A6115 Petition to Compel/Confirm/Vacate Arbitration	2., 5.
	Writ of Mandate (02)	☐ A6151 Writ - Administrative Mandamus ☐ A6152 Writ - Mandamus on Limited Court Case Matter ☐ A6153 Writ - Other Limited Court Case Review	2., 8. 2. 2.
	Other Judicial Review (39)	☐ A6150 Other Writ /Judicial Review	2., 8.
Provisionally Complex Litigation	Antitrust/Trade Regulation (03)	☐ A6003 Antitrust/Trade Regulation	1., 2., 8.
	Construction Defect (10)	☐ A6007 Construction Defect	1., 2., 3.
	Claims Involving Mass Tort (40)	☐ A6006 Claims Involving Mass Tort	1., 2., 8.
	Securities Litigation (28)	☐ A6035 Securities Litigation Case	1., 2., 8.
	Toxic Tort Environmental (30)	☐ A6036 Toxic Tort/Environmental	1., 2., 3., 8.
	Insurance Coverage Claims from Complex Case (41)	☐ A6014 Insurance Coverage/Subrogation (complex case only)	1., 2., 5., 8.
Enforcement of Judgment	Enforcement of Judgment (20)	☐ A6141 Sister State Judgment ☐ A6160 Abstract of Judgment ☐ A6107 Confession of Judgment (non-domestic relations) ☐ A6140 Administrative Agency Award (not unpaid taxes) ☐ A6114 Petition/Certificate for Entry of Judgment on Unpaid Tax ☐ A6112 Other Enforcement of Judgment Case	2., 9. 2., 6. 2., 9. 2., 8. 2., 8. 2., 8., 9.
Miscellaneous Civil Complaints	RICO (27)	☐ A6033 Racketeering (RICO) Case	1., 2., 8.
	Other Complaints (Not Specified Above) (42)	☐ A6030 Declaratory Relief Only ☐ A6040 Injunctive Relief Only (not domestic/harassment) ☐ A6011 Other Commercial Complaint Case (non-tort/non-complex) ☐ A6000 Other Civil Complaint (non-tort/non-complex)	1., 2., 8. 2., 8. 1., 2., 8. 1., 2., 8.
Miscellaneous Civil Petitions	Partnership Corporation Governance (21)	☐ A6113 Partnership and Corporate Governance Case	2., 8.
	Other Petitions (Not Specified Above) (43)	☐ A6121 Civil Harassment ☐ A6123 Workplace Harassment ☑ A6124 Elder/Dependent Adult Abuse Case ☐ A6190 Election Contest ☐ A6110 Petition for Change of Name ☐ A6170 Petition for Relief from Late Claim Law ☐ A6100 Other Civil Petition	2., 3., 9. 2., 3., 9. 2.(3), 9. 2. 2., 7. 2., 3., 4., 8. 2., 9.

SHORT TITLE: Schuller, et. al. vs. Buena Ventura Post Acute Care Center	CASE NUMBER

Item III. Statement of Location: Enter the address of the accident, party's residence or place of business, performance, or other circumstance indicated in Item II., Step 3 on Page 1, as the proper reason for filing in the court location you selected.

REASON: Check the appropriate boxes for the numbers shown under Column C for the type of action that you have selected for this case. ☐1. ☐2. ☑3. ☐4. ☐5. ☐6. ☐7. ☐8. ☐9. ☐10.			ADDRESS: 1016 S. Record Ave.
CITY: Los Angeles	STATE: CA	ZIP CODE: 90023	

Item IV. *Declaration of Assignment*: I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that the above-entitled matter is properly filed for assignment to the Stanley Mosk courthouse in the Central District of the Superior Court of California, County of Los Angeles [Code Civ. Proc., § 392 et seq., and Local Rule 2.0, subds. (b), (c) and (d)].

Dated: March 13, 2015

(SIGNATURE OF ATTORNEY/FILING PARTY)

PLEASE HAVE THE FOLLOWING ITEMS COMPLETED AND READY TO BE FILED IN ORDER TO PROPERLY COMMENCE YOUR NEW COURT CASE:

1. Original Complaint or Petition.
2. If filing a Complaint, a completed Summons form for issuance by the Clerk.
3. Civil Case Cover Sheet, Judicial Council form CM-010.
4. Civil Case Cover Sheet Addendum and Statement of Location form, LACIV 109, LASC Approved 03-04 (Rev. 03/11).
5. Payment in full of the filing fee, unless fees have been waived.
6. A signed order appointing the Guardian ad Litem, Judicial Council form CIV-010, if the plaintiff or petitioner is a minor under 18 years of age will be required by Court in order to issue a summons.
7. Additional copies of documents to be conformed by the Clerk. Copies of the cover sheet and this addendum must be served along with the summons and complaint, or other initiating pleading in the case.