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UNITED STATES BANKRUPTCY COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA – LOS ANGELES DIVISION

In re Beverly Community Hospital Association dba Beverly Hospital, Debtor.	Case No. 2:23-bk-12359-SK Chapter 11 **CREDITOR, ELOY SANCHEZ, ET AL'S EXHIBIT "A" TO THE DECLARATION OF BENJAMIN IKUTA RE: MOTION FOR RELIEF FROM AUTOMATIC STAY (ECF NO. 871)** **Hearing**: Date: December 6, 2023 Time: 8:30 am Ctrm: 1575 U.S. Bankruptcy Court 255 E. Temple Street Los Angeles, CA 90010

TO THE HONORABLE SANDRA KLEIN, U.S. BANKRUPTCY JUDGE; THE DEBTORS AND ITS COUNSEL; AND OTHER PARTIES ENTITLED TO NOTICE:

Creditor, Eloy Sanchez, individually and as Successor-in-Interest for Eva Sanchez, Olga Bautista, Jose Sanchez and Alvaro Sanchez's submits their Exhibit "A" to the Declaration of Benjamin Ikuta, Esq. re *Motion for Relief of Stay* (ECF No. 871), which inadvertently did not get filed with the *Relief of Stay Motion*.

Dated: November 14, 2023 **POLIS & ASSOCIATES, APLC**

By: **/s/ Thomas J. Polis**
Thomas J. Polis, Esq.
Counsel for Creditor, Eloy Sanchez, individually and as Successor-in-Interest for Eva Sanchez, Olga Bautista, Jose Sanchez and Alvaro Sa

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EXHIBIT “A”

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES, CENTRAL DISTRICT (STANLEY MOSK COURTHOUSE)

ELOY SANCHEZ, Individually and as Successor-In-Interest for EVA SANCHEZ; OLGA BAUTISTA; JOSE SANCHEZ; and ALVARO SANCHEZ,

Plaintiffs,

vs.

BEVERLY HOSPITAL; ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO; and DOES 1 through 100, Inclusive,

Defendants.

CASE NO: 23STCV24996

[UNLIMITED CIVIL]

COMPLAINT FOR DAMAGES:

1) **DEPENDENT ABUSE AND NEGLECT;**
2) **WRONGFUL DEATH; and**
3) **NEGLIGENCE THROUGH A SURVIVAL ACTION (CCP §377.20).**

DECLARATION OF ELOY SANCHEZ UNDER CODE OF CIVIL PROCEDURE SECTION 377.32

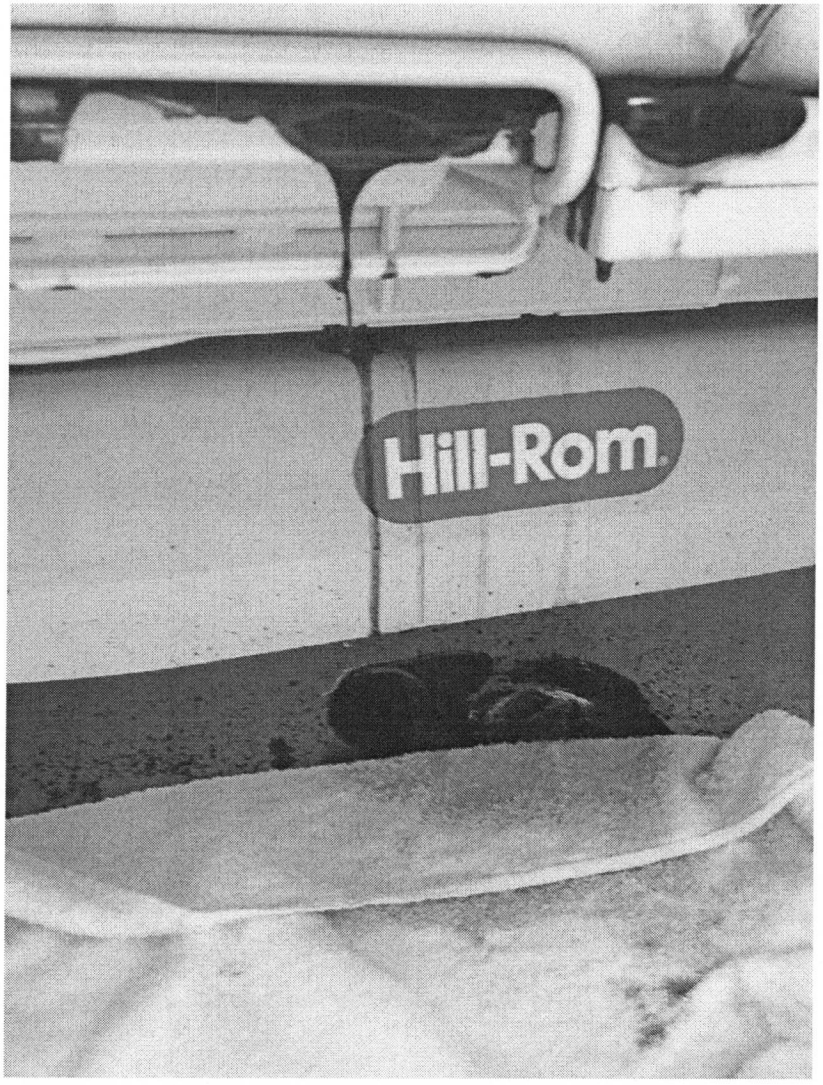
(DEMAND FOR JURY TRIAL)

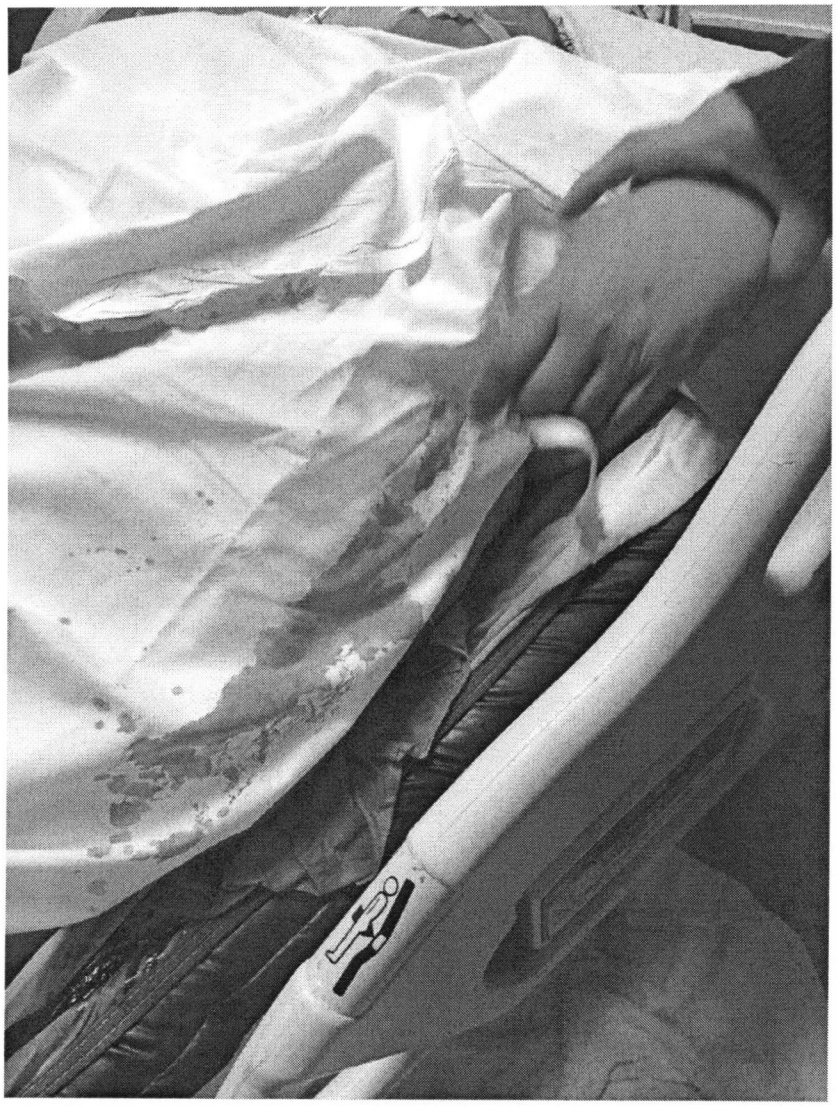
Plaintiffs ELOY SANCHEZ, Individually and as Successor-In-Interest for EVA SANCHEZ; OLGA BAUTISTA; JOSE SANCHEZ; and ALVARO SANCHEZ allege and complain as follows:

1. This case is about an understaffed and undertrained hospital, which while on the brink of bankruptcy, recklessly and wrongfully allowed a patient to bleed to death completely unattended while no one watched or cared. And then, even after killing her, the hospital willfully hid and concealed the medical records from the grieving family, who were only trying to seek answers.

2. EVA SANCHEZ bled for hours from a ***known risk***, her arteriovenous fistula site. The entire reason she was hospitalized in the first place was bleeding from her fistula.

3. EVA SANCHEZ bled to death for hours while the staff and employees at Beverly Hospital did nothing. There was so much blood that was completely missed and ignored by the nursing staff, that the blood was pooling on the floor. The following are pictures showing the extensive blood loss of Ms. SANCHEZ very shortly after her death:





4. EVA SANCHEZ ("EVA SANCHEZ" or "Ms. SANCHEZ") is an individual who at all relevant times herein was domiciled in Los Angeles County, California. EVA SANCHEZ passed away on August 11, 2022. She brings her claims by and through her Successor in Interest and spouse, ELOY SANCHEZ.

5. Plaintiff ELOY SANCHEZ is the surviving spouse and OLGA BAUTISTA, JOSE SANCHEZ, and ALVARO SANCHEZ are the surviving children of EVA SANCHEZ. Plaintiffs ELOY SANCHEZ, OLGA BAUTISTA, JOSE SANCHEZ, and ALVARO SANCHEZ bring the wrongful death cause of action in their individual capacities as Plaintiffs.

6. BEVERLY HOSPITAL and ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO (collectively, "Beverly Hospital") are at all times California corporations and, at all times herein mentioned, were doing business as a general acute care hospital located at 309 West Beverly Blvd.,

Montebello, CA 90640.

7. Plaintiffs are informed and believe and therefore allege that at all times relevant to this complaint, DOES 1 through 100 were individuals and/or entities, rendering care and services to EVA SANCHEZ and whose conduct caused the injuries and damages alleged herein.

8. Plaintiffs are ignorant of the true names and capacities of those Defendants sued herein as DOES 1 through 100, and for that reason have sued such Defendants by fictitious names. Plaintiffs will seek leave of the Court to amend this Complaint to identify said Defendants when their identities are ascertained. (Defendants ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL and DOES 1 through 10 are hereinafter referred to as "Beverly Hospital."

FIRST CAUSE OF ACTION DEPENDENT ABUSE AND NEGLECT

(By EVA SANCHEZ, by and through her Successor in Interest, ELOY SANCHEZ, Against DEFENDANTS)

9. Plaintiffs hereby incorporate the allegations set forth in the paragraphs above of the Complaint as though set forth at length herein.

10. EVA SANCHEZ was born on December 5, 1961. Given her vulnerability and her medical condition, Ms. SANCHEZ had physical or mental limitations that restricted her ability to carry out normal activities or to protect her rights.

11. Frankly, Plaintiffs do not know exactly what happened due to BEVERLY HOSPITAL's illegal and improper refusal in violation of state and federal law to provide Ms. SANCHEZ's medical records. However, Plaintiffs do have the FORM CMS-2567 finding of deficiency from the California Department of Public Health in relation to the wrongdoing of Ms. SANCHEZ.

12. Specifically, Ms. SANCHEZ was admitted to BEVERLY HOSPITAL around 9:00 p.m. on August 8, 2022. At that time, Ms. SANCHEZ had a history of diabetes, hypertension, and due to kidney failure was being treated through hemodialysis. She was admitted for evaluation for bleeding from her left upper extremity arteriovenous fistula, which was a connection between her artery and vein on her arm that was used for the hemodialysis.

13. On August 10, 2022 around 6:51 p.m., Ms. SANCHEZ's vital signs were abnormal, with a temperature of 102 degrees, a tachycardic pulse of 110, a high respiratory rate of 24, and hypertension with

a systolic reading of 152. Ms. SANCHEZ's vital signs triggered Systemic Inflammatory Response Syndrome, a serious a serious condition in which there is swelling throughout the whole body. Again, given the complete refusal of BEVERLY HOSPITAL to provide the medical chart, it is impossible to tell what happened. But based on late, after-the-fact written nursing notes *after* Ms. SANCHEZ's death, it appears that the plan was to admit Ms. SANCHEZ to the Telemetry Unit due to the abnormal vital signs.

14. Plaintiffs are informed and believe and thereupon allege that Ms. SANCHEZ arrived at the Telemetry Unit on August 10, 2022 at 8:10 p.m. A Nursing Note at 8:10 p.m. indicated that Ms. SANCHEZ was alert and oriented X 2 (when a patient knows who they are and where they are, but not what time it is or what is happening to them). However, there was no documentation of vital signs for Ms. SANCHEZ within two hours of arrival at the Telemetry Unit. Moreover, there was no physical examination or ongoing assessment, which would have identified continued bleeding from Ms. Sanchez's fistula site.

15. In violation of hospital policy, vital signs were finally taken four hours after admission to Telemetry, at around midnight on August 11, 2022, when the patient's pulse was even more tachycardic at 122 and the patient had worsening hypertension of 170/82. However, the attending nurse, which was a traveling nurse and not properly trained or education by the hospital, did not assess the fistula site for bleeding whatsoever.

16. In short, due to gross understaffing and undertraining, ***no employee or anyone at the hospital ever assessed or evaluated Ms. SANCHEZ's fistula site*** from the time she was admitted to the telemetry unit despite her abnormal vital signs. This was particularly egregious given that the entire reason Ms. SANCHEZ was admitted in the first place was due to bleeding at her fistula site.

17. Due to the complete neglect and failure to have adequate nursing staff, Ms. SANCHEZ quite literally bled to death from her fistula site. No one noticed her massive blood loss until 2:42 a.m., when Ms. SANCHEZ went into full cardiopulmonary arrest. By the time the attending emergency room physician, Pranav Desai, M.D. arrived in response to the Code Blue around 2:42 a.m., Ms. SANCHEZ had already bled out. Due to massive blood loss, Ms. SANCHEZ had no signs of life, no pulse, and no heartbeat.

18. Because she had been neglected and not watched or monitored for hours, Ms. SANCHEZ was allowed to bleed for a long period of time. There was blood on the floor, all over the gurney, and underneath the patient. Ms. SANCHEZ had lost so much blood, that there was no more active bleeding

from the AV fistula because the patient had lost almost all of her blood. Ms. SANCHEZ did not respond to multiple rounds of CPR. A blood transfusion ordered by Dr. Desai was too little, too late, as she had lost so much blood and was lifeless. She was pronounced dead at 3:16 a.m.

19. Ms. SANCHEZ was completely neglected. She did not have an assessment by a registered nurse at *any* time between 8:10 p.m. and 2:42 a.m. even though in the Telemetry Unit, assessments are required within 2 hours of admission. In the Telemetry Unit, patients must be assessed to identify any changes in condition, including when a patient is bleeding from any site.

20. The ***only*** charting was a "Late Entry" nurses note by the Registered Nurse, who documented ***after*** Ms. SANCHEZ's death on August 11, 2022 at 6:23 a.m. In that note, the nurse indicated that Ms. SANCHEZ was lethargic upon admission to the Telemetry Unit, but opened eyes and answered questions. The DACS confirmed that Ms. SANCHEZ's vital signs was taken and recorded at 12 a.m. (4 hours after arrival to the Telemetry unit), but there were no notes whatsoever that an assessment or physical examination had taken place, including assessment of the fistula site.

21. To make matters worse, the nursing staff completely failed to follow a physician's order for the monitoring of blood glucose levels and the administration of insulin. Ms. SANCHEZ was diabetic. On August 10, 2022 at 6:50 p.m., Ms. SANCHEZ's glucose levels were at an very high 241 mg/dL. However, in direct violation of doctor's orders, the nursing staff failed to provide her with much-needed insulin. There was no documentation as to why the insulin was not administered.

22. According to the doctor's orders, Ms. SANCHEZ's blood sugar should have been checked every six hours in order to provide her with the appropriate levels of insulin. Ms. SANCHEZ's blood sugar should have been checked at midnight. However, her blood sugar was never checked and she was never provided insulin. This failure to test Ms. SANCHEZ's glucose levels and provide insulin caused Ms. SANCHEZ to experience ketoacidosis, causing Ms. SANCHEZ confusion, lethargy, and adventually caused her to go into a diabetic coma. This caused Ms. SANCHEZ an inability to communicate, including inform the nursing staff of her bleeding fistula site.

23. This action is not being filed on the basis of professional negligence. (See Welfare and Institutions Code section 15657.2)

24. In a desperate effort to hide its egregious neglect and wrongdoing, Beverly Hospital refused

to provide the family with Ms. SANCHEZ's medical records in violation of federal and state law, including HIPAA, HITECH, Evidence Code section 1158, and Health and Safety Code section 123110. Despite repeatedly stating that the family had a right to medical records, the hospital lied to the family and told them that a measly 32 pages of records were the complete chart. There were no nursing notes, no imaging reports, missing physician consults, missing laboratory values, missing transfusion records, and missing vital signs.

25. After consulting with the law firm of Ikuta Hemesath, LLP, it was clear that the records were not complete even though the family clearly requested a full set of medical records. The family again requested records from the hospital but were completely ignored.

26. Accordingly, on June 13, 2023, the law firm of Ikuta Hemesath, LLP sent a letter under Evidence Code section 1158 demanding the records on Plaintiffs' behalf.

27. On June 21, 2023, over the 5-day limit allowed by Evidence Code section 1158, Beverly Hospital sent a link of 174 pages of records but wanted payment of $90.90. After Plaintiffs paid this amount, the 174 records that were provided consisting nothing but billing records and not the actual medical records.

28. Subsequently, again after the deadline, the hospital then sent a new bill for $1,420.55 for 3,973 pages of medical records.

Release of Information for Sanchez, Eva

Record Number: 579-2302108

Patient Information

Patient Name	Sanchez, Eva	Date of Service	ANY AND ALL
Date of Birth	12/5/1961	Request Received	6/13/2023
MR Number	M001002047	Page Count	3973
Your Ref #	MEDICAL RECORDS		
Info Requested	Entire Chart		

Recipient Information

Name	IKUTA HEMESATH	Email	BEN@IH-LLP.COM
Address	132 N BROADWAY	Phone #	9492265854
City	SANTA ANA	Fax #	3237254336
State	CA		
Zip	92706		

Your current balance is $1,420.55

Pay Bill Online | View Invoice

29. These charges were meant to try and prohibit Plaintiffs from being able to afford and access the medical records and were part of the ongoing fraud by Beverly Hospital to try and conceal and hide their reckless and inexcusable neglect. Indeed Evidence Code section 1158(e) limits costs to only ten cents

per page. Given that there were a total of 4,147 pages at issue, the ***most*** that Beverly Hospital could legally charge was $414.70. Yet, Beverly Hospital charged over three times that amount, $1,511.45 for 4,147 pages of records even though Beverly Hospital had initially lied to the Sanchez family and told them that 32 pages was the complete chart.

30. Thereafter, Ms. SANCHEZ's husband ELOY SANCHEZ repeatedly attempted to obtain the chart, but was refused access to the chart. After ELOY SANCHEZ retained an attorney to obtain the records under Evidence Code 1158, Beverly Hospital, without ***any*** valid explanation, again refused to produce records. Even the records that were finally produced appear to be incomplete and missing critical Nursing Notes, Medication Administration Records, Code Blue notes, and various other notes. Plaintiffs are informed and believe, and thereupon allege, that the medical records are incomplete and inaccurate.

31. Indeed, despite multiple complaints to Beverly Hospital and correspondence with various officers, directors, and managing agents, Beverly Hospital fraudulently concealed from the family what actually happened to Ms. SANCHEZ. Despite receiving correspondence from Jamie Chang, M.D., M.B.A. (Chief Clinical Operations Officer), Jennifer McReynolds (Vice President Quality Management), and Robert Gonzales (Leader of Patient Experience), no one from the hospital ever informed the family what happened to their mother, fraudulently concealing the horrible neglect and wrongful conduct committed.

32. This fraudulent concealment in hiding the records supports that Beverly Hospital ratified the wrongful conduct and neglect. (See *Samantha B. v. Aurora Vista Del Mar, LLC* (2022) 77 Cal.App.5th 85. This was also a violation of Health and Safety Code Section 1279.1(c), which states: "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The hospital concealed and hid from the family about what happened to their mother.

33. As an Acute Care Hospital, Beverly Hospital is subject to various federal and state regulations, including Title 22, Division 5, Chapter 1 of the California Code of Regulations. Here, Defendants committed reckless neglect by violating applicable state and federal regulations. (*Fenimore v. Regents of the University of California* (2016) 245 Cal.App.4th 1339, 1348.) Indeed, the California Department of Public Health ("CDPH") investigated this exact case and determined that Defendants violated regulations. The Department specifically found that Beverly Hospital failed to follow 42 Code

of Federal Regulation section 482.23(b)(6) by completely failing to supervise and evaluate the traveling and contract nurses. The Department also found that Defendants violated 42 Code of Federal Regulations sections 482.23 by not properly administration medication and failing to have an organized nursing service.

34. Pursuant to California Code of Regulations, title 22, section 70211, Defendants owed a duty to provide nursing service that was organized, staffed, equipped and supplied to meet the needs of EVA SANCHEZ. Defendants wrongfully withheld this required service to EVA SANCHEZ, causing EVA SANCHEZ' injury and death.

35. Defendants owed a duty to EVA SANCHEZ to provide services with a sufficient budget and staffing to meet EVA SANCHEZ' care needs pursuant to 42 Code of Federal Regulations part 482.23(b) and California Code of Regulations, title 22, section 70217. The Defendants wrongfully withheld this required service to EVA SANCHEZ, thereby causing injury to EVA SANCHEZ as alleged herein.

36. Indeed, BEVERLY HOSPITAL was on the verge of bankruptcy and ***knew*** it could not provide effective or adequate nursing staff. Plaintiffs are informed and believe, and thereupon allege, that Defendants violated Title 22 of the California Code of Regulations, section 70217(a)(10), which requires a 1:4 nurse-to-patient ratio **at all times** in the Telemetry Unit. What's worse, Plaintiffs are informed and believe, and thereupon allege, that Defendants ***knew*** that it did not have adequate staffing to satisfy the 1:4 nursing ratio given its financial difficulties. While it hid its understaffing and its financial difficulties from patients, finally in April 2023 BEVERLY HOSPITAL did file for bankruptcy. Plaintiffs are informed and believe that prior to finally filing for bankruptcy, BEVERLY HOSPITAL did everything it could to cut corners and limit budgets and staffing in order to stay in business, including having insufficient and inadequate staffing 8 months earlier when BEVERLY HOSPITAL and its nurses recklessly allowed EVA SANCHEZ to bleed to death unmonitored.

37. The Defendants voluntarily and intentionally assumed responsibility for providing supervisory and custodial care services to EVA SANCHEZ. At all relevant times, Defendants had the care and custody of EVA SANCHEZ and were responsible for EVA SANCHEZ' health, safety and well-being. This was particularly important given that EVA SANCHEZ was vulnerable and in a diabetic coma due to her uncontrolled and untreated hyperglycemia.

38. Indeed, not only did the reckless failure to provide insulin or even test EVA SANCHEZ' glucose levels cause Ms. SANCHEZ to be in such a vulnerable condition that she could not inform the nursing staff of her bleeding fistula, the failure to follow the physician orders as to the testing of glucose and administration of insulin also constitutes dependent adult abuse. (See *Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 97; *Sababin v. Superior Court* (2006) 144 Cal.App.4th 81, 88.)

39. The Defendants knew that EVA SANCHEZ depended upon them to assist with her needs and safety because upon her admission to ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL, they ***knew*** she had a history of a bleeding fistula. Despite this knowledge, the Defendants denied or withheld medical care to EVA SANCHEZ, in conscious disregard of the high probability of injury to her, such that she suffered an untimely death.

40. Defendants engaged in neglect under Welfare and Institutions Code section 15610.57(b) due to a "Failure to protect from health and safety hazards." Beverly Hospital failed to protect Ms. SANCHEZ from her ***known*** and ***significant*** risk of bleeding to death by not evaluating or assessing her fistula within 2 hours of her admission to the Telemetry Unit in ***direct violation*** of their own polices and procedures. (See *Samantha B. v. Aurora Vista Del Mar, LLC* (2022) 77 Cal.App.5th 85 [where the second district criticized and distinguished *Carter v. Prime Healthcare Paradise Valley LLC* (2011) 198 Cal.App.4th 396, 406 for not recognizing that "failure to protect from health and safety hazards" qualifies as neglect.].) Likewise, the failure to treat Ms. Sanchez's significant hyperglycemia in direct violation of doctor orders constituted a failure to protect Ms. SANCHEZ from a known health and safety hazard.

41. Plaintiffs are informed and believe, and thereupon allege, that ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL was understaffed. There was insufficient nursing staff to adequately provide care and treatment to EVA SANCHEZ as there was insufficient nursing staff to provide ***individualized*** care.

42. The Defendants operated in such a way as to make their individual identities indistinguishable, and they are, therefore, the mere alter-egos of one another. Specifically, corporate and business shell layers were formed for the sole purpose of insulating the individual beneficiaries of the management fees from liability, while obscuring the identities of those responsible for the care and services being provided to patients and residents at ADVENTIST HEALTH WHITE MEMORIAL

MONTEBELLO and BEVERLY HOSPITAL. By creating individual shell entities to hold the individual licenses for each individual facility, the owners and/or beneficiaries of the management fees are able to hide from public disclosure ownership, management, and control over other facilities to create the false appearance of each individual facility being independent of one another. At all relevant times to this action however, the Defendants had a unity of interest and ownership such that their separate personalities did not meaningfully exist.

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

44. The DEFENDANTS managed themselves, governed and controlled the care and custodial services provided to EVA SANCHEZ, and, by virtue of their management and control, voluntarily and intentionally assumed responsibility for and provided care to EVA SANCHEZ during her admission to ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL.

45. The DEFENDANTS' neglect and abuse of EVA SANCHEZ was due to the fact that DEFENDANTS underfunded and understaffed ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL in order to decrease expenses. As part of their cost-cutting scheme, the DEFENDANTS implemented cost cutting measures at ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL, which included failing maintain the required number of nurses for their units. Had DEFENDANTS had proper staffing, EVA SANCHEZ's individualized care plan would have been followed and she would not have been exposed to the health and safety hazard of exactly the thing that she was admitted for. Consequentially, EVA SANCHEZ would not have passed away.

46. The DEFENDANTS intentionally underfunded and understaffed ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL, even though the DEFENDANTS knew that their conduct severely jeopardized the health, safety, welfare, and dignity of their patients,

including EVA SANCHEZ.

47. The DEFENDANTS implemented and carried out their cost-cutting scheme with knowledge such a scheme was designed to exploit elderly and dependent adults, a class expressly deemed by the Legislature of the State of California as a vulnerable segment of our population who require a heightened level of protection.

48. The DEFENDANTS knew from surveys and complaints that ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL was underfunded and understaffed, yet the DEFENDANTS failed to do anything to correct this, even though the DEFENDANTS knew that patients, including EVA SANCHEZ, would and did suffer. The DEFENDANTS' acts and omissions as alleged herein constitute recklessness, malice, oppression, and fraud, in part, because they knew about and were on notice of the problems at ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL, yet intentionally ignored these problems at the expense of the health, safety, and well-being of their patients, including EVA SANCHEZ. Had the DEFENDANTS heeded the warnings of the complaints and surveys that uncovered the problems at ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL, the injuries to EVA SANCHEZ could have and would have been prevented.

49. Indeed, the ***same*** finding of deficiency by the California Department of Public Health included ***22 other patients***. This included serious and repeated violations, showing that DEFENDANTS ***knew*** of its problems and yet did nothing about it. Besides Ms. Sanchez, the Department found that Beverly Hospital consistently violated its own policies, failed to provide baseline care plans for multiple patients, failed to perform a venous thromboembolism risk assessment on two separate patients in violation of physician orders and their own policy, failed to have communication or interpretation services, failed to adhere to proper IV Therapy for five patients, failed to properly perform dialysis on a patient, failed to follow DVT prophylaxis measures for patients, and various other serious failures.

50. The DEFENDANTS ratified the conduct of each of their co-defendants in that they mandated, knew, and/or acquiesced to the chronic understaffing of ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL and were aware that such understaffing led to injury to patients.

51. The DEFENDANTS had within their power, ability and discretion to mandate that ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL employ adequate staff to meet the needs of their patients, including EVA SANCHEZ, yet each of the DEFENDANTS intentionally and/or with conscious disregard failed to do so.

52. The harm inflicted upon EVA SANCHEZ would not have occurred but for the willful disregard by the DEFENDANTS of their duties to EVA SANCHEZ.

53. As a direct result of the DEFENDANTS' conduct as alleged herein, the DEFENDANTS allowed EVA SANCHEZ to suffer pain, indignity, injury, and ultimately death, all of which were entirely preventable had the DEFENDANTS provided enough sufficiently trained staff at ADVENTIST HEALTH WHITE MEMORIAL MONTEBELLO and BEVERLY HOSPITAL to provide EVA SANCHEZ with the amount of care, monitoring, and supervision that state and federal regulations required.

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

55. The injuries suffered by EVA SANCHEZ through the misconduct and reckless neglect of the DEFENDANTS, as alleged herein, resulted from their provision of custodial care to EVA SANCHEZ. This misconduct on the part of the DEFENDANTS included, without limiting the generality of the foregoing and merely by way of example, the failure to adequately monitor, supervise, and observe EVA SANCHEZ; the failure to protect EVA SANCHEZ from health and safety hazards; the failure to provide her with adequate hygiene assistance; and the failure to prevent dehydration and the pressure ulcers.

56. These failures are not all related to the performance of medical services in a manner inferior to "the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing;" rather, they are related to the obligation by those responsible for attending to the basic needs and comforts of EVA SANCHEZ -regardless of their professional standing - to provide basic custodial care. No professional license is required to ensure that EVA SANCHEZ was supervised, monitored, or otherwise not neglected. No professional license is required to ensure that the DEFENDANTS not be underfunded or inadequately staffed or inadequately trained. No professional license is required to ensure that simple orders

as to feeding is followed. In sum, the acts and omissions alleged herein are acts or omissions related to "custodial" services, not "professional" services.

57. The DEFENDANTS' failures to act as a reasonable person would under the same circumstances, including the failure to assist EVA SANCHEZ with any medical care for the substantial bleed constitutes "neglect" under Welfare and Institutions Code section 15610.57(b)(1), and such neglect was committed with recklessness, malice, oppression, and fraud.

58. As a direct and proximate result of this neglect of EVA SANCHEZ's needs, EVA SANCHEZ sustained multiple injuries and death. DEFENDANTS willfully, intentionally, and/or recklessly caused or permitted EVA SANCHEZ to be injured and/or to be placed in a situation such that her health was in danger. DEFENDANTS' conduct, as alleged herein, created circumstances or conditions likely to produce great bodily harm, and they willfully caused or permitted EVA SANCHEZ to suffer, or inflicted upon her, unjustifiable physical pain and mental suffering.

SECOND CAUSE OF ACTION FOR WRONGFUL DEATH

(By Plaintiffs OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ, and ELOY SANCHEZ against All Defendants)

59. Plaintiffs hereby incorporate the allegations set forth above as if fully set forth herein.

60. Plaintiffs OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ, and ELOY SANCHEZ bring this cause of action for wrongful death under Code of Civil Procedure section 377.60.

61. EVA SANCHEZ died on August 11, 2022, as a result of the acts and omissions of the DEFENDANTS as set forth supra.

62. Plaintiff OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ are the surviving children of EVA SANCHEZ, and ELOY SANCHEZ is the surviving spouse of EVA SANCHEZ. They bring this claim for Wrongful Death in their individual capacities.

63. The DEFENDANTS owed duties to protect EVA SANCHEZ from the abuse, and neglect alleged supra, which ultimately caused EVA SANCHEZ's death. However, the DEFENDANTS breached those duties by allowing EVA SANCHEZ to bleed to death despite knowing that her fistula was at risk of bleeding. They also completely failed to provide EVA SANCHEZ with insulin despite her hyperglycemia and failure to test her glucose in direct violation of doctor orders. This wrongful conduct lead to EVA

SANCHEZ's death.

64. The breaches of DEFENDANTS' duties caused injury and death to EVA SANCHEZ.

65. As described above, the various violations of the Title 22 of the California Code of Regulations amounts to Negligence Per Se.

66. The DEFENDANTS' acts and omissions as alleged supra were the direct, actual, legal, and proximate causes of EVA SANCHEZ's injuries and death.

67. EVA SANCHEZ would not have suffered death but for DEFENDANTS' conduct and breaches of duty.

68. Prior to EVA SANCHEZ's death, Plaintiff OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ, and ELOY SANCHEZ enjoyed the love, society, comfort, and attention of their loving matriarch.

69. As a proximate result of the acts and omissions by all the DEFENDANTS alleged supra, Plaintiffs OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ, and ELOY SANCHEZ sustained the loss of love, society, comfort, and attention of their loving matriarch, EVA SANCHEZ, for which they seek general damages.

70. As an additional result of the acts and omissions by all DEFENDANTS alleged supra, EVA SANCHEZ's family incurred funeral and burial expenses for the burial of EVA SANCHEZ, for which they seek special damages.

THIRD CAUSE OF ACTION FOR NEGLIGENCE

(By EVA SANCHEZ, by and through her Successor in Interest, ELOY SANCHEZ, Against DEFENDANTS)

71. Plaintiff and Decedent EVA SANCHEZ brings this Survivorship cause of action through his successor in interest, ELOY SANCHEZ pursuant to Code of Civil Procedure section 377.20.

72. Plaintiff and Decedent EVA SANCHEZ did not die right away from DEFENDANTS' neglectful and wrongful conduct. To the contrary, Decedent EVA SANCHEZ suffered a painful, frightening, and traumatic event in being allowed to bleed to death while completely unmonitored by DEFENDANTS' staff. She was unable to cry for help while bleeding to death due to the severe hyperglycemia due to DEFENDANTS' wrongful withholding of insulin in direct violation of physician orders.

73. As a direct actual, legal, and proximate cause of DEFENDANTS' conduct, as alleged herein, EVA SANCHEZ suffered unjustifiable and substantial physical pain, mental suffering, loss of enjoyment of life, disfigurement, physical impairment, inconvenience, grief, anxiety, and emotional distress and eventually died on August 11, 2022. For these non-economic damages, Plaintiff EVA SANCHEZ seeks damages ***separate, apart, and in addition to*** the general damages sought by EVA SANCHEZ's heirs in the second cause of action. (See Code Civ. Proc., § 377.34(b).)

PRAYER

WHEREFORE, Plaintiffs pray for judgment against the Defendants, and each of them, as follows:

1. For punitive and exemplary damages according to proof (first cause of action only);
2. For attorney's fees (first cause of action only);
3. For OLGA BAUTISTA, JOSE SANCHEZ, ALVARO SANCHEZ, and ELOY SANCHEZ's noneconomic damages for the loss of EVA SANCHEZ's love, companionship, comfort, care, assistance, protection, affection, society, moral support for the second cause of action for wrongful death (second cause of action only);
4. For EVA SANCHEZ's pre-death pain and suffering damages as available under Code of Civil Procedure section 377.34(b) (first and third causes of action)
5. For interest as allowed by law;
6. For costs of suit as allowed by law; and
7. For such other and further relief as the Court deems just and proper.

Dated: October 12, 2023

IKUTA HEMESATH, LLP

By: _____
Benjamin T. Ikuta, Esq.
Attorneys for Plaintiffs

/ / /

/ / /

/ / /

/ / /

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a trial by jury in this action.

Dated: October 12, 2023

IKUTA HEMESATH, LLP

By: _____
Benjamin T. Ikuta, Esq.
Attorneys for Plaintiffs

DECLARATION OF SUCCESSOR IN INTEREST PURSUANT TO CODE OF CIVIL PROCEDURE SECTION 377.32

I, Eloy Sanchez, declare:

1. I have personal knowledge of the facts contained in this declaration.
2. I am the Successor in Interest of Decedent Eva Sanchez, who passed away on August 11, 2022 in Los Angeles, California.
3. No proceeding is now pending in California for administration of the decedent's estate.
4. I am the decedent's successor in interest (as defined in Section 377.11 of the California Code of Civil Procedure) and succeeds to the decedent's interest in the action or proceeding.
5. No other person has a superior right to commence the action or proceeding or to be substituted for the decedent in the pending action or proceeding.
6. A copy of decedent's death certificate is attached to this declaration.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on July 1, 2023 at Los Angeles, California.

7/1/2023

DocuSigned by:
Eloy Sanchez
2D884570EAE9436...

Eloy Sanchez

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

3052022194223

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 REV 1/08

3202219043434
LOCAL REGISTRATION NUMBER

STATE FILE NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT – FIRST (Given)	2. MIDDLE	3. LAST (Family)
EVA	-	SANCHEZ

AKA. AS SO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)	4. DATE OF BIRTH mm/dd/ccyy	5. AGE YRS	If under 1 year: Months / Days	If under 24 hours: Hours / Minutes	6. SEX
EVA OLGA SANCHEZ	12/05/1961	60			F

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP at Time of Death	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 hours)
CA	[redacted]	☐ YES ☒ NO ☐ UNK	MARRIED	08/11/2022	0316

13. EDUCATION – Highest Level Degree (See instruction on back)	14/13. WAS DECEDENT HISPANIC/LATINO/A/SPANISH? (If yes, see instruction on back)	15. DECEDENT'S RACE – Up to 3 races may be listed (See instruction on back)
HS GRADUATE	☒ YES HISPANIC ☐ NO	CAUCASIAN

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION
HOMEMAKER	OWN HOME	41

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)				
406 SOUTH FERRIS AVENUE				
21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
LOS ANGELES	LOS ANGELES	90022	50	CA

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
ALVARO SANCHEZ, SON	5600 VIA SAN DELARRO STREET, LOS ANGELES, CA 90022

SPOUSE/RDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP – FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
ELOY	LEDESMA	SANCHEZ	
31. NAME OF FATHER/PARENT – FIRST	**32. MIDDLE**	**33. LAST**	**34. BIRTH STATE**
MARTIN	CEJA	RAMIREZ	MEXICO
35. NAME OF MOTHER/PARENT – FIRST	**36. MIDDLE**	**37. LAST (BIRTH NAME)**	**38. BIRTH STATE**
MARIA	-	GONZALEZ	MICH. MX

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION	
08/23/2022	AT SEA OFF THE COAST OF LOS ANGELES COUNTY	
41. TYPE OF DISPOSITION(S)	**42. SIGNATURE OF EMBALMER**	**43. LICENSE NUMBER**
CREMATE/SCATTER AT SEA	▸ DAMIEN NIGEL WRIGHT	EMB9406
44. NAME OF FUNERAL ESTABLISHMENT	**45. LICENSE NUMBER**	**46. SIGNATURE OF LOCAL REGISTRAR**	**47. DATE mm/dd/ccyy**
TORRES MORTUARY	FD2234	▸ MUNTU DAVIS MD	08/23/2022

PLACE OF DEATH

48. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
BEVERLY HOSPITAL	☒ IP ☐ ER/OP ☐ DOA	☐ Home ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
LOS ANGELES	309 W BEVERLY BLVD	MONTEBELLO

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terms of events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death	108. DEATH REPORTED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(a) CARDIAC ARREST	(a) MINS	☒ YES ☐ NO
Sequentially list conditions, if any, leading to cause on line a. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(b) CARDIAC ARRHYTHMIA	(b) MINS	109. AUTOPSY PERFORMED? ☐ YES ☒ NO
	(c) ELECTROLYTE IMBALANCE	(c) HRS	110. AUTOPSY PERFORMED? ☐ YES ☒ NO
	(d) END STAGE RENAL DISEASE	(d) YRS	111. USED IN DETERMINING CAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
BLEEDING ARTERIOVENOUS FISTULA

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date)
FISTULOGRAM AND REPAIR 08/10/2022

113A. IF FEMALE, PREGNANCY? ☐ YES ☒ NO ☐ UNK

INFORMANT'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED		115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
Decedent Attended Since (a) mm/dd/ccyy	Decedent Last Seen Alive (b) mm/dd/ccyy	▸ GABRIEL NOAH WATERMAN, MD	A144802	08/19/2022
08/10/2022	08/10/2022	118. TYPE OR PRINT ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, AND ZIP CODE: GABRIEL NOAH WATERMAN, MD 15230 HAWTHORNE BOULEVARD, LAWNDALE, CA 90260		

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.
MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending Investigation ☐ Could not be determined

120. INJURED AT WORK? ☐ YES ☐ NO ☐ UNK

121. INJURY DATE mm/dd/ccyy

122. HOUR (24 hours)

123. PLACE OF INJURY (e.g., home, construction site, vacation area, etc.)

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)

126. SIGNATURE OF CORONER / DEPUTY CORONER

127. DATE mm/dd/ccyy

128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER

STATE REGISTRAR	A	B	C	D	E	FAX AUTH.#	CENSUS TRACT
					[redacted]		

CERTIFIED COPY OF VITAL RECORD
STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

This is a true certified copy of the record filed in the County of Los Angeles Department of Public Health if it bears the Registrar's signature in purple ink.

003554032

Deputy Official and Registrar — DATE ISSUED AUG 24 2022

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar

DO 25

PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is: 19800 MacArthur Blvd., Suite 1000, Irvine, CA 92612

A true and correct copy of the foregoing document entitled: **CREDITOR, ELOY SANCHEZ, ET AL'S EXHIBIT "A" TO THE DECLARATION OF BENJAMIN IKUTA RE: MOTION FOR RELIEF FROM AUTOMATIC STAY (ECF NO. 871)** will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF)**: Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On (*date*) **November 14, 2023**, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

See attached

☒ Service information continued on attached page

2. SERVED BY UNITED STATES MAIL: On (*date*) **November 14, 2023**, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows. Listing the judge here constitutes a declaration that mailing to the judge will be completed no later than 24 hours after the document is filed.

See attached

☒ Service information continued on attached page

3. SERVED BY PERSONAL DELIVERY, OVERNIGHT MAIL, FACSIMILE TRANSMISSION OR EMAIL (state method for each person or entity served): Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on (*date*) _____, I served the following persons and/or entities by personal delivery, overnight mail service, or (for those who consented in writing to such service method), by facsimile transmission and/or email as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

☐ Service information continued on attached page

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

November 14, 2023	Cristina Allen	/s/ Cristina Allen
Date	*Printed Name*	*Signature*

CONTINUED PROOF OF SERVICE

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF)**:

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2. **SERVED BY UNITED STATES MAIL**:

See attached

SECTION II – U.S. MAIL SERVICE

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Hon. Sandra R Klein
U.S. Bankruptcy Court
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Los Angeles, CA 90012

Debtor
Beverly Community Hospital Association
309 West Beverly Blvd
Montebello, CA 90640

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Medline Industries, LP
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Outset Medical
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Sodexo Inc & Affiliates
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UNAC/UHCP
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In re: BEVERLY COMMUNITY HOSPITAL ASSOCIATION; 23-12359-SK

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