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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF FRESNO

JOSH DANSBY JR.,

Plaintiff,

vs.

SIERRA MEADOWS SENIOR LIVING LLC; and DOES 1 through 250, inclusive,

Defendants.

CASE NO. 18CECG00406

COMPLAINT FOR DAMAGES

1) Elder Abuse (Pursuant to the Elder Adult and Dependent Adult Civil Protection Act – *Welfare and Institutions Code* §§15600, *et seq.*)
2) Negligent Hiring and Supervision (CACI 426)
3) Assault & Battery

Assigned to Hon., Dept.

Action Filed:
Trial Date: None Set

COMES NOW JOSH DANSBY JR. and alleges upon information and belief as follows:

1. Plaintiff JOSH DANSBY JR. (hereinafter sometimes referred to as "PLAINTIFF") is and was at all times relevant hereto a resident of the County of Fresno, State of California. JOSH DANSBY JR. brings this action by and through his Attorney-in-Fact, Stephanie Powers.

2. Defendants DOES 1-5 are individuals who are believed to be the individuals who assaulted and battered JOSH DANSBY JR. and were at all times relevant hereto residents of the County of Orange in the State of California. Specifically DOE 1 is believed to be the former roommate of JOSH DANSBY JR. at the defendant SIERRA MEADOWS SENIOR LIVING LLC. facility.

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3. Defendants SIERRA MEADOWS SENIOR LIVING LLC, and DOES 6-50 (which hereinafter are sometimes referred to as the "FACILITY"), were at all relevant times in the business of providing custodial care as a Residential Care Facility for the Elderly using the fictitious business name Bella Vista Memory Care Community located at 5425 W. Spruce, Fresno, CA 93722, and were subject to the requirements of state law regarding the operation of a Residential Care Facility for the Elderly ("RCFE") in the State of California.

4. Defendants and DOES 51-100 (hereinafter referred to as the "PARENT DEFENDANTS") owned, operated, managed and/or controlled the operations of the FACILITY, at all times relevant hereto, as a Residential Care Facility for the Elderly and were at all times relevant hereto subject to the requirements of state law governing the operation of a Residential Care Facility for the Elderly in the State of California (hereinafter the FACILITY and the PARENT DEFENDANTS shall sometimes be referred to collectively as "DEFENDANTS").

5. The DEFENDANTS, by and through the corporate officers and directors including, Terrance John Cox (Chief Executive Officer), Donna Hurley (Administrator/Manager) and others presently unknown to JOSH DANSBY JR. and according to proof at 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 patients of the FACILITY, including JOSH DANSBY JR., the causal relationship between understaffing and the increased likelihood of harm to residents resulting from such understaffing, and the FACILITY'S history of being issued deficiencies by the State of California's Department of Social Services. That notwithstanding this knowledge, these officers, directors, and/or managing agents meaningfully disregarded this advance knowledge even though they knew the understaffing could, would and did lead to unnecessary injuries to residents of their FACILITY, including JOSH DANSBY JR.

6. JOSH DANSBY JR. is ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 250, and for that reason have sued such Defendants by fictitious names. JOSH DANSBY JR. will seek leave of the Court to amend this Complaint to identify said Defendants when their identities are ascertained.

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7. At all relevant times, SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 and each of them, 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 maximizing profits from the operation of the FACILITY by underfunding and understaffing the FACILITY. Moreover, the DEFENDANTS aided and abetted each other in accomplishing the acts and omissions alleged herein. (See Restatement (Second) of Torts §876 (1979)).

8. At all relevant times, SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250, by their acts and omissions as alleged herein, operated pursuant to an agreement, with a common purpose and community of interest, with an equal right of control, and subject to participation in profits and losses, as further alleged herein, such that they operated a joint enterprise or joint venture, subjecting each of them to liability for the acts and omissions of each other.

FIRST CAUSE OF ACTION
ELDER ABUSE
[By JOSH DANSBY JR. Against All Defendants Except DOES 1-5.]

9. JOSH DANSBY JR. hereby incorporates the allegations asserted in paragraphs 1 through 8 above as though set forth at length below.

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

11. That SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 were to provide "care or services" to JOSH DANSBY JR. and were to be "care custodians" of JOSH DANSBY JR. and in a trust and fiduciary relationship with JOSH DANSBY JR. That the DEFENDANTS provided "care or services" to dependent adults and the elderly, including JOSH DANSBY JR., and housed dependent adults and the elderly, including JOSH DANSBY JR.

12. That SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 "neglected" JOSH DANSBY JR. as that term is defined in *Welfare & 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 as is more fully alleged herein.

13. SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 are owners and

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operators of a residential care facility for the elderly (RCFE). Residential care facilities for the elderly are an intermediate step between independent living and nursing homes. They are specifically geared to persons over 60 years of age, and do not provide medical care treatment. They are intended as a "humane approach to meeting the housing, social, and service needs of older persons," by providing a home life environment for older persons who require a variety of care and needs. *Please see*, *Health and Safety Code* §1559.1(g). All such facilities are generally governed by the California Residential Care Facilities for the Elderly Act (1989), (*Health and Safety Code* §§1569-1569.87). The governing regulations of residential care facilities for the elderly are set forth in 22 Cal. *Code of Regulations* §§87100-87730.

14. In or around February of 2017, JOSH DANSBY JR. was admitted into the FACILITY. JOSH DANSBY JR.'S admitting conditions into the FACILITY included, but not limited to and according to proof at trial, Alzheimer's dementia with behavioral disturbances, a medical history of strokes and heart attacks, a surgical history of cornea transplants in both eyes and pacemaker placement. Accordingly, upon admission into the FACILITY, JOSH DANSBY JR. required attention and care which included services to protect him from health and safety hazards, a fact well known to SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250.

15. Additionally, it is alleged that at all times relevant hereto SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 were fully aware of the dangerous propensities of DOE 1 which required, for the health and safety of other FACILITY residents including JOSH DANSBY JR., that interventions be put in place for the protection of all FACILITY residents.

16. And in fact, by the time JOSH DANSBY JR. was admitted into the FACILITY DOE 1 was knowingly aggressive resident of the FACILITY who placed the health and safety of all other FACILITY at high and knowing risk for physical assault by DOE 1. And accordingly, at all times relevant hereto SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 maintained DOE 1 as a resident of the FACILITY when they were legally precluded from doing so pursuant to 22 *Code of Regulations* §87455(c), referenced above, provides, in pertinent part, as follows:

> (c) No resident shall be accepted or retained if any of the following apply:
> (2) The resident requires 24-hour, skilled nursing or intermediate care as specified in *Health and Safety Code* §§1569.72(a) and (a)(1).

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(3) The resident' primary need for care and supervision results from either:
(A) An ongoing behavior, caused by a mental disorder, that would upset the general resident group; or
(B) Dementia, unless the requirements of Section 87705, Care of Persons with Dementia, are met.

17. Rather than these required services so as to protect JOSH DANSBY JR. from the knowingly aggressive propensities of DOE 1, SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 actually placed JOSH DANSBY JR. and DOE 1 as roommates. And predictably, in a path of occurrence which was well known to be inevitable to SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 and yet ignored by them, in or around September of 2017, SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 so completely failed to provide required services to DOE 1 and JOSH DANSBY JR. so as to protect JOSH DANSBY JR. from a violent physical attack by DOE 1. Immediately, family members of JOSH DANSBY JR. complained to SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 asking that appropriate and required services be provided so as to protect JOSH DANSBY JR. from another violent physical assault by DOE 1 in the FACILITY.

18. Rather than appropriately intervene as requested by JOSH DANSBY JR.'S daughter so as to prevent future altercations, the FACILITY staff failed to separate JOSH DANSBY JR. and DOE 1 forcing JOSH DANSBY JR. to remain the roommate of DOE 1, notwithstanding their known physical propensities and history of physically aggressive behaviors of DOE 1

19. .The Administrator explained the wrongful withholding of necessary care to protect JOSH DANSBY JR. as claiming that there was no alternative, all the while with SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 being solely concerned with cashing checks and ill begotten financial gain all the while knowingly disregarding the dangerous position in which they placed JOSH DANSBY JR. in the refusal of SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 to provide required care to protect the health and safety of JOSH DANSBY JR.

20. As the direct and proximate result of the wrongful withholding of required care by SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 to protect JOSH DANSBY JR. from known health and safety hazards of the violent DOE 1, on or about December 30, 2018, DOE 1 once again violently assaulted JOSH DANSBY JR.

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21. Rather than promptly notify JOSH DANSBY JR.'S family of the resultant rapidly increasing accumulation of blood in his right eye, the FACILITY in an attempt to fraudulently conceal their misconduct, staff waited for days following the incident before transferring JOSH DANSBY JR. to St. Agnes Hospital Emergency Room where JOSH DANSBY JR. was determined to have suffered a corneal detachment due to the trauma from the entirely preventable assault of JOSH DANSBY JR. by DOE 1

22. On or about January 3, 2018, JOSH DANSBY JR. underwent surgical removal of JOSH DANSBY JR.'s right eye necessitated by the entirely preventable resident-to-resident altercation in the FACILITY alleged hereinabove.

23. That SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 were by definition a "mandated reporter" of suspected abuse pursuant to the provisions of *Welfare & Institutions Code* §15630.

24. That the conduct of DOE 1 in the assault of JOSH DANSBY JR. was definitonally physical abuse of JOSH DANSBY JR. pursuant to *Welfare & Institutions Code* §15610.63.[1]

25. That SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 were at all times relevant hereto "mandated reporters" of suspected abuse pursuant to the provisions of *Welfare & Institutions Code* §15630.[2]

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[1] *Welfare & Institutions Code* §15610.63 provides, in pertinent part, as follows:
"Physical abuse" means any of the following:
(a) Assault, as defined in Section 240 of the Penal Code.
(b) Battery, as defined in Section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

[2] *Welfare & Institutions Code* §15630 provides as follows:
(a) Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.
(b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that

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he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658, immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent, or an Internet report shall be made through the confidential Internet reporting tool established in Section 15658, within two working days.

(A) If the suspected or alleged abuse is physical abuse, as defined in Section 15610.63, and the abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the following shall occur:

(i) If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, but also no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(ii) If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(iii) When the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia, and there is no serious bodily injury, as reasonably determined by the mandated reporter, drawing upon his or her training or experience, the reporter shall report to the local ombudsman or law enforcement agency by telephone, immediately or as soon as practicably possible, and by written report, within 24 hours.

(iv) When applicable, reports made pursuant to clauses (i) and (ii) shall be deemed to satisfy the reporting requirements of the federal Elder Justice Act of 2009, as set out in Subtitle H of the federal Patient Protection and Affordable Care Act (Public Law 111-148), Section 1418.91 of the Health and Safety Code, and Section 72541 of Title 22 of California Code of Regulations. When a local law enforcement agency receives an initial report of suspected abuse in a long-term care facility pursuant to this subparagraph, the local law enforcement agency may coordinate efforts with the local ombudsman to provide the most immediate and appropriate response warranted to investigate the mandated report. The local ombudsman and local law enforcement agencies may collaborate to develop protocols to implement this subparagraph.

(B) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other law, the department may implement subparagraph (A), in whole or in part, by means of all-county letters, provider bulletins, or other similar instructions without taking regulatory action.

(C) If the suspected or alleged abuse is abuse other than physical abuse, and the abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, a telephone report and a written report shall be made to the local ombudsman or the local law enforcement agency.

(D) With regard to abuse reported pursuant to subparagraph (C), the local ombudsman and the local law enforcement agency shall, as soon as practicable, except in the case of an emergency or pursuant to a report required to be made pursuant to clause (v), in which case these actions shall be taken immediately, do all of the following:

(i) Report to the State Department of Public Health any case of known or suspected abuse occurring in a long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code.

(ii) Report to the State Department of Social Services any case of known or suspected abuse occurring in a residential care facility for the elderly, as defined in Section 1569.2 of the Health and Safety Code, or in an adult day program, as defined in paragraph (2) of subdivision (a) of Section 1502 of the Health and Safety Code.

(iii) Report to the State Department of Public Health and the California Department of Aging any case of known or suspected abuse occurring in an adult day health care center, as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.

(iv) Report to the Bureau of Medi-Cal Fraud and Elder Abuse any case of known or suspected criminal

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activity.

(v) Report all cases of known or suspected physical abuse and financial abuse to the local district attorney's office in the county where the abuse occurred.

(E) (i) If the suspected or alleged abuse or neglect occurred in a state mental hospital or a state developmental center, and the suspected or alleged abuse or neglect resulted in any of the following incidents, a report shall be made immediately, but no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting abuse, to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, and also to the local law enforcement agency:

(I) A death.

(II) A sexual assault, as defined in Section 15610.63.

(III) An assault with a deadly weapon, as described in Section 245 of the Penal Code, by a nonresident of the state mental hospital or state developmental center.

(IV) An assault with force likely to produce great bodily injury, as described in Section 245 of the Penal Code.

(V) An injury to the genitals when the cause of the injury is undetermined.

(VI) A broken bone when the cause of the break is undetermined.

(ii) All other reports of suspected or alleged abuse or neglect that occurred in a state mental hospital or a state developmental center shall be made immediately, but no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting abuse, to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, or to the local law enforcement agency.

(iii) When a local law enforcement agency receives an initial report of suspected or alleged abuse or neglect in a state mental hospital or a state developmental center pursuant to clause (i), the local law enforcement agency shall coordinate efforts with the designated investigators of the State Department of State Hospitals or the State Department of Developmental Services to provide the most immediate and appropriate response warranted to investigate the mandated report. The designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and local law enforcement agencies may collaborate to develop protocols to implement this clause.

(iv) Except in an emergency, the local law enforcement agency shall, as soon as practicable, report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse.

(v) Notwithstanding any other law, a mandated reporter who is required to report pursuant to Section 4427.5 shall not be required to report under clause (i).

(F) If the abuse has occurred in any place other than a long-term care facility, a state mental hospital, or a state developmental center, the report shall be made to the adult protective services agency or the local law enforcement agency.

(2) (A) A mandated reporter who is a clergy member who acquires knowledge or reasonable suspicion of elder or dependent adult abuse during a penitential communication is not subject to paragraph (1). For purposes of this subdivision, "penitential communication" means a communication that is intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization is authorized or accustomed to hear those communications and under the discipline tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.

(B) This subdivision shall not be construed to modify or limit a clergy member's duty to report known or suspected elder and dependent adult abuse if he or she is acting in the capacity of a care custodian, health practitioner, or employee of an adult protective services agency.

(C) Notwithstanding any other provision in this section, a clergy member who is not regularly employed on either a full-time or part-time basis in a long-term care facility or does not have care or custody of an elder or dependent adult shall not be responsible for reporting abuse or neglect that is not reasonably observable or discernible to a reasonably prudent person having no specialized training or experience in elder or dependent care.

(3) (A) A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report, pursuant to paragraph (1), an incident if all of the following conditions exist:

(i) The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior

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constituting physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect.

(ii) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

(iii) The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

(iv) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

(B) This paragraph shall not be construed to impose upon mandated reporters a duty to investigate a known or suspected incident of abuse and shall not be construed to lessen or restrict any existing duty of mandated reporters.

(4) (A) In a long-term care facility, a mandated reporter shall not be required to report as a suspected incident of abuse, as defined in Section 15610.07, an incident if all of the following conditions exist:

(i) The mandated reporter is aware that there is a proper plan of care.

(ii) The mandated reporter is aware that the plan of care was properly provided or executed.

(iii) A physical, mental, or medical injury occurred as a result of care provided pursuant to clause (i) or (ii).

(iv) The mandated reporter reasonably believes that the injury was not the result of abuse.

(B) This paragraph shall not be construed to require a mandated reporter to seek, nor to preclude a mandated reporter from seeking, information regarding a known or suspected incident of abuse prior to reporting. This paragraph shall apply only to those categories of mandated reporters that the State Department of Public Health determines, upon approval by the Bureau of Medi-Cal Fraud and Elder Abuse and the state long-term care ombudsman, have access to plans of care and have the training and experience necessary to determine whether the conditions specified in this section have been met.

(c) (1) Any mandated reporter who has knowledge, or reasonably suspects, that types of elder or dependent adult abuse for which reports are not mandated have been inflicted upon an elder or dependent adult, or that his or her emotional well-being is endangered in any other way, may report the known or suspected instance of abuse.

(2) If the suspected or alleged abuse occurred in a long-term care facility other than a state mental health hospital or a state developmental center, the report may be made to the long-term care ombudsman program. Except in an emergency, the local ombudsman shall report any case of known or suspected abuse to the State Department of Public Health and any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(3) If the suspected or alleged abuse occurred in a state mental health hospital or a state developmental center, the report may be made to the designated investigator of the State Department of State Hospitals or the State Department of Developmental Services or to a local law enforcement agency. Except in an emergency, the local law enforcement agency shall report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(4) If the suspected or alleged abuse occurred in a place other than a place described in paragraph (2) or (3), the report may be made to the county adult protective services agency.

(5) If the conduct involves criminal activity not covered in subdivision (b), it may be immediately reported to the appropriate law enforcement agency.

(d) If two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and there is agreement among them, the telephone report or Internet report, as authorized by Section 15658, may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(e) A telephone report or Internet report, as authorized by Section 15658, of a known or suspected instance of elder or dependent adult abuse shall include, if known, the name of the person making the report, the name and age of the elder or dependent adult, the present location of the elder or dependent adult, the names and addresses of family members or any other adult responsible for the elder's or dependent adult's care, the nature and extent of the elder's or dependent adult's condition, the date of the incident, and any other information, including information that led that person to suspect elder or dependent adult abuse, as requested by the agency receiving the report.

(f) The reporting duties under this section are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be

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26. That notwithstanding the fact that SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 had received information which confirmed the "physical abuse" of JOSH DANSBY JR., SIERRA MEADOWS SENIOR LIVING LLC and DOES 6-250 consciously, intentionally and in an effort to fraudulently conceal their misconduct did not report as required nor fulfill their mandated reporter responsibilities consistent with that set forth om *Welfare & Institutions Code* §15630.

27. The DEFENDANTS were well aware that if they failed to provide JOSH DANSBY JR. with the aforementioned care, supervision, and monitoring, to protect him from the known violent propensities of DOE 1, there was a high probability that JOSH DANSBY JR. would suffer injury. That DEFENDANTS consciously disregarded this risk and failed to provide JOSH DANSBY JR. with the aforementioned required care, leading directly to JOSH DANSBY JR.'s injuries as alleged herein.

28. The FACILITY failed to meet the requirements of Title 22 C.C.R. §87705 in that the FACILITY'S plan of operation failed to address the needs of residents with dementia including failing to maintain procedures for notifying residents' physician, family members and conservator when a resident's behavior or condition changes; failed to provide safety measures to address behaviors such as wandering and aggressive behavior; failed to provide dementia care training to staff who provide

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established, provided they are not inconsistent with this chapter.

(g) (1) Whenever this section requires a county adult protective services agency to report to a law enforcement agency, the law enforcement agency shall, immediately upon request, provide a copy of its investigative report concerning the reported matter to that county adult protective services agency.

(2) Whenever this section requires a law enforcement agency to report to a county adult protective services agency, the county adult protective services agency shall, immediately upon request, provide to that law enforcement agency a copy of its investigative report concerning the reported matter.

(3) The requirement to disclose investigative reports pursuant to this subdivision shall not include the disclosure of social services records or case files that are confidential, nor shall this subdivision be construed to allow disclosure of any reports or records if the disclosure would be prohibited by any other provision of state or federal law.

(h) Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment. Any mandated reporter who willfully fails to report, or impedes or inhibits a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, if that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 discovers the offense.

(i) For purposes of this section, "dependent adult" shall have the same meaning as in Section 15610.23.

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direct care to residents with dementia including assisting with activities of daily living; and failed to maintain an adequate number of direct care staff to support each resident's physical, social, emotional, safety and health care needs as identified in each resident's appraisal. That the FACILITY knew that non-compliance with these regulatory requirements would result in a high probability of harm to residents including JOSH DANSBY JR., but nonetheless consciously disregarded these requirements and failed to provide JOSH DANSBY JR. with the required care and supervision he required in direct violation of regulations, leading directly to JOSH DANSBY JR.'S injuries.

29. That as a result of the DEFENDANTS' failure to provide sufficient staff in both number and training to meet JOSH DANSBY JR.'s needs and protect him from the knowingly violent DOE 1, JOSH DANSBY JR. was forced to suffer unjustifiable pain and suffering through the deprivation of required medical and custodial care. That this unjustifiable pain and suffering was the result of DEFENDANTS' failure to provide sufficient staff, in both number and training, so as to be able to provide residents, including JOSH DANSBY JR., with their required medical and custodial care. That because of the failure of the DEFENDANTS to provide the services required under state rules, laws and regulations, while a resident at the FACILITY, JOSH DANSBY JR. suffered dangerous, unnecessary and painful injuries as alleged herein. DEFENDANTS' failures were a direct result of their inability to properly train their staff in fall risk prevention and failure to provide appropriate staff to prevent JOSH DANSBY JR. from falling, verbally and physically fighting other residents and suffering the loss of his eye.

30. During JOSH DANSBY JR.'S residency in the FACILITY, DOE 1 exhibited aggressive and violent propensities all of which were well known to the DEFENDANTS by and through their managing agents, or in which in the exercise of reasonable diligence should have been known to the DEFENDANTS. These violent propensities rendered DOES 1a danger to other residents utilizing the services of the FACILITY and rendered DOES 1-10 lawfully unsuitable for admission and retention in the FACILITY. The DEFENDANTS consciously disregarded this knowledge and failed to protect JOSH DANSBY JR. from health and safety hazards, including but not limited to the violent propensities of DOES 1 through 10 and as a direct result JOSH DANSBY JR. suffered injury.

31. JOSH DANSBY JR.'S injuries as alleged herein would not have occurred had the

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DEFENDANTS simply put in place reasonable measures to protect JOSH DANSBY JR. and other FACILITY residents from the known violent propensities of DOES 1-10.

32. As the result of this knowledge the DEFENDANTS knew that JOSH DANSBY JR. required basic and easily provided specific attention and care and constant monitoring and supervision to prevent physical assaults which commonly occur in RCFEs such as the FACILITY. This included room and body checks at least every thirty minutes, provision of a room close to the nurses station, keeping JOSH DANSBY JR. away and safe from other residents, such as DOES 1, who possessed knowingly violent propensities.

33. Notwithstanding this advance knowledge of a known peril, the DEFENDANTS did not identify the care needs of JOSH DANSBY JR. so as to protect his from health and safety hazards, did not develop an individual, written patient care plan for JOSH DANSBY JR. so as to protect his from health and safety hazards, did not review, evaluate and update the patient care plan of JOSH DANSBY JR. so as to protect his from health and safety hazards, did not notify the attending physician of JOSH DANSBY JR. so as to protect his from health and safety hazards.

34. Notwithstanding this advance knowledge of a known peril, the DEFENDANTS did not identify the care needs of DOES 1-10 and did not develop an individual, written patient care plan for DOES 1-10.

35. Simply stated the DEFENDANTS simply ignored their obligation to protect JOSH DANSBY JR. from health and safety hazards by ignoring the violent tendencies of DOES 1-10. And, in an action the DEFENDANTS knew was inevitable where they ignored the needs of the FACILITY residents, ultimately DOES 1-10 violently assaulted and injured JOSH DANSBY JR..

36. JOSH DANSBY JR.'S condition rendered him particularly vulnerable to those known by the DEFENDANTS to have violent propensities such as DOES 1-10. That with the knowledge of the frailty of JOSH DANSBY JR. and his particular vulnerability to those with known violent tendencies such as DOES 1-10, it was incumbent upon the DEFENDANTS to protect JOSH DANSBY JR. from the health and safety risks imposed by DOES 1-10. The mechanisms of this required protection included, without limiting the generality of the foregoing, 1:1 assistance for JOSH DANSBY JR. when in the proximity DOES 1-10, isolation from DOES 1-10 and Care Planning which

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addressed this known hazard. The DEFENDANTS provided none of these required services thereby causing injury to JOSH DANSBY JR. as alleged herein.

37. While a resident of the FACILITY, the DEFENDANTS wrongfully withheld required care for JOSH DANSBY JR. as the abject result of the failure of the DEFENDANTS to take action with required interventions to protect JOSH DANSBY JR. from health and safety hazards, JOSH DANSBY JR. suffered an unprovoked and entirely preventable physical assault and battery at the hands of DOES 1-10.

38. RCFE'S such as the FACILITY do not provide medical care to their residents, and in fact, cannot do so pursuant to applicable statutes and regulations. Because a RCFE is not a medical facility, California law, specifically 22 C.C.R. §87455, prohibits a RCFE from admitting or retaining anyone who requires a level of care beyond that which may be provided in the non-medical facility. In addition, 22 C.C.R. §87615, prohibits a RCFE from accepting and retaining a resident who requires 24-hour, skilled nursing or intermediate care.

39. Despite the legal mandates set forth in the immediately preceding paragraph, before and during the residency of JOSH DANSBY JR. at the FACILITY, the DEFENDANTS were aware that JOSH DANSBY JR. was suffering from conditions which precluded his lawful admission into the DEFENDANTS' RCFE. The DEFENDANTS were aware that JOSH DANSBY JR. required more care and supervision than that which the FACILITY could or would provide as the direct result of insufficiency of staff, in both number and training, at the FACILITY and the fact that the non-medical FACILITY was precluded by law from providing the care JOSH DANSBY JR. required and deserved.

40. That at all times relevant hereto the FACILITY was to meet the personnel requirements of 22 California *Code of Regulations* §87411(a) which mandated that the "[F]acility personnel shall at all times be sufficient in numbers, and competent to provide the services necessary to meet resident needs. The FACILITY failed to meet this regulatory obligation, thereby causing injury to JOSH DANSBY JR.

41. That at all times relevant hereto pursuant to Title 22 C.C.R. §87456, the DEFENDANTS owed a duty to JOSH DANSBY JR. to perform an evaluation of the suitability of DOE 1 for admission into, and retention in, the FACILITY. The DEFENDANTS failed to meet this

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duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR.

42. That at all times relevant hereto pursuant to Title 22 C.C.R. §87457, the DEFENDANTS owed a duty to JOSH DANSBY JR. to perform a pre-admission appraisal of DOE 1 in order to identify whether the FACILITY was equipped and able to meet the needs of DOE 1 so as to protect the health and safety of other FACILITY residents, including JOSH DANSBY JR. The DEFENDANTS failed to properly perform the pre-admission appraisal accurately with respect to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR.

43. The DEFENDANTS owed a duty to JOSH DANSBY JR. to observe DOE 1 for changes in physical, mental, emotional and social functioning and that appropriate assistance is provided when such observation reveals unmet needs so as to protect the health and safety of other FACILITY residents, including JOSH DANSBY JR. This observation was to document changes in DOE 1's physical, medical, mental, and social condition, as required by 22 C.C.R. §87466 so as to protect the health and safety of other FACILITY residents, including JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR.

44. The DEFENDANTS owed a duty to JOSH DANSBY JR. to determine the amount of supervision necessary for DOE 1 by assessing the mental status of in accordance with the provisions of 22 C.C.R. §87461 so as to ensure DOE 1 received appropriate attention and care so as to protect the health and safety of other FACILITY residents, including JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR. thereby causing injury to JOSH DANSBY JR. DEFENDANTS failed to properly assess and re-assess DOE 1 's mental limitations and mobility limitations which resulted in JOSH DANSBY JR. suffering a fall, resident-to-resident altercation and resulting injuries.

45. The DEFENDANTS owed a duty to JOSH DANSBY JR. to update the pre-admission appraisal, in writing, as frequently as necessary to note significant changes and to keep the appraisal accurate of DOE 1 so as to protect the health and safety of other FACILITY residents, including JOSH DANSBY JR. This re-appraisal was to document changes in DOE 1's physical, medical, mental, and social condition, as required by 22 C.C.R. §87463 so as to ensure JOSH DANSBY JR.

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received appropriate attention and care. The DEFENDANTS failed to meet this duty to, thereby causing injury to JOSH DANSBY JR.

46. That at all times relevant hereto pursuant to Title 22 of the California C.C.R. §87205 was to have a Governing Body responsible for insuring the FACILITY adhered to applicable rules, laws and regulations so as to ensure the health and safety of JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR. The Governing Body failed to ensure that adequate staff were available to properly supervise JOSH DANSBY JR. which resulted in his fall and resident-to-resident altercation. The Governing Body also failed to ensure that the DEFENDANTS' staff failures were a direct result of their inability to properly train their staff in fall risk prevention, and resident-to-resident altercation prevention and failure to provide appropriate staff to prevent him from falling, acting with physically aggressive behaviors towards fellow residents and suffering injury.

47. That at all times relevant hereto pursuant to Title 22 California *Code of Regulations* §87211, the FACILITY was to submit reports to State Licensing authorities relating to occurrences which would place the FACILITY on notice of problem areas in the operations of the FACILITY which would endanger the health and safety of JOSH DANSBY JR. The DEFENDANTS failed to meet this legal obligation, thereby recklessly allowing known perils to exist in the FACILITY causing injury to JOSH DANSBY JR. DEFENDANTS' failure to correct the problems which existed as manifested in the Department of Social Services' records included their inability to properly train and staff the FACILITY which led directly to JOSH DANSBY JR.'s assault by DOE 1 and resulting injuries.

48. That at all times relevant hereto pursuant to the provisions of Title 22 California *Code of Regulations* §87213 the FACILITY was to have in effect a financial plan which ensured that the FACILITY had sufficient budgetary allowance so as to ensure the sufficiency of FACILITY operations to protect the health and safety of JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR.

49. That at all times relevant hereto pursuant to Title 22 California *Code of Regulations* §87405 the FACILITY was required to only accept and retain those residents for whom it could

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provide lawful care so as to ensure the adequacy of staff allotment to protect JOSH DANSBY JR. from health and safety hazards. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR.

50. That at all times relevant hereto pursuant to requirements of Title 22 California *Code of Regulations* §87411(c) the FACILITY was to very specifically train its staff so as to ensure the health and safety of JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR. The DEFENDANTS' staff's failures were a direct result of their inability to properly train their staff in fall risk and resident-to-resident altercation prevention and failure to provide appropriate staff to prevent JOSH DANSBY JR. from falling, acting with physically aggressive behaviors towards fellow residents and suffering injuries as a result.

51. That at all times relevant hereto pursuant 22 California *Code of Regulations* §87468 the DEFENDANTS were required to respect the resident rights of JOSH DANSBY JR. so as to ensure the health, safety and dignity of JOSH DANSBY JR. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR. The DEFENDANTS failed to ensure the safety of JOSH DANSBY JR. and said failures were a direct result of DEFENDANTS' inability to properly train their staff in fall risk prevention and failure to provide appropriate staff to prevent JOSH DANSBY JR. from falling, acting with physically aggressive behaviors towards fellow residents and suffering the resulting injuries.

52. That at all times relevant hereto pursuant to 22 California *Code of Regulations* §87464(f)(3) the FACILITY was to provide JOSH DANSBY JR. with personal assistance and care so as to protect him from health and safety hazards. The DEFENDANTS failed to meet this duty to JOSH DANSBY JR., thereby causing injury to JOSH DANSBY JR. The DEFENDANTS failed to ensure the safety of JOSH DANSBY JR. and said failures were a direct result of DEFENDANTS' inability to properly train their staff in fall and resident-to-resident altercation risk prevention and failure to provide appropriate staff to protect JOSH DANSBY JR. from health and safety hazards.

53. The FACILITY allowed JOSH DANSBY JR. to be accepted into, and retained as a resident of, the FACILITY at the time of which JOSH DANSBY JR. suffered from a "restricted health condition" as defined in 22 California *Code of Regulations* §87612 and the FACILITY failed to meet

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the requirements for restricted health condition admission into a residential care facility for the elderly as set forth in Title 22, California *Code of Regulations* §87613.

54. The FACILITY admitted and/or retained JOSH DANSBY JR. as a resident of the FACILITY at a time in which JOSH DANSBY JR. suffered from a prohibited health condition which precluded admission and/or retention in the residential care facility for the elderly as defined in Title 22, California *Code of Regulations* §87615 in that JOSH DANSBY JR. requires 24-hour, skilled nursing or intermediate care as specified in *Health and Safety Code* §§1569.72(a) and (a)(1) and JOSH DANSBY JR.'s primary need for care and supervision results from both ongoing behavior, caused by a mental disorder, that would upset the general resident group and dementia without the FACILITY the requirements of Section 87705, Care of Persons with Dementia, being met.

55. The FACILITY staff advertised, promoted or otherwise held themselves as providing special care, programming and/or environments for residents suffering from dementia. Unfortunately, the FACILITY did not meet the training requirements of a facility advertising dementia special care, programming and environments as required by Title 22, California *Code of Regulations* §87707 thereby causing injury to JOSH DANSBY JR.

56. That the injuries suffered by JOSH DANSBY JR. while a resident of the FACILITY were the result of the DEFENDANTS' plan to cut costs at the expense of their residents such as JOSH DANSBY JR. Integral to this plan was the practice and pattern of staffing the FACILITY 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 failure to provide required medical and custodial care of many residents of the FACILITY, and most specifically, JOSH DANSBY JR. The DEFENDANTS failed to ensure the safety of JOSH DANSBY JR. and said failures were a direct result of DEFENDANTS' inability to properly train their staff in fall risk prevention and failure to provide appropriate staff to prevent JOSH DANSBY JR. from falling, physically fighting with other residents and suffering the resulting injuries alleged hereinabove.

57. The DEFENDANTS, by and through the corporate officers, directors and managing

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agents set forth in paragraph 5 and according to proof at time of trial, ratified the conduct of their co-defendants and FACILITY, in that they were, or in the exercise of reasonable diligence should have been, aware of the understaffing of FACILITY, in both number and training, the relationship between understaffing and sub-standard provision of care to residents of the FACILITY including JOSH DANSBY JR. Furthermore, the DEFENDANTS, by and through the corporate officers and directors set forth in paragraph 5 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 residents of the FACILITY, including JOSH DANSBY JR., and insufficiency of financial budgets to lawfully operate the FACILITY. The DEFENDANTS and their Governing Body failed to ensure the safety of JOSH DANSBY JR. and said failures were a direct result of DEFENDANTS' inability to properly train their staff in falls and resident-to-resident altercation prevention and failure to provide appropriate staff to prevent JOSH DANSBY JR. from suffering unnecessary falls, resident-to-resident altercations and injury.

58. The DEFENDANTS, and pled based upon information and belief, enacted, established and implemented the financial plan and scheme which led to FACILITY being understaffed, in both number and training, by way of imposition of financial limitations on the FACILITY 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 JOSH DANSBY JR. by the FACILITY. These choices and decisions were, and are, at the express direction of the DEFENDANTS' management personnel including the corporate officers and directors, having power to bind the DEFENDANTS set forth in paragraph 5 and according to proof at time of trial. The DEFENDANTS and their Governing Body failed to ensure the safety of JOSH DANSBY JR.

59. The Corporate authorization and enactment of DEFENDANTS, alleged in the preceding paragraphs, constituted the permission and consent of the FACILITY'S misconduct by the DEFENDANTS, by and through the corporate officers and directors, who had within their power the ability and discretion to mandate that FACILITY employ adequate staff to meet the needs of their residents, including JOSH DANSBY JR., as required by applicable rules, laws and regulations governing the operation of a Residential Care Facility for the Elderly in the State of California. The

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DEFENDANTS and their Governing Body failed to ensure the safety of JOSH DANSBY JR.

60. Based upon information and belief, it is alleged that after receiving "complaint investigations" from the Department of Social Services, that the DEFENDANTS, by and through its officers, directors, and managing agents set forth in paragraph 5 and according to proof at time of trial, and as a matter of corporate policy, created and implemented plans and schemes to hide the truth from the Complainants and/or the State of California. In so doing, these corporate officers, acting with the full knowledge, consent, authority and direction of the DEFENDANTS, ratified and participated in the unlawful and deceptive conduct alleged herein.

61. The DEFENDANTS, and each of them, were aware (and thus had notice and knowledge) of the danger to their residents when they violated applicable rules, laws and regulations, yet they acted in conscious disregard of these known perils and at the expense of legally mandated minimum care to be provided to residents in Residential Care Facilities for the Elderly in the State of California.

62. That the DEFENDANTS, and each of them, knew of these violations of applicable rules, laws and regulations at the FACILITY and the corresponding injuries to residents of the FACILITY. That the DEFENDANTS' managing agents and the governing body of the DEFENDANTS knew, prior to the injuries to JOSH DANSBY JR. as alleged herein, of the FACILITY'S violations of applicable rules, laws, and regulations. That DEFENDANTS, and their managing agents, knew that these violations typically occur in Residential Care Facilities for the Elderly which is under-staffed in number and training.

63. Notwithstanding the knowledge of the DEFENDANTS, and their managing agents set forth in paragraph 5 and according to proof at time of trial, the DEFENDANTS consciously chose not to increase staff, in number or training, at the FACILITY and as the direct result thereof JOSH DANSBY JR. suffered injuries alleged herein. This ignorance, on the part of the DEFENDANTS, constituted at a minimum, a reckless disregard for the health and safety of JOSH DANSBY JR. The DEFENDANTS failed to ensure the safety of JOSH DANSBY JR.

64. That in doing the acts alleged herein, the DEFENDANTS failed to use that degree of care that a reasonable person would have used in a similar situation in that they: (a) admitted and

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retained JOSH DANSBY JR. when the DEFENDANTS, by and through the individuals enumerated above, knew that the FACILITY was insufficiently staffed in both number and competency so as to be able to provide care which met legal and regulatory standards; (b) failed to protect JOSH DANSBY JR. from health and safety hazards; and (c) failed to provide the custodial care JOSH DANSBY JR. required so as to protect from JOSH DANSBY JR. health and safety hazards. The DEFENDANTS failed to protect JOSH DANSBY JR. from health and safety hazards by having insufficient staff to actually ensure that JOSH DANSBY JR. did not suffer the injuries as alleged herein.

65. The DEFENDANTS' conduct, as alleged herein, created circumstances or conditions likely to produce great bodily harm, and DEFENDANTS caused or permitted JOSH DANSBY JR. to suffer, or inflicted upon JOSH DANSBY JR., unjustifiable physical pain and mental suffering.

66. By engaging in the conduct, neglect, and abuse, as alleged herein DEFENDANTS' actions were malicious, oppressive, fraudulent and/or reckless.

SECOND CAUSE OF ACTION
NEGLIGENT HIRING AND SUPERVISION (CACI 426)
[By JOSH DANSBY JR. Against All Defendants Except DOES 1-10.]

67. JOSH DANSBY JR. hereby incorporates the allegations asserted in paragraphs 1 through 66 above as though set forth below.

68. That the DEFENDANTS negligently hired, supervised and/or retained employees including Donna Hurley and many caregivers, assistants, and others whose names are presently not known to Plaintiff but will be sought via discovery.

69. That Donna Hurley and others whose names are presently not known to JOSH DANSBY JR. 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 of DEFENDANTS' FACILITY such as JOSH DANSBY JR.

70. 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.

71. The DEFENDANTS failed to properly and completely conduct a comprehensive pre-

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employment interview process and reference checks as to Donna Hurley and others whose names are presently not known to JOSH DANSBY JR. 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 residential care facility for the elderly in California.

72. 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 Donna Hurley and others whose names are presently not known to JOSH DANSBY JR. 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 residential care facility for the elderly in California.

73. That as the result of the unfitness of Donna Hurley and many certified nursing assistants, registered nurses, licensed vocational nurses and others whose names are presently not known to JOSH DANSBY JR. but will be sought via discovery, JOSH DANSBY JR. was injured in an amount and manner to be proven at time of trial.

74. That the DEFENDANTS negligence in hiring, supervising and/or retaining Donna Hurley and others whose names are presently not known to JOSH DANSBY JR. but will be sought via discovery, caused JOSH DANSBY JR. injury in an amount and manner to be proven at time of trial.

THIRD CAUSE OF ACTION
ASSAULT AND BATTERY
[By JOSH DANSBY JR. Against DOES 1-5 only]

75. JOSH DANSBY JR. hereby incorporates the allegations asserted in paragraphs 1 through 76 above as though set forth below.

76. In doing the acts alleged of herein, DOES 1-5 harmfully and offensively, and without permission, touched and injured the person of JOSH DANSBY JR.

77. As the result of the Assault and Battery JOSH DANSBY JR. suffered injury in an amount and manner set forth above and according to proof at time of trial.

WHEREFORE, PLAINTIFF prays for judgment and damages as follows:

1. For general damages according to proof;

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2. For special damages according to proof;

3. For attorney's fees pursuant to *Welfare & Institutions Code* §15657(a) (as to the First Cause of Action only);

4. For punitive and exemplary damages (as to the First Cause of Action only);

5. For costs of suit; and

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

DATED: January 30, 2018

GARCIA, ARTIGLIERE & MEDBY

By: _____

Stephen M. Garcia
William M. Artigliere
David M. Medby
Attorneys for Plaintiff

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