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Attorneys for Plaintiff, ADAM PLARES, SR., Individually and as Successor-in-Interest to the Estate of Vera Plares

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

ADAM PLARES, SR., Individually and as Successor-in-Interest to the Estate of Vera Plares,

Plaintiff,

-vs.-

COVENANT CARE CALIFORNIA, LLC. DBA MISSION SKILLED NURSING & SUB-ACUTE CENTER, COVENANT CARE MISSION, INC., SUNCREST HOSPICE SAN JOSE LLC, DBA SUNCREST HOSPICE, and DOES 1 through 60, inclusive,

Defendants.

Case No. 24CV440133

COMPLAINT FOR WRONGFUL DEATH AND SURVIVIAL DAMAGES

1. **Wrongful Death;**
2. **Elder Abuse;**
3. **Violation of Health & Safety Code § 1430; and**
4. **Survival Action**

DEMAND FOR JURY TRIAL

PLAINTIFF Adam Plares, Sr. (hereinafter "Plares Sr." or PLAINTIFF) individually and as Successor-In-Interest to the Estate of Vera Plares, hereby files this instant complaint against DEFENDANTS COVENANT CARE CALIFORNIA, LLC. DBA MISSION SKILLED NURSING & SUB-ACUTE CENTER, COVENANT CARE MISSION, INC., and SUNCREST HOSPICE SAN JOSE

LLC, DBA SUNCREST HOSPICE (collectively hereinafter "DEFENDANTS") and DOES 1-60, inclusive, PLAINTIFF alleges as follows:

INTRODUCTION

1. When the Plares Family made the difficult decision to place their matriarch in assistant living, they wholeheartedly chose Mission. Not once did it ever cross any of the Plares family members' minds that their beloved, mom, grandma, great grandma, or "Grandma Vera" as they referred to her, would be brutally attacked and murdered by her live-in roommate. Mission and Suncrest knowingly and willingly placed an aggressive patient, with a documented history of violence towards residents, who has been placed on multiple 5150 holds, and who was nearly twenty years younger and mobile, in Vera Plares' room, DEFENDANTS' most vulnerable patient. Less than 48 hours after the brutal attack, Vera Plares succumbed to her injuries and passed away. Vera Plares died a tragic death at the hands of Mission and Suncrest who had complete control and responsibility of her living placement.

STANDING FOR CLAIM

2. Pursuant to Code of Civil Procedure §377.60, et. seq., PLAINTIFF acts as a personal representative of his now deceased mother Vera Plares and seeks wrongful death and survival damages. PLAINTIFF has complied with Code of Civil Procedure § 364 (Notice of Intent to Sue.) In addition, PLAINTIFF has standing under Welfare and Institutions Code § 15657.3(d) to commence and maintain this action as decedent's lawful heir and has standing as an individual to bring this cause of action for the wrongful death of his mother.

PARTIES AND JURISDICTION

3. Vera Plares is the decedent and matriarch of the Plares Family, she was 98 years old at the time of her death. Plares Sr. is the son of Vera Plares. PLAINTIFF is a resident of Santa Clara County, California. In making the claims herein, PLAINTIFF brings this action on behalf of himself, and the decedent, Vera Plares, who died on December 15, 2023.

(a) The sole heir and successor of Vera Plares is:

i. Adam Plares Sr. her son.

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4. Defendant Covenant Care California, LLC., is a limited liability company formed under the laws of the State of California. Pursuant to documents filed by Covenant Care California, LLC with the California Secretary of State, it does business throughout California, and in the county of Santa Clara, with its principal place of business and mailing address located at 120 Vantis Drive, Suite 200, Aliso Viejo, CA., 92656. Defendant Covenant Care California, LLC. does business as Mission Skilled Nursing & Sub-Acute Center (hereinafter "Mission") and is located at 410 N. Winchester Boulevard, Santa Clara, CA. 95050.

5. Defendant Covenant Care Mission, Inc., is a stock corporation. Covenant Care Mission, Inc., does business in California, and in the county of Santa Clara, with its principal place of business and mailing address located at 120 Vantis Drive, Suite 200, Aliso Viejo, CA., 92656.

6. Defendant Suncrest Hospice San Jose, LLC, is a limited liability company formed in Delaware, with its principal address at 9800 S. Monroe, Suite 809, Sandy, Utah, 84070. Defendant Suncrest does business as Suncrest Hospice (hereinafter "Suncrest") and is also a California Registered entity at 2804 Gateway Oaks Drive, Sacramento, California, 95833.

7. The true names and capacities, whether individual, corporate, associate, or otherwise, of the defendants named herein as DOES 1 through 60, inclusive are presently unknown to the PLAINTIFF. On information and belief, each of the defendants designated as a "DOE" is legally responsible for the events or injuries alleged herein, and proximately caused the damages described.

8. In owning, operating, managing, and/or supervising the subject facility, DEFENDANTS and DOES 1 through 60, inclusive, and each of them, held themselves out to the general public, Adam Plares Sr., the Plares family, and Vera Plares in particular, as being in compliance with all applicable federal and state laws.

9. On information and belief, at all times mentioned herein each defendant was the agent,

partner, joint venturer, representative, and/or employee of the remaining DEFENDANTS and was acting within such agency, partnership, joint venture or employment.

10. On information and belief, at all times mentioned herein each defendant as an agent, partner, joint venturer, representative, and/or employee of the remaining DEFENDANTS and was acting with malice, recklessness and/or negligence which led to and caused Vera Plares manner cause of death.

11. Venue is proper in the County of Santa Clara because DEFENDANTS exist, transact business, and/or have offices in this judicial district. Further, venue is proper as PLAINTIFF and the decedent are residents of Santa Clara. Lastly, venue is proper in this Court pursuant to Code of Civil Procedure § 395 because certain and specific acts and omissions complained of arose in the county of Santa Clara.

DEFENDANTS COVENANT CARE CALIFORNIA LLC AND COVENENAT CARE MISSION INC. ARE ALTER-EGOS OF ONE ANOTHER AND FORM A SINGLE ENTERPRISE

12. There is sufficient unity of interest and ownership among Defendant Covenant Care California, LLC, dba Mission Skilled Nursing & Sub-Acute Center and Defendant Covenant Care Mission, Inc., and between each of them, such that acts of one are for the benefit and can be imputed to the acts of the others. While Defendant Covenant Care California, LLC. dba Mission Skilled Nursing & Sub-Acute Center and Defendant Covenant Care Mission, Inc. have formed multiple corporations and LLCs, they in fact act as one entity and, ultimately, are all completely owned and controlled by Defendant Covenant Care California, LLC.

13. As noted above, the named business entities have the same address and the same agent for service of process. On information and belief, both Defendants above used the same accountant. PLAINTIFF is informed and believes, and based thereon alleges, that all transactions between the entities are part of one general ledger.

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FACTS COMMON TO ALL CAUSES OF ACTION

14. On information and belief, Mission and Suncrest are in a contractual business relationship, whereby Suncrest provides services to Mission patients and Mission provides services to Suncrest patients concurrently.

15. Mission is a 133 bed, nursing and rehabilitation facility providing short-term and long-term residency in Santa Clara, California. On its website it exclaims "We are Family Serving Family!" and "At Mission Skilled Nursing & Subacute Center, we are committed to providing the highest quality of care in a safe, relaxed atmosphere."

16. Suncrest Hospice provides medical care to patients in an effort to ease any ailment they may be experiencing, in addition to other services. Suncrest is located within Mission and is situated in a specific wing of the facility. Suncrest works with and through Mission to provide Mission patients medical care. Suncrest has its own licensed physician and staff at Mission. On its website, Suncrest's motto is "You can't add to your life more time, so let Suncrest give the time you have more life" and it acknowledges the importance of safety stating, "Growing older brings increasing challenges with safely living independently, which can cause many older individuals to consider moving to an assisted living or skilled nursing facility."

17. Vera Plares, the Plares Family matriarch and who family, friends, and church members call "Grandma," was born on January 10, 1925, in Rincon, New Mexico. At the young age of 14 years old, she moved with her family to Alviso, California. Vera worked in the local canneries and on a ranch into adulthood. She married young with her legacy leaving behind five (5) children, nine (9) grandchildren, nineteen (19) great grandchildren, four (4) great-great grandchildren, and dozens of family members. Vera Plares was quick-witted and funny. She was sharp in mind and spirit and was known for her playful nature. In 2023, at 98 years old, she was

honored at her church Filipino Assembly of the First Born as its oldest living member. Vera Plares was murdered in December of the same year.

18. Plares Sr. is the youngest son of Vera Plares. Plares Sr. has a son named Adam Plares Jr., who is a retired San Jose Police Officer. Plares Sr. and Jr. visited Vera on an at minimum bi-monthly basis, as Plares Sr. is essentially immobile, and Adam Jr. lives out of town. Plares Sr., however, would speak to Vera Plares daily via telephone to check in and see how she was doing.

19. Vera Plares' oldest son, Anthony "Tony" Plares was married to Evelyn Plares (hereinafter "Evelyn.") Evelyn, a widow, visited Vera Plares at minimum, on a weekly basis.

20. Melanie Plares (hereinafter "Melanie") is the niece of Vera Plares. Melanie, her husband Eugene Plares and two children, Eli Plares and Sierra Plares, were frequent visitors of Vera Plares.

21. Prior to entering her residency at Mission, there was no official power of attorney established because Vera Plares could make medical decisions on her own. Vera Plares did, however, always keep Evelyn, Plares Sr. and Karl Plares (her grandson) apprised of and included them in her medical care and decision making.

22. In approximately April 2023, Vera Plares began her residency at Mission. Nearly each day Vera Plares was a resident of Mission, a family member would pay her a visit.

23. In approximately July 2023, Vera Plares was transferred to the hospice wing at Mission due to a bed sore on her sacrum that was not properly healing. In conjunction with the transfer, Mission and Suncrest were now responsible for her medical care, safety, and well-being. Despite her transfer to hospice, Vera Plares was never prescribed end of life care. Rather, the goal was to facilitate her bed sore healing.

24. At some point after being transferred, DEFENDANTS made the calculated decision to place Vera Plares with roommate Connie Delucca (hereinafter "Connie") in Room 302.

25. Mission and/or Suncrest knew that:

(a) Connie is approximately 20 years younger than Vera Plares;

(b) Connie is mobile, and able to move around;

(c) Vera Plares was considered non-mobile at the time she was transferred to the new wing at Mission;

(d) Connie has a history of being violent at Mission; and

(e) Connie has a history of prior 5150 holds[1].

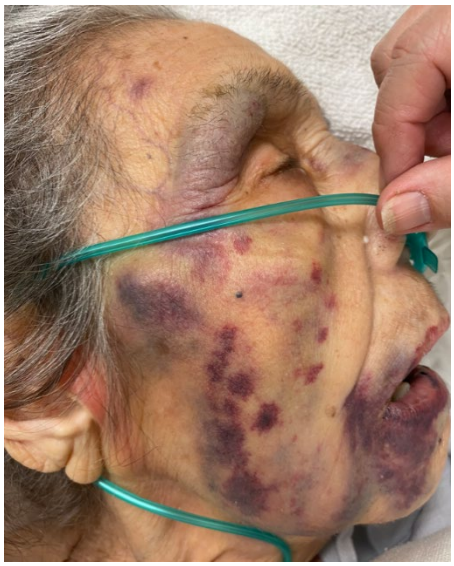
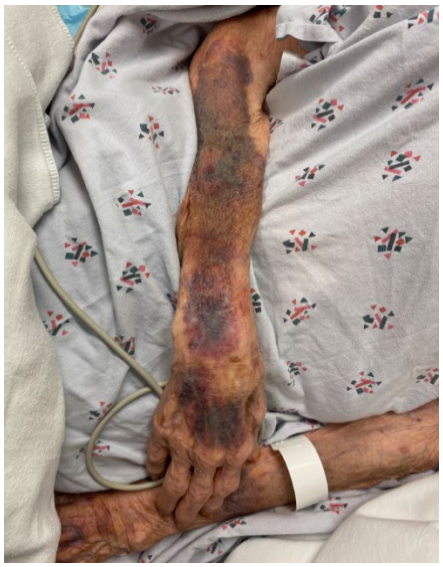
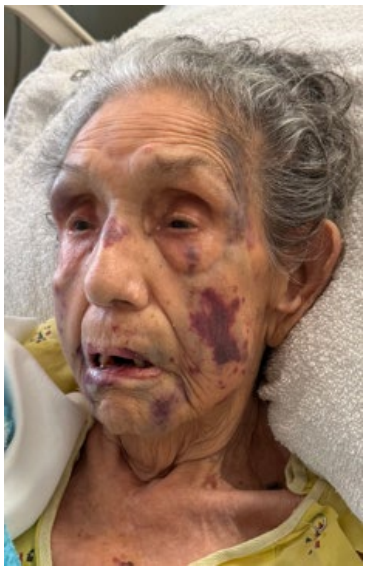
26. In at minimum but not limited to, one prior documented incident, Connie physically attacked another patient at Mission. Mission, Suncrest and its staff knew, or should have known of Connie's history of violence.

27. On December 13, 2023, at approximately 6:00 p.m., staff nurse Sheena Quiambao (hereinafter "Sheena") was making rounds and provided Vera Plares with her medications.

28. At approximately, 8:30 p.m., staff nurse Irene Gaspar (hereinafter "Irene") checked on Vera Plares and Connie and noted they were both in their beds.

29. At some point between approximately 8:30 p.m. and 9:00 p.m., Sheena went into Room 302 to treat Connie but observed the curtain was drawn in between the roommates so she didn't have a view of Vera Plares. Sheena failed to put forth any effort to physically walk over and check on Vera Plares at that time.

30. On December 13, 2023, Vera Plares was brutally physically attacked by Connie. Connie's brutal attack caused multiple injuries and bruises throughout Vera Plares' arms, hands, neck, face and mouth, including a chipped tooth, and blood dripping from her mouth. On information and belief, Connie used her 32-inch cane as the main source of beating Vera Plares.

[1] A 5150 hold is an involuntary 72-hour psychiatric hospitalization when a patient is evaluated to be a danger to others, herself, or gravely disabled.

31. At approximately 9:30 p.m., a staff nurse named Irene Gaspar (hereinafter "Irene") was the first to find Vera Plares in the aftermath of the brutal attack. Irene contacted Sheena upon finding Vera Plares. Sheena then contacted a supervisor named Liezel Tupinio and informed her of the state Vera Plares was in. Irene noted Vera Plares was lying in bed with bruising on her face, blood on the corner of her mouth, and a chipped front tooth. At some point thereafter, Irene and Sheena removed Vera Plares from Room 302 and attempted to ask her what happened. They then asked Connie what happened, and Connie said something to the effect of "What if I did do it and I can't remember."

32. The Plares family was not immediately notified of the brutal attack after Vera Plares was found.

33. Approximately three entire hours went by, until finally, the family was called and notified. Mission and Suncrest failed in its duty of care to notify the Plares family members of this brutal attack on a timely basis.

34. At approximately 11:00 p.m., Evelyn was called by staff nurse Sheena. Sheena reported to Evelyn that Vera Plares had been "attacked," had bruising, swelling, and a chipped tooth, and asked for permission to take her to the hospital, namely Valley Medical Center.

35. At approximately 1:00 a.m., Evelyn received a second phone call, wherein a staff member from Suncrest named Maria informed her, it was decided by Maria and Dr. Wang (Suncrest's physician) that Vera Plares would not be taken to the emergency room per hospice protocol. At some point after, Vera Plares was moved from Room 302, the room she was attacked in and her living area, to Room 207. Her belongings stayed in Room 302 until her family moved them.

36. On December 14, 2023, between approximately 10-10:30 a.m., Evelyn arrived on scene at Mission. Vera Plares' only words to Evelyn were "It was terrible, it was terrible." Evelyn proceeded to ask her mother-in-law, "Who did it?"

37. At approximately 1:00 -1:30 p.m., Melanie arrived at Mission to check on Vera Plares at the request of Plares Sr. Evelyn was still onsite at Mission when Melanie arrived. Melanie got close to Vera Plares to let her know she was there. Vera Plares in response, brought Melanie close to her face, and nose and lowered Melanie's mask down, and stared at her. Melanie then asked "Grandma, who hurt you?"

38. Melanie was angry at this point and started asking additional questions in an attempt to figure out who hurt her beloved Grandma. She proceeded to ask staff "Who made the decision to not take her (Vera) to the emergency room?" There was no response. However, a hospice nurse overheard her and stated it was a decision made per hospice protocol by a hospice nurse and the hospice medical doctor (Dr. Wang.) On information and belief, at no point did Dr. Wang physically go into the facility to examine Vera Plares after her brutal beating. Melanie then informed the nurse Vera Plares was not on end-of-life care and was awake and talking the day prior to the attack and exclaimed "Grandma was brutally attacked by someone in your facility last night and no one knows what happened. She is no longer speaking, and we have no idea the extent of her pain levels or injuries." Thereafter, Melanie insisted they take her off hospice and send her to Valley Medical Center where she could receive appropriate care. She then asked a social worker named Chris "What did the police say and can I (Melanie) have the case number?" Chris responded, "I don't know if I am allowed to give it to you."

39. After Melanie pressured the staff for it, the case number was given to her.

40. Melanie proceeded to contact her nephew Plares Jr. (he was on his way to Mission from out of town). She was surprised to hear from Plares Jr. that he had called the police station in an attempt to retrieve a copy of the police report and was told no police report had been done, only a reference number for the call was documented. Consequently, Adam Jr. insisted and requested a police report be filed immediately. A police report was thereafter completed.

41. Shortly thereafter, a family decision was made to take Vera Plares off hospice care and to take her to the Emergency Room at Valley Medical Center. The paramedics were called to transfer her.

42. At approximately 4:00 p.m., transport arrived at Mission and proceeded to take Vera Plares to Valley Medical Center. Melanie followed transport to the hospital. She met Plares Jr. at the hospital in the ambulance bay and they both proceeded to wait for an hour or so for Vera to be admitted to an Emergency Department room.

43. Once Vera Plares was admitted into a room, the police department's CSI team arrived to collect evidence of blood under her fingernails, in an attempt to retrieve DNA evidence.

44. On December 15, 2023, at approximately 12:00 p.m. to 1:00 a.m., x-rays and a CT scan were conducted. Once completed Melanie went home and Plares Jr. waited with Vera Plares until around

4:00 a.m. for the test results to be completed, to provide her comfort, and for her to be transferred to a hospital room.

45. On December 15, 2023, in the morning, Vera Plares' health was obviously declining. She was out of it, could no longer speak, and "looked really bad." Melanie had visited her at Valley Medical Center in the morning but needed to go pick up Evelyn to go to Mission to collect Vera's belongings and medical records. Vera Plares granddaughter Jasmine Catala was present visiting her when Melanie arrived. Jasmine stayed with Vera Plares until Melanie's husband Eugne and their daughter Sierra arrived. The family stayed with her for approximately two hours.

46. Shortly after Eugene and Sierra left, Evelyn and Melanie headed back to Valley Medical Center so Evelyn could sign admission paperwork and sit with Vera Plares. While Melanie was parking and Evelyn was signing paperwork, the Valley Medical Center doctor taking care of Vera Plares called Evelyn. She informed Evelyn that Vera Plares had just passed away not long ago. Vera Plares passed away alone in her hospital bed. The Plares family was and has since been distraught.

47. The coroner determined the cause of death to be blunt force trauma, homicide. Upon learning of the cause of Vera Plares' tragic death, the Santa Clara police department stepped into action. A detective at the police department began an investigation into Mission and Suncrest. The investigation has since been handed to the district attorney to make the decision whether murder charges will be brought.

FIRST CAUSE OF ACTION

WRONGFUL DEATH

(On behalf of all Plaintiff against all Defendants)

48. PLAINTIFF refers to and incorporates by reference all preceding paragraphs above as though fully set forth herein.

49. At all times mentioned herein DEFENDANTS, as alter-egos and/or agents, owed a duty to use ordinary care and such other care as required by law, in the treatment and protection of their patient, Vera Plares.

50. At the time of Vera Plares' residency at Mission, there were also statutory and regulatory duties which set forth the standard of care required at the facility, including but not limited to: a) Provide

adequate monitoring, assessment and re-assessment of her condition as set forth in 22 California Code of Regulations §72311, b) ensure that the facility had adequate qualified personnel to care for Vera Plares as set forth in Health and Safety Code §1599.1(a), and c) ensure residents are safe and free from violence.

51. DEFENDANTS failed to use that degree of care that a reasonable person would use in providing for the basic needs and treatment of Vera Plares and failed to comply with the basic statutory and regulatory standards of care.

52. As a result of DEFENDANTS' wrongful conduct, abuse and neglect as detailed above, Vera Plares was physically beaten and abused while in the custody of Mission and Suncrest, causing her eventual death on December 15, 2023.

53. Prior to her death, the decedent was the mother of PLAINTIFF Plares Sr.

54. As a result of the acts of DEFENDANTS and DOES 1 through 60, inclusive, and each of them, as alleged above, Vera Plares died, and PLAINTIFF has lost the love, companionship, comfort, affection, and society of his mother, for which PLAINTIFF seeks general damages.

55. As a further result of the acts of the DEFENDANTS, and each of them, as alleged above, the decedent's family incurred funeral and burial expenses for the burial of Vera Plares, for which the PLAINTIFF seeks special damages.

56. As a result, Plares Sr. was deprived of his rights under the law, and he brings this claim in his individual and representative capacities and seeks wrongful death and survival damages.

WHEREFORE PLAINTIFF prays for damages as hereinafter set forth.

SECOND CAUSE OF ACTION

ELDER ABUSE

(On behalf of all Plaintiff against all Defendants)

57. PLAINTIFF refers to and incorporates by reference all preceding paragraphs above as though fully set forth herein.

58. PLAINTIFF is informed and believes, and based thereon alleges, that DEFENDATS were required to provide skilled nursing care, room and board, twenty-four-hour supervision, and personal care and assistance to the residents. Care and supervision required of DEFENDANTS included custodial care and services, physician services, skilled nursing services, dietary services, pharmaceutical services,

and activities and services as more specifically described in 22 California Code of Regulations §72301, et seq.

59. It is well known and has been expressly noted by the California Legislature due to its adoption of Welfare and Institutions Code § 1560(a)-(d) that the elderly segment of the population is particularly subject to various forms of abuse and neglect. Physical infirmity or mental impairment, such as those experienced by Vera Plares, often place the elder in a dependent and vulnerable position. At the same time, such infirmity and dependence leave the elderly, such as Vera Plares, incapable of asking for help or protection.

60. Recognizing the problems described in the preceding paragraph, the California legislature promulgated the Elder Abuse and Dependent Adult Civil Protection Act ("EADACPA"). This act is codified in the Welfare and Institutions Code §15600. Pursuant to additions, the California legislature found and declared that infirm, elderly, and dependent adults are a disadvantaged population, and that few civil cases are brought in connection with their abuse due to the problems of proof and delays, plus the lack of incentive to prosecute such suits.

61. The EADACPA defines an "elder" as any person residing in California who is an adult sixty-five (65) years of age or older. As further defined under EADACPA, "abuse of an elder" is either: (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or (b) The deprivation by a care custodian of goods or services necessary to avoid physical harm or mental suffering. (Welfare & Institutions Code § 15610.07.)

62. The Welfare and Institutions Code §15610.57 defines "neglect" as: "The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (Welfare & Institutions Code §15610.57(a)(1).) Under the code, neglect includes but is not limited to: (a) Failure to provide medical care for physical or mental health needs; and (b) Failure to protect from health and safety hazards. (Welfare & Institutions Code §15610.57(b).)

63. Vera Plares was ninety-eight years old while under the care of DEFENDANTS pursuant to the EADACPA.

64. DEFENDANTS, and each of them, had a duty, under applicable federal and state laws (which were designed for the protection and benefit of residents such as Vera Plares) to provide for and to protect Vera Plares' health and safety. DEFENDANTS, and each of them, also had a common-law duty to provide for the health and welfare of Vera Plares. Without limiting the generality of the foregoing, DEFENDANTS had, among other duties, the duty with respect to Vera Plares' health and welfare to:

(a) Protect Vera Plares from sustaining injuries to her person;

(b) Monitor and accurately record Vera Plares' condition, and notify the attending physician and family members of any meaningful change in her condition;

(c) Note and properly react to emergent conditions;

(d) Accurately monitor and provide for Vera Plares' health, comfort and safety;

(e) Maintain accurate records of Vera Plares' condition and activities; and

(f) Treat Vera Plares with dignity and respect, without abuse.

65. Additionally, Title 22 CCR §72311(a)(3) required DEFENDANTS to promptly notify Vera Plares' healthcare practitioner of "[a]ny sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient." PLAINTIFF is informed and believes, and based thereon alleges, that the DEFENDANTS had a custom and practice of violating all of these regulations. During Vera Plares' residency at Mission, DEFENDANTS, and each of them, as agents, alter-egos and co-conspirators failed to use the degree of care that a reasonable person in the same situation would have used in protecting Vera Plares from health and safety hazards. DEFENDANTS, and each of them, made the decision to house Vera Plares with Connie, a known violent roommate with a history of violence at the facility towards other residents. As a result, DEFENDANTS withheld care from Vera Plares and deliberately disregarded Vera Plares with the high degree of probability that injury to Vera Plares would result. DEFENDANTS' actions were a conscious choice of a course of action with respect to Vera Plares' risk assessment and the determination of her needs, with knowledge of the serious danger in which Vera Plares was placed as a result of such actions.

66. As a direct result of each DEFENDANTS' neglect, Vera Plares was injured in her person and health, and sustained serious physical injuries and damages, including serious physical injuries such as bruises, chipped teeth, a bloodied mouth, and ultimately death.

67. DEFENDANTS' conduct constitutes "neglect" as that term is defined in Welfare and Institutions Code §§15610.63 and 15610.57 in that DEFENDANTS failed to use the degree of care that a reasonable person having the custody of Vera Plares would exercise. DEFENDANTS, acts were done with recklessness, oppression, fraud or malice as defined in Welfare and Institutions Code §15657.

68. As a result of DEFENDANTS' reckless neglect as alleged, PLAINTIFF seeks all economic damages to which he is entitled according to proof at trial.

69. As a result of the recklessness, malice, oppression or fraud herein alleged, PLAINTIFF is entitled to an award of punitive damages pursuant to Civil Code § 3294 and trebling of those damages pursuant to Civil Code § 3345.

70. As a result, Plares Sr. was deprived of his rights under the law and he brings this claim in his individual and representative capacities and seeks wrongful death and survival damages.

WHEREFORE PLAINTIFF prays for damages as hereinafter set forth.

THIRD CAUSE OF ACTION

VIOLATION OF PATIENT RIGHTS PURSUANT TO

HEALTH AND SAFETY CODE § 1430 (b)

(On behalf of all Plaintiff against all Defendants)

71. PLAINTIFF refers to and incorporate by reference all preceding paragraphs above as though fully set forth herein.

72. Decedent, as a resident of a nursing home and over the age of 65, had a right to be treated with dignity and respect. 42 CFR §483.10, 483.15(a); 22 CCR § 72527(a)(11). The conduct of DEFENDANTS, as previously alleged, failed to treat Vera Plares with the dignity and respect to which she was entitled under the law as she was placed with Connie, a violent and mobile roommate with prior 5150 holds and nearly beaten to death with Connie's 32-inch cane.

73. As a result, Vera Plares was deprived of her rights under the law and Plares Sr. brings this claim in his representative capacities and seeks wrongful death and survival damages.

WHEREFORE PLAINTIFF prays for damages as hereinafter set forth.

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FOURTH CAUSE OF ACTION

SURVIVAL ACTION

(CCP § 377.34(b))

(On behalf of all Plaintiff against all Defendants)

74. PLAINTIFF refers to and incorporate by reference all preceding paragraphs above as though fully set forth herein.

75. DEFENDANTS owed Vera Plares and PLAINTIFF a duty of care and breached this duty by failing to take action as described above.

76. As a result of DEFENDANTS' conduct, Vera Plares was killed by Connie at Mission on December 15, 2023. Vera Plares lived for a period of time after being brutally beaten by Connie before succumbing to her death.

77. The conduct of DEFENDANTS was malicious, oppressive, and fraudulent, such that the imposition of punitive damages is warranted against them.

78. PLAINTIFF Adam Plares, Sr. is successor in interest to Vera Plares pursuant to CCP § 377.32 and seeks survival damages on Vera Plares' behalf, in the form of Vera Plares' pain, suffering, and disfigurement, as well as punitive damages against DEFENDANTS.

WHEREFORE PLAINTIFF prays for damages as hereinafter set forth.

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PRAYER FOR RELIEF

WHEREFORE, PLAINTIFF prays for relief and requests entry of judgment in his favor and against DEFENDANTS COVENANT CARE CALIFORNIA, LLC. DBA MISSION SKILLED NURSING & SUBACUTE CENTER, COVENANT CARE MISSION, INC., SUNCREST HOSPICE SAN JOSE LLC, DBA SUNCREST HOSPICE and Does 1-60, inclusive, as follows:

1. For wrongful death damages, in an amount to be proven at trial;

2. For survival damages, including for pre-death pain and suffering, in an amount to be proven at trial;

3. For punitive and exemplary damages under Welfare and Institutions Code § 15657(a) and Civil Code § 3294;

4. For treble and punitive damages and penalties under Civil Code § 3345;

5. For reasonable costs of this suit;

6. For attorneys fees;

7. For pre-judgment and post-judgment interest at the maximum legal rate; and

8. For such further other relief as the Court may deem just, proper, and appropriate.

Date: May 29, 2024

GOYETTE, RUANO & THOMPSON

By: _____

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DEMAND FOR JURY TRIAL

PLAINTIFF demands a trial by jury.

Date: May 29, 2024

GOYETTE, RUANO & THOMPSON

By: _____

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