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EXEMPT FROM FEES
GOV'T. CODE § 6103



SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

**THE PEOPLE OF THE STATE OF CALIFORNIA,**

Plaintiff,

**v.**

**SWEETWATER CARE OPCO, LLC; SWEETWATER CARE RESOURCE, LLC; SWEETWATER YV CHOLLA OPCO, LLC; SWEETWATER YV JOSHUA OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC; AJC HEALTHCARE, LLC; JBG PARTNERS, LLC; ALMOND VIEW CARE CENTER, LLC; BROOKSIDE CARE CENTER, LLC; EVERGREEN CARE CENTER, LLC; FEATHER RIVER CARE CENTER, LLC; FOWLER CARE CENTER, LLC; GRAND OAKS CARE, LLC; VINDRA, INC.; NOBLE CARE CENTER, LLC; ORCHARDS AT TULARE, LLC; PALMS CARE CENTER, LLC; RANCHO SECO CARE CENTER, LLC; RIVERWALK CARE CENTER, LLC; ROLLING HILLS CARE CENTER, LLC; GATEWAY CARE, LLC; SHASTA VIEW CARE CENTER, LLC;**

Case No.: 25CU033612N

**COMPLAINT FOR PERMANENT INJUNCTION, CIVIL PENALTIES, RESTITUTION, AND OTHER EQUITABLE RELIEF**

**(Business and Professions Code, §§ 17200, 17500 et seq.)**

**VALLEY VIEW CARE CENTER, LLC; VINEYARDS AT FOWLER, LLC; AARON CHESLEY; JAMES GAMETT; AND DOES 1 THROUGH 300, INCLUSIVE,**

Defendants.

Plaintiff, the People of the State of California ("Plaintiff" or the "People"), bring this suit, represented by the Attorney General of the State of California, who is authorized to protect the general public, including elder and dependent adults within the State of California from unlawful, unfair, and fraudulent business practices. The People hereby allege the following on information and belief.

## I. INTRODUCTION

1. Defendants engaged in repeated and persistent violations of California minimum staffing laws applicable to the operation of skilled nursing facilities ("SNFs"). While Defendants engaged in over 25,000 violations of California staffing laws between 2020 and 2024 according to their own staffing data, Defendants collected millions of dollars in public funds, including over $196 million in revenue from the Medi-Cal program, through the end of 2023.

2. The Legislature of the State of California recognized that elders and dependent adults are at risk of abuse, neglect, or abandonment and that this state has a responsibility to protect these persons. The Legislature has further recognized that the sufficient staffing of a Skilled Nursing Facility is imperative to prevent such patient harms. SNF patients often have medical diagnoses and other physical or mental limitations that render them unable to ask for help or to care for themselves. As such, these vulnerable patients are dependent upon the owners and operators of SNFs to operate with nursing staff in sufficient numbers to comply with laws in order to ensure their needs are met and rights are not violated. Research demonstrates that insufficient staffing is associated with an increase of patient harm.

3. Given the above concerns, California law mandates that a SNF provide 3.5 hours of direct care per patient, per day. (Health & Saf. Code, § 1276.65, subd. (c)(1)(B).) Licensed nurses are one of the two principal vehicles for the delivery of care to patients in a SNF. Licensed nurses are responsible, within the appropriate scope of their nursing licensure, for carrying out critical

aspects of the nursing process including conducting patient assessments, care planning, initiating appropriate interventions to meet risks, evaluating the patient's ongoing condition, and evaluating efficacy of their plans of care. Furthermore, licensed nurses are responsible for provision of nursing care to meet more complex medical needs such as administering medications at several points in the day, carrying out orders for therapies, assessing wounds, checking vital signs, and provision of wound treatments. Defendants chronically failed to meet this staffing obligation.

4. The second principal vehicle for the delivery of care to patients in a SNF comes from certified nurse assistants ("CNAs"). CNAs assist patients with the most basic activities of daily living such as grooming, toileting, bathing, eating, moving, and supervision. Because of the vital role that CNAs play in the appropriate operation of a SNF, California law further mandates – as a separate and independent obligation – that 2.4 hours of the 3.5 direct care hours come from CNAs. (Health & Saf. Code, § 1276.65, subd. (c)(1)(C).) Defendants also chronically failed to meet this staffing obligation.

5. Although California law mandates a minimum of 3.5 direct care hours per patient day, with 2.4 hours from CNAs, this minimum staffing requirement is exactly that: a minimum. SNF patients have needs that persist 24 hours a day. Many of these needs cannot be "scheduled." Thus, a SNF must have sufficient staff to address the unplanned incidents and emergencies that invariably arise. Moreover, patients who are sicker will require additional staffing resources. California law accordingly also requires a facility to staff for the acuity needs of its patients. (Health & Saf. Code, § 1276.65, subd. (d).) In other words, a SNF is required to have staff sufficient in numbers to meet the medical needs of its particular patient population. This is a staffing obligation that is independent of the minimum staffing requirement to provide 3.5 direct care nursing hours per patient day. As set forth in detail below, Defendants consistently failed to provide sufficient staff to meet the medical needs of the relevant patient populations.

6. Violations of the laws and regulations related to staffing and other aspects of nursing care expose this fragile population to *preventable* injuries, harms, and violations of patient rights. While Defendants were understaffed in violation of California law, patients developed pressure ulcers so deep that a hip joint was visible, suffered unwitnessed falls with bone fractures, eloped

from facilities unbeknownst to staff resulting in head trauma, developed medical emergencies unnoticed by staff, suffered bone fractures for days without appropriate assessment or care, and were left for extended periods of time soiled in urine and feces.

7. Defendants operated a quickly growing chain of SNFs in the State of California, which grew from two licensed facilities in 2020 to seventeen in 2024. At all times, Defendants had a duty to comply with laws and regulations pertaining to nurse staffing and patient care. Defendants had an equally important duty to comply with their own promises to patients regarding nurse staffing and the quality of patient care. Each time Defendants admitted a patient into one of their facilities, they contracted to provide appropriate care in exchange for payment. However, as set forth below, Defendants engaged in a systemic, chain-wide business practice of understaffing that prioritized facility acquisitions, growth, and profit at the expense of compliance with their promises to patients and California laws.

8. Understaffing is associated with missed nursing care, omissions in care, and increased incidence in adverse resident outcomes including hospitalizations, emergency room use, incidence and prevalence of pressure injuries, restraint use, urinary catheterizations and infections, contractures, inappropriate antipsychotic drug use, violations of SNF regulations, patient death, and infections.[1]

9. The Defendants' unlawful, unfair, and fraudulent business practices violate California's Unfair Competition Law (Bus. & Prof. Code, § 17200 et seq.). Patients of the Defendants' chain of SNFs have been subjected to persistent and continuous violations of their rights to minimum nursing staff levels required by law and regulations, violations of their Patient Rights as defined under California law, substandard nursing care, and preventable harms, as alleged more fully herein.

## II. PARTIES

10. Plaintiff is the People of the State of California, by and through the Attorney General of California, who is authorized by Business and Professions Code sections 17204 and 17206 to

[1] Charlene Harrington, et al., *Nursing Home Guide to Adjusted Nurse Staffing for Resident Case-Mix*, Journal of the American Geriatrics Society, 2025; 0:1-9.

enforce the Unfair Competition Law, or "UCL" (Bus. & Prof. Code, § 17200 et seq.).

11. Defendants are a chain of skilled nursing facilities operating in the State of California that are owned through multiple layers of limited liability companies by the ultimate beneficial owners, Defendants AARON CHESLEY ("CHESLEY") and JAMES GAMETT ("GAMETT"). Through limited liability companies wholly owned by Defendants CHESLEY and GAMETT, millions of dollars of funds, arising largely from public funding such as Medi-Cal and Medicare, were extracted from SNF revenues for purported "management" services, "administrative" services, or profits.

12. **The SWEETWATER OWNER DEFENDANTS:** Defendant AARON CHESLEY is the sole member, managing member, and 100% owner of AJC HEALTHCARE, LLC, a Utah limited liability company ("AJC"). AJC does business in the State of California from its business address of 662 Encinitas Blvd., Suite 216, in Encinitas, California. Defendant GAMETT is the member and 100% owner of JBG PARTNERS, LLC, a Nevada limited liability company ("JBG"). JBG does business in the State of California from its business address of 662 Encinitas Blvd., Suite 216, in Encinitas, California. In cost reports submitted to the State of California Department of Health Care Access and Information ("HCAI"), Defendants CHESLEY and GAMETT have been identified as the sole members of the Governing Board of Defendants VALLEY CARE CENTER, YUCCA VALLEY NURSING, BROOKSIDE CARE CENTER, NOBLE CARE CENTER, RANCHO SECO CARE CENTER, and VINEYARDS AT FOWLER which are discussed in greater detail in paragraph 14, *infra*. Together, Defendants CHESLEY, GAMETT, AJC, JBG, and DOES 1-25, directly or indirectly owned, operated, and/or controlled the SWEETWATER MANAGEMENT DEFENDANTS and SWEETWATER FACILITY DEFENDANTS discussed *infra*. Defendants CHESLEY and GAMETT were the managers of each limited liability company listed in paragraphs 13 and 14 *infra*. Defendants CHESLEY, GAMETT, AJC, JBG, and DOES 1-25 are hereinafter referred to as the "SWEETWATER OWNER DEFENDANTS."

13. **The SWEETWATER MANAGEMENT DEFENDANTS:** Defendant SWEETWATER CARE OPCO, LLC, a Nevada Limited Liability Company, and Defendant

SWEETWATER CARE RESOURCE, LLC, a California Limited Liability Company, and DOES 26-50, (hereinafter the "SWEETWATER MANAGEMENT DEFENDANTS"), were owned by Defendants AJC and JBG. Defendant SWEETWATER CARE RESOURCE, LLC's principal place of business was located at 662 Encinitas Boulevard, Carlsbad, California until it relocated to 1000 Aviara Parkway, Carlsbad, California. SWEETWATER CARE RESOURCE, LLC, was the sole entity that paid the lease at the principal place of business addresses, however each of the entities listed in paragraphs 13-14 herein did business from the same addresses without having to pay rent to utilize this office space. The SWEETWATER MANAGEMENT DEFENDANTS were at all relevant times herein responsible for the operation, management, and/or control of the SWEETWATER FACILITY DEFENDANTS discussed at paragraph 14, through provision of management, administrative, and other services. In exchange for these services, the SWEETWATER MANAGEMENT DEFENDANTS extracted revenue from the SWEETWATER FACILITY DEFENDANTS that was derived in whole or part from public funds paid by Medi-Cal or Medicare to provide nursing care to SNF patients. For instance, the SWEETWATER MANAGEMENT DEFENDANTS extracted $17,458,378 from facility revenues for purported "management" and "administrative" services from 2020-2023.

14. **The SWEETWATER FACILITY DEFENDANTS:** Defendants AJC and JBG hold equal ownership interests in three Nevada limited liability companies, which in turn were the members of the eighteen California limited liability companies and one California corporation which serve as the licensees of the Sweetwater skilled nursing facilities detailed in this paragraph:

a) **Defendant SWEETWATER CARE OPCO, LLC,** is a Nevada limited liability company and is owned by its members Defendant AJC and Defendant JBG. Defendant SWEETWATER CARE OPCO, LLC, and DOES 51-60, are members of the California limited liability companies which held the licenses to operate the following two skilled nursing facilities, and were thus jointly responsible for the operation, management, and control of said facilities:

i. Defendant SWEETWATER YV CHOLLA OPCO, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California

("VALLEY CARE CENTER"). VALLEY CARE CENTER, and DOES 61-65, held the license to operate the 58-bed skilled nursing facility, doing business as "Valley Care Center," with its principal place of business located at 8515 Cholla Avenue, in the City of Yucca Valley, in the County of San Bernardino, in the State of California.

ii. Defendant SWEETWATER YV JOSHUA OPCO, LLC, is a California limited liability company, located at 1000 Aviara Parkway, in Carlsbad, California ("YUCCA VALLEY NURSING"). YUCCA VALLEY NURSING, and DOES 66-70, held the license to operate the 99-bed skilled nursing facility, doing business as "Yucca Valley Nursing and Rehabilitation Center," with its principal place of business located at 57333 Joshua Lane, in the City of Yucca Valley, in the County of San Bernardino, in the State of California.

b) **Defendant SWC CA OPCO, LLC,** is a Nevada limited liability company and is owned by its members, Defendant AJC and Defendant JBG, whose principal place of business is 662 Encinitas Blvd., Suite 216, in Encinitas, California. Defendant SWC CA OPCO, LLC, and DOES 71-80, were the members of the following five California limited liability companies, and were thus jointly responsible for the operation, management, and control of said facilities:

i. Defendant EVERGREEN CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, in Carlsbad, California ("EVERGREEN CARE CENTER"). Defendant SWC CA OPCO, LLC, is the sole member of EVERGREEN CARE CENTER. EVERGREEN CARE CENTER, and DOES 81-90, held the license to operate the 49-bed skilled nursing facility doing business as "Evergreen Care Center," with its principal place of business at 5265 Huntington Avenue, in the City of Fresno, in the County of Fresno, in the State of California.

ii. Defendant PALMS CARE CENTER, LLC, is a California limited liability company, previously located at 662 Encinitas Boulevard, Suite 216 in

Encinitas, California, and currently located at 1000 Aviara Parkway, Carlsbad, California ("PALMS CARE CENTER"). Defendant SWC CA OPCO, LLC, is the sole member of PALMS CARE CENTER. PALMS CARE CENTER, and DOES 91-100, held the license to operate the 62-bed skilled nursing facility doing business as "Palms Care Center," with its principal place of business at 1010 Ventura Avenue, in the City of Chowchilla, in the County of Madera, in the State of California.

iii. Defendant VALLEY VIEW CARE CENTER, LLC, is a California limited liability company, previously located at 662 Encinitas Blvd, Suite 216 in Encinitas, California, and currently located at 1000 Aviara Parkway, Carlsbad, California ("VALLEY VIEW CARE CENTER"). Defendant SWC CA OPCO, LLC, is the sole member of VALLEY VIEW CARE CENTER. VALLEY VIEW CARE CENTER, and DOES 101-110, held the license to operate the 53-bed skilled nursing facility doing business as "Valley View Care Center," with its principal place of business at 729 Browning Road, in the City of Delano, in the County of Kern, in the State of California.

iv. Defendant FOWLER CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("FOWLER CARE CENTER"). Defendant SWC CA OPCO, LLC, is the sole member of FOWLER CARE CENTER. FOWLER CARE CENTER, and DOES 111-120, held the license to operate the 46-bed skilled nursing facility doing business as "Fowler Care Center," with its principal place of business at 8448 East Adams Avenue, in the City of Fowler, in the County of Fresno, in the State of California.

v. Defendant ROLLING HILLS CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("ROLLING HILLS CARE CENTER"). Defendant SWC CA OPCO, LLC, is the sole member of ROLLING HILLS CARE CENTER. ROLLING HILLS

CARE CENTER, and DOES 121-130, held the license to operate the 34-bed skilled nursing facility doing business as "Rolling Hills Care Center," with its principal place of business at 2108 Stillman Street, in the City of Selma, in the County of Fresno, in the State of California.

c) **Defendant SWC CA OPCO 2, LLC,** is a Nevada limited liability company, and is owned by its members, Defendant AJC and Defendant JBG, whose principal place of business is 662 Encinitas Boulevard, Suite 216, in Encinitas, California. Defendant SWC CA OPCO 2, LLC, and DOES 131-140, are the members of the eleven California limited liability companies and shareholders of the corporation that holds the license to operate the following twelve skilled nursing facilities, and were thus jointly responsible for the operation, management, and control of said facilities:

i. Defendant ALMOND VIEW CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("ALMOND VIEW"). Defendant SWC CA OPCO 2, LLC, is the sole member of ALMOND VIEW. ALMOND VIEW, and DOES 141-150, held the license to operate the 99-bed skilled nursing facility, doing business as "Almond View Care Center" with its principal place of business as 1224 E Street, in the City of Williams, in the County of Colusa, in the State of California.

ii. Defendant BROOKSIDE CARE CENTER, LLC, is a California limited liability company previously located at 662 Encinitas Blvd, Suite 216 in Encinitas, California, and currently located at 1000 Aviara Parkway, Carlsbad, CA 92011 ("BROOKSIDE CARE CENTER"). Defendant SWC CA OPCO 2, LLC, is the sole member of BROOKSIDE CARE CENTER. BROOKSIDE CARE CENTER, and DOES 151-160, held the license to operate the 99-bed skilled nursing facility, doing business as "Brookside Care Center," with its principal place of business at 1221 Rosemarie Lane, in the City of Stockton, in the County of San Joaquin, in the State of California.

iii. Defendant FEATHER RIVER CARE CENTER, LLC, is a California limited

liability company, located at 1000 Aviara Parkway, Carlsbad, California ("FEATHER RIVER"). Defendant SWC CA OPCO 2, LLC, is the sole member of FEATHER RIVER. FEATHER RIVER, and DOES 161-170, held the license to operate the 50-bed skilled nursing facility, doing business as "Feather River Care Center" with its principal place of business as 1 Gilmore Lane, in the City of Oroville, in the County of Butte, in the State of California.

iv. Defendant GRAND OAKS CARE, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California. ("GRAND OAKS"). Defendant SWC CA OPCO 2, LLC, is the sole member of GRAND OAKS. GRAND OAKS, and DOES 171-180, held the license to operate the 99-bed skilled nursing facility, doing business as "Grand Oaks Care Center" with its principal place of business as 897 North M Street, in the City of Tulare, in the County of Tulare, in the State of California.

v. Defendant NOBLE CARE CENTER, LLC, is a California limited liability company, previously located at 662 Encinitas Blvd, Suite 216 in Encinitas, California, and currently located at 1000 Aviara Parkway, Carlsbad, California ("NOBLE CARE CENTER"). Defendant SWC CA OPCO 2, LLC, is the sole member of NOBLE CARE CENTER. NOBLE CARE CENTER, and DOES 181-190, held the license to operate the 99-bed skilled nursing facility doing business as "Noble Care Center," with its principal place of business at 2740 North California Street, in the City of Stockton, in the County of San Joaquin, in the State of California.

vi. Defendant ORCHARDS AT TULARE, LLC, is a California limited liability company, located at 1000 Aviara Parkway, in Carlsbad, California ("ORCHARDS AT TULARE"). Defendant SWC CA OPCO 2, LLC, is the sole member of ORCHARDS AT TULARE. ORCHARDS AT TULARE, and DOES 191-200, held the license to operate the 99-bed skilled nursing facility, doing business as "Orchards at Tulare" with its principal place of business as

604 E. Merritt Avenue, in the City of Tulare, in the County of Tulare, in the State of California.

vii. Defendant RANCHO SECO CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("RANCHO SECO"). Defendant SWC CA OPCO 2, LLC, is the sole member of RANCHO SECO. RANCHO SECO, and DOES 201-210, held the license to operate the 99-bed skilled nursing facility, doing business as "Rancho Seco Care Center" with its principal place of business as 144 F Street, in the City of Galt, in the County of Sacramento, in the State of California.

viii. Defendant SHASTA VIEW CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("SHASTA VIEW"). Defendant SWC CA OPCO 2, LLC, is the sole member of SHASTA VIEW. SHASTA VIEW, and DOES 211-220, held the license to operate the 55-bed skilled nursing facility, doing business as "Shasta View Care Center" with its principal place of business as 1795 Walnut Street, in the City of Red Bluff, in the County of Tehama, in the State of California.

ix. Defendant THE VINEYARDS AT FOWLER, LLC, is a California limited liability company, previously located at 662 Encinitas Blvd, Suite 216 in Encinitas, California, and currently located at 1000 Aviara Parkway, Carlsbad, California ("VINEYARDS AT FOWLER"). Defendant SWC CA OPCO 2, LLC, is the sole member of VINEYARDS AT FOWLER. VINEYARDS AT FOWLER, and DOES 221-230, held the license to operate the 49-bed skilled nursing facility doing business as "The Vineyards at Fowler," with its principal place of business at 1306 East Sumner Avenue, in the City of Fowler, in the County of Fresno, in the State of California.

x. Defendant GATEWAY CARE, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("SEQUOIA VISTA"). Defendant SWC CA OPCO 2, LLC, is the sole member of SEQUOIA VISTA.

SEQUOIA VISTA, and DOES 231-240, held the license to operate the 99-bed skilled nursing facility, doing business as "Sequoia Vista Care Center" with its principal place of business as 3710 W Tulare Avenue, in the City of Visalia, in the County of Tulare, in the State of California.

xi. Defendant RIVER WALK CARE CENTER, LLC, is a California limited liability company, located at 1000 Aviara Parkway, Carlsbad, California ("RIVER WALK"). Defendant SWC CA OPCO 2, LLC, is the sole member of RIVER WALK. RIVER WALK, and DOES 241-250, held the license to operate the 99-bed skilled nursing facility, doing business as "River Walk Care Center" with its principal place of business as 1100 W. Morton Avenue, in the City of Porterville, in the County of Tulare, in the State of California.

xii. Defendant VINDRA, INC., is a California Corporation, located at 1000 Aviara Parkway, Carlsbad, California ("MEADOWOOD NURSING CENTER"). Defendant SWC CA OPCO 2, LLC, is the sole shareholder of MEADOWOOD NURSING CENTER. MEADOWOOD NURSING CENTER, and DOES 251-260, held the license to operate the 99-bed skilled nursing facility, doing business as "Meadowood Nursing Center" with its principal place of business as 3805 Dexter Lane, in the City of Clearlake, in the County of Lake, in the State of California.

15. Together, the Defendants named in paragraph 14, *supra*, and DOES 51-260, are collectively referred to herein as the "SWEETWATER FACILITY DEFENDANTS."

16. The SWEETWATER OWNER DEFENDANTS, the SWEETWATER MANAGEMENT DEFENDANTS, and the SWEETWATER FACILITY DEFENDANTS, are collectively referred to as the "SWEETWATER DEFENDANTS."

17. DOES 261-300 are other business entities or persons violating laws related to the ownership, administration, operation, management, or control of skilled nursing facilities owned and/or operated by Defendants herein, or were related party entities under common ownership or control of the SWEETWATER DEFENDANTS, or are otherwise responsible for the violations of

laws at issue herein.

18. Defendants DOES 1-300 are hereinafter collectively referred to as "DOES." Plaintiff is unaware of the true names and capacities of defendants sued herein as DOES 1 through 300, inclusive, and therefore sues these defendants by such fictitious names. Each fictitiously named defendant is responsible in some manner for the violations of law alleged herein. Plaintiff will amend this Complaint to add the true names and capacities of the fictitiously named defendants once they are determined. Whenever reference is made in this Complaint to "Defendants," such reference shall include DOES as well as the named Defendants.

19. No Defendant is a distinct part of a general acute care facility or a state-owned hospital or developmental center. Nor does any Defendant operate as a "special treatment program service unit distinct part" within the meaning of Health and Safety Code section 1276.9.

20. At all relevant times, some or all Defendants acted as the agent of the others, and all Defendants acted within the scope of their agency if acting as an agent of another.

21. At all relevant times, each Defendant acted: a) as a principal; b) under express or implied agency; and/or c) with actual or ostensible authority to perform the acts alleged in this Complaint on behalf of every other named Defendant.

22. Defendants have engaged in a conspiracy, common enterprise, and common course of conduct which include overt acts, the purpose of which is and was to engage in the violation of laws alleged in this complaint. On information and belief, the conspiracy, common enterprise, and common course of conduct continue to the present in whole or part.

23. Defendants have operated in such a way as to make their individual identities indistinguishable, and are, therefore, the mere alter egos of one another and part of a single enterprise with each other. There is a unity of interest and ownership between and among Defendants, such that in reality their separate personalities do not meaningfully exist. For instance, the Defendants CHESLEY and GAMETT have identical equitable ownership interests in the SWEETWATER FACILITY DEFENDANTS and SWEETWATER MANAGEMENT DEFENDANTS. Each of the SNFs are owned by a limited liability company, which is owned in equal part by Defendants AJC and JBG, which in turn are wholly owned by Defendants

CHESLEY and GAMETT. The SWEETWATER MANAGEMENT DEFENDANTS are owned in equal part by Defendants AJC and JBG, which in turn are wholly owned by Defendants CHESLEY and GAMETT. The SWEETWATER DEFENDANTS share the same office space, as evidenced by shared business addresses according to filings with the California Secretary of State. The SWEETWATER DEFENDANTS share managers, officers, directors, and/or employees. As such, Defendants are alter egos of one another, and part of a single enterprise, in the operation of the SWEETWATER FACILITY DEFENDANTS.

24. Defendants regularly conducted their business in and throughout the State of California and are jointly profiting from the SNFs located in California, including from revenues generated from provision of care to Medi-Cal patients in the State of California, and from revenues generated from "temporary" staffing agencies wholly owned indirectly and directly by Defendants GAMETT and CHESLEY which functioned by providing temporary nursing staff to the SWEETWATER FACILITY DEFENDANTS at prices and on terms established by the SWEETWATER OWNER DEFENDANTS and/or SWEETWATER MANAGEMENT DEFENDANTS.

25. Defendants combined their property, skill, and/or knowledge with the intent to carry out a single business undertaking; namely, the operation of a chain of skilled nursing facilities by and through "management" and "administrative services" provided by the SWEETWATER MANAGEMENT DEFENDANTS and/or SWEETWATER OWNER DEFENDANTS. Defendants herein had ownership interest in the SWEETWATER FACILITY DEFENDANTS directly and indirectly by and through ownership of each other and had joint control in the business in order to benefit from its revenues, such that Defendants were part of a joint venture in the operation of the SWEETWATER FACILITY DEFENDANTS.

26. Each and every Defendant, named and unnamed, conspired with and aided and abetted each and every other Defendant to commit the unlawful, unfair, and deceptive practices alleged herein. The SWEETWATER OWNER DEFENDANTS and the SWEETWATER MANAGEMENT DEFENDANTS had a direct stake in the success of the operations of the SWEETWATER FACILITY DEFENDANTS and used the services of the SWEETWATER

MANAGEMENT DEFENDANTS to increase profits to the enterprise arising from the nursing care rendered at the individual SNFs.

27. Whenever in this complaint reference is made to any act of any corporate Defendant, such allegation shall be deemed to mean that such corporate Defendant did the acts alleged in the complaint through its officers, directors, agents, employees, subsidiaries, and/or representatives while they were acting within the ostensible scope of their authority.

## III. STANDING, JURISDICTION, AND VENUE

28. The People have standing to bring this action by direct statutory authorization pursuant to Business and Professions Code sections 17204, 17206, and 17206.1.

29. This Court has original jurisdiction over this action pursuant to article VI, section 10 of the California Constitution.

30. This Court has jurisdiction over Defendants because the Defendants were individuals, limited liability companies, and/or corporations either domiciled in, or engaged in substantial, continuous, and systematic business activities in California, or purposely availed themselves of the forum benefits of the State of California with respect to the operation of the SWEETWATER FACILITY DEFENDANTS, so as to render exercise of jurisdiction just and proper.

31. The violations of laws and regulations alleged in this Complaint have been committed throughout the State of California, including, but not limited to, in the Counties of Butte, Colusa, Fresno, Kern, Lake, Madera, Sacramento, San Bernardino, San Diego, San Joaquin, Tehama, and Tulare.

32. Venue is proper in this Court pursuant to Code of Civil Procedure section 395.5 because Defendants operated, managed, and/or controlled a skilled nursing facility or management/administrative services provider in the Counties of Butte, Colusa, Fresno, Kern, Lake, Madera, Sacramento, San Bernardino, San Diego, San Joaquin, Tehama, and Tulare and therefore Defendants' liability arises in part in the County of San Diego.

33. Venue is also proper in this Court pursuant to Code of Civil Procedure section 393, subdivision (a), because the violations of law that occurred in the Counties of Butte, Colusa, Fresno, Kern, Lake, Madera, Sacramento, San Bernardino, San Diego, San Joaquin, Tehama, and

Tulare are a "part of the cause" upon which the Plaintiff seeks the recovery of penalties imposed by statute.

## IV. STATUTORY BACKGROUND

34. The Legislature of the State of California has recognized that elders and dependent adults are at greater risk of abuse, neglect, or abandonment by their caretakers, and may suffer from physical impairments and other poor health conditions that place them in a dependent and vulnerable position. (Welf. & Inst. Code, § 15600.) This at-risk population includes patients of California's SNFs. SNFs in the State of California have a duty to operate in compliance with the minimum standards established by laws and regulations 24 hours per day, seven days per week.

### A. Laws Protecting California SNF Patients

35. SNFs operating in the State of California have a mandatory duty to comply with numerous laws and regulations. Those laws and regulations include, but are not limited to, those highlighted in the following paragraphs.

36. To protect the vulnerable population of SNF patients, the California legislature established minimum staffing laws. The Legislature of the State of California found and declared that "[s]killed nursing facilities need adequate staffing levels in order to provide the quality of care that patients deserve."[2]

37. A SNF is required to employ an adequate number of qualified personnel. (Health & Saf. Code, § 1599.1, subd. (a); see also Health & Saf. Code, § 1276.65, subd. (d).)

38. SNFs are required to provide a minimum of 3.5 direct care service hours[3] per patient day, of which 2.4 hours must be provided by a certified nurse assistant.

39. California's direct care service hour requirements discussed in the preceding paragraph are minimum standards only. Separate and apart from compliance with these minimum standards, SNFs are also required to employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all

[2] Bill Number: AB 1075.

[3] "Direct Care Service Hours" are the actual hours of work performed per patient day by a registered nurse, licensed vocational nurse, psychiatric technician, certified nurse assistant, or nurse assistant participating in an approved training program. (Health & Saf. Code, § 1276.65.)

relevant state and federal staffing requirements. (Health & Saf. Code, § 1276.65; Cal. Code Regs., tit. 22, § 72329.1.) This includes provision of services from a registered nurse for at least (8) eight consecutive hours per day seven days per week.

40. SNFs must operate in such a manner that nursing staff provide quality nursing services at all times. (Cal. Code Regs., tit. 22, § 72311.) SNFs may never operate in such a manner that licensed vocational nursing staff practice outside the scope of vocational nursing practice as required by California Code of Regulations, title 16, section 2518.5; and at no time may SNFs operate in such a manner that certified nurse assistants, licensed vocational nurses, or other personnel who are not registered nurses provide care or services to patients that can only be provided by a registered nurse pursuant to California Code of Regulations, title 16, section 1443.5, or other sections which set forth the appropriate scope of practice for a licensed vocational nurse or registered nurse in the State of California.

41. SNF patients are entitled to enjoy the "fundamental human rights" set forth in California's Patient Bill of Rights. (Cal. Code Regs., tit. 22, § 72527.) Those rights include, but are not limited to, rights as specified in Health and Safety Code section 1599.1.

**B. California's Unfair Competition Law**

42. California's Unfair Competition Law ("UCL") is codified at Business and Professions Code section 17200, et seq. Pursuant to Business and Professions Code section 17200 "unfair competition shall mean and include any unlawful, unfair, or fraudulent business act or practice ..." The violation of any law, statute, regulation, or other legal mandate can serve as a basis for an "unlawful" act under the UCL. Section 17203 of the Business and Professions Code provides that "[a]ny person who engages, has engaged, or proposes to engage in unfair competition may be enjoined in any court of competent jurisdiction" and that "[t]he court may make such orders or judgments . . . as may be necessary to prevent the use or employment by any person of any practice which constitutes unfair competition . . . or as may be necessary to restore to any person in interest any money or property . . . which may have been acquired by means of such unfair competition."

43. Business and Professions Code section 17206, subdivision (a), provides that any

person violating the UCL "shall be liable for a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the People of the State of California by the Attorney General or by any district attorney." Where the act is perpetrated against a senior or disabled individual, the violator is subject to an additional $2,500 civil penalty for each act. (Bus & Prof. Code, § 17206.1.) Under section 17205, these penalties are "cumulative to each other and to the remedies or penalties available under all other laws of this state." Furthermore, the Court may treble civil penalties in actions brought by, or on behalf of, or for the benefit of, senior citizens or disabled persons (Civ. Code, § 3345.)

## V. FACTUAL ALLEGATIONS

44. The SWEETWATER DEFENDANTS were paid millions of dollars, primarily from public funds through the Medi-Cal and Medicare programs, to provide care to elderly, frail, and disabled persons. Between 2020 and 2023, the SWEETWATER DEFENDANTS were paid $299,292,076 in public funds to provide nursing care to the patients in their SNFs, roughly two-thirds of which ($196,183,015) was paid by the Medi-Cal program.

45. The SWEETWATER DEFENDANTS operate for-profit companies that voluntarily applied to participate in the Medicare and Medi-Cal programs. Participation in the Medicare and Medi-Cal programs are conditioned upon compliance with laws and regulations.

46. The SWEETWATER DEFENDANTS promised to comply with laws and regulations each time they executed a Medi-Cal provider agreement. They further promised not to engage in neglect or abuse of patients as a condition of participation in the Medi-Cal program.

47. The SWEETWATER DEFENDANTS were not required to accept any particular SNF patient, and at all relevant times had the right to deny new admissions if they were unable to meet the needs of their patients. Each time Defendants chose to accept a new patient, the SWEETWATER FACILITY DEFENDANTS contracted with the patient, or their responsible party, as part of their admission agreement that the SNF would ensure the patient's rights[4] were

[4] California Code of Regulations, title 22, section 72527; Health and Safety Code section 1599.1.

not violated. These rights include, but are not limited to, the patient's rights to:

a) Be free from mental and physical abuse;

b) Reside in a Facility which employs an adequate number of qualified personnel to carry out the functions of the facility;

c) Good personal hygiene;

d) Care to prevent bedsores;

e) Measures to prevent incontinence; and

f) To a clean and sanitary facility

48. As alleged more fully below, the SWEETWATER DEFENDANTS engaged in systemic and continuous violations of California law in the operation of their nineteen California skilled nursing facilities, constituting violations of the UCL.

**Violations of Staffing and Other Laws and Regulations**

49. The SWEETWATER DEFENDANTS engaged in a systemic and chain-wide pattern of violations of California's minimum staffing laws in the operation of nineteen SNFs across the State of California. These violations are established through payroll records maintained internally by the SWEETWATER FACILITIES and SWEETWATER MANAGEMENT DEFENDANTS as well as through data reported by these entities to government agencies on a quarterly basis.

50. In late January 2020, the SWEETWATER DEFENDANTS were licensed to operate their first two California facilities, YUCCA VALLEY NURSING and VALLEY CARE CENTER. In the four years since that time, the SWEETWATER DEFENDANTS engaged in rapid growth of operations in the State of California and became licensed to operate an additional seventeen SNFs through the end of 2024. Once the SWEETWATER FACILITIES were licensed to operate SNFs in California, the SWEETWATER DEFENDANTS assumed a non-delegable duty to comply with applicable laws and regulations, including California's minimum staffing laws discussed *supra*.

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51. As shown in Table 1, since becoming licensed to operate in California, the SWEETWATER FACILITIES operated in violation of California's minimum staffing levels on over 14,126 instances through the end of 2024.[5]

**Table 1. California Minimum Staffing Violations**

| Facility | Days Licensed | Days Below 3.5 DHPPD | % of Days | Days Below 2.4 CNA PPD | % of Days |
|---|---|---|---|---|---|
| Almond View Care Center | 469 | 119 | 25% | 1 | 0% |
| Brookside Care Center | 880 | 223 | 25% | 68 | 8% |
| Evergreen Care Center | 459 | 68 | 15% | 115 | 25% |
| Feather River Care Center | 581 | 155 | 27% | 11 | 2% |
| Fowler Care Center | 1154 | 409 | 35% | 334 | 29% |
| Grand Oaks Care | 155 | 8 | 5% | 6 | 4% |
| Meadowood Nursing Center | 550 | 263 | 48% | 319 | 58% |
| Noble Care Center | 792 | 351 | 44% | 274 | 35% |
| Orchards at Tulare | 399 | 12 | 3% | 9 | 2% |
| Palms Care Center | 1341 | 799 | 60% | 396 | 30% |
| Rancho Seco Care Center | 862 | 574 | 67% | 303 | 35% |
| River Walk Care Center | 134 | 8 | 6% | 0 | 0% |
| Rolling Hills Care Center | 1222 | 217 | 18% | 253 | 21% |
| Sequoia Vista | 420 | 19 | 5% | 10 | 2% |
| Shasta View Care Center | 449 | 191 | 43% | 275 | 61% |
| Valley Care Center | 1328 | 1270 | 96% | 1255 | 95% |
| Valley View Care Center | 1337 | 315 | 24% | 361 | 27% |
| Vineyards at Fowler | 714 | 190 | 27% | 282 | 39% |
| Yucca Valley Nursing | 1290 | 1252 | 97% | 1271 | 99% |
| Total | 14536 | 6443 | 35% | 5543 | 30% |

52. As shown in Table 1, the SWEETWATER FACILITY DEFENDANTS consistently operated at staffing levels below California minimum staffing levels, in violation of California law, and they did so on a chain wide basis. On 6,443 occasions – *more than one out of every three days* in a California SWEETWATER FACILITY – skilled nursing patients were exposed to staffing levels that were below, and in violation of, California's overall 3.5 minimum staffing level. At some SWEETWATER FACILITIES, such as YUCCA VALLEY NURSING, patients

[5] The Days Below 2.4 CNA PPD calculation excludes any violations which occurred during a time period that any SWEETWATER FACILITY had a workforce shortage or patient need waiver issued by the California Department of Public Health ("CDPH").

were exposed to staffing in violation of California's minimum staffing levels on 97% of days. Similarly, at VALLEY CARE CENTER, this was the case on 96% of days.

53. The SWEETWATER DEFENDANTS violated California's Minimum CNA requirement on 5,543 occasions – 30% of days in operation – in which the SWEETWATER FACILITIES failed to have at least 2.4 hours of CNA staffing per patient day.

54. On 2,140 instances – or 13% of operational days – the SWEETWATER DEFENDANTS failed to provide a daily minimum of 8 registered nurse hours for patients.

55. The SWEETWATER DEFENDANTS chose to operate the SWEETWATER FACILITIES with nursing staff levels that were insufficient to meet California minimum staffing levels despite being on notice of their continuous pattern of violations. For instance, the SWEETWATER MANAGEMENT DEFENDANTS and the SWEETWATER FACILITY DEFENDANTS used a "Key Factor Report" as early as 2021. This Key Factor Report contained a daily calculation of actual nursing hours worked by registered nurses, licensed vocational nurses, and certified nurse assistants. This report was circulated among Defendants' personnel on a weekly basis and revealed actual daily staffing levels that frequently fell below California's 3.5 nursing hour minimum requirement and California's 2.4 CNA minimum hour requirement. Despite knowledge of this pattern of violation of California law, the SWEETWATER DEFENDANTS continued to engage in a pattern of staffing violations and staffing practices over a period of years.

56. Upon information and belief, the SWEETWATER FACILITY DEFENDANTS continue to violate the staffing requirements discussed at paragraphs 37-38, as noted in table 1. Upon information and belief, the SWEETWATER FACILITY DEFENDANTS also continue to fail to provide a daily minimum of 8 registered nurse hours as discussed at paragraph 39.

57. Separate and apart from the minimum staffing requirement of 3.5 direct care nursing hours per patient day, a SNF operating in California must also have sufficient staff to meet the medical needs of its patients based on their actual medical condition, also referred to as the patient's "acuity" needs. The SWEETWATER FACILITY DEFENDANTS consistently failed to provide sufficient nursing staff to meet the acuity needs of their patients as required by state law

as discussed at paragraph 39 and 40 *supra.* The specific needs of individual residents vary based upon numerous factors and characteristics including the patients' needs, strengths, goals, functional and health status, medical conditions, needs for assistance with activities of daily living, supervision, and medical care needs. The nursing staff of the SWEETWATER FACILITIES conducted nursing assessments of each patient at the time of admission, annually, and at various other intervals. These nursing assessments provide evidence of the specific acuity level of the patient population at each SWEETWATER FACILITY. This in turn establishes the amount of nursing staff necessary to meet the acuity needs of the patient population of each SWEETWATER FACILITY.[6]

58. A comparison of the actual nursing staff levels as reported by each SWEETWATER FACILITY against the specific nursing staff level needs of the corresponding patient population according to their acuity needs indicates that the SWEETWATER FACILITY DEFENDANTS failed to provide enough nursing staff to meet patients' acuity needs as required by California law on over 11,000 occasions during the relevant time period. Upon information and belief, the SWEETWATER FACILITY DEFENDANTS continue to fail to provide enough nursing staff to meet their patient's acuity needs.

59. Nurse understaffing in SNFs causes and contributes to preventable harms and injuries to vulnerable patients. When SNFs lack sufficient nurse staffing to timely change a patient's linens and clothing after those become soiled with urine or feces, and when SNFs lack sufficient nurse staffing to timely reposition bed-bound patients who cannot otherwise reposition themselves, patients can develop skin breakdown, painful pressure ulcers, and/or infections. These infections can lead to sepsis and result in death. When SNFs lack sufficient nursing staff to provide supervision, toileting assistance at proper intervals including after meals, and to institute fall prevention interventions like alarms, mats, and lowered beds as required by patient care plans, patients can suffer unwitnessed falls that result in injuries that include bone fractures and death. When SNFs lack nursing staff to provide sufficient supervision to address risks of elopement or

[6] Charlene Harrington, et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Services Insights Vol. 13 (Aug. 2020).

aggressive behaviors, patients can engage in preventable altercations, sexual behaviors, and elopements that can result in injury and death. When SNFs lack enough nursing staff to ensure patients are assessed by a registered nurse when they exhibit changes in condition, patients who are in a medical emergency can suffer complications and death due to delays in transfers to a higher level of care. When SNFs lack enough nursing staff to administer patient medications, doses of needed medications may be given late, or not at all. When SNFs lack enough nursing staff, staff do not have time to bathe, shower, groom, or provide hygiene services to ensure patients maintain dignity and remain clean, dry, and comfortable.

60. Numerous patients of the SWEETWATER FACILITY DEFENDANTS sustained injuries or suffered violations of their rights on dates when the facilities were operating in violation of California minimum staffing levels according to Defendants' staffing data. The following are a few of many examples of the SWEETWATER DEFENDANTS' repeated and persistent pattern of illegality:

a) **Patient suffered multiple hip fractures and series of falls when facility was understaffed:** Patient A was admitted to VALLEY CARE CENTER, in May 2021, with a medical history that included dementia and fall risk. According to Defendants' staffing data, on July 12, 2021, VALLEY CARE CENTER was staffed at 2.73 nursing hours overall, 1.42 of which were from CNA hours, both of which fell below California minimum staffing levels. On the same date, Patient A suffered a fall. On August 17, 2021, VALLEY CARE CENTER was staffed at 1.84 nursing hours overall, 1.09 of which were from CNA hours. On this date, Patient A suffered another fall. Nursing staff did not reassess Patient A's fall risk or update Patient A's fall care plan to implement interventions to prevent falls after either of these falls. On October 24, 2021, the facility was staffed at 1.55 nursing hours overall, 0.58 of which were CNA hours. On this date, Patient A was found on the floor after an unwitnessed fall, and nursing staff noted facial lacerations but did not send Patient A to the hospital until the following day, where the patient was diagnosed with a hip fracture and given sutures for the lip laceration. On December 23, 2021, the patient suffered yet another

fall and fractured the same hip injured two months earlier, on a day when the facility was staffed at 1.84 total nursing hours, 1.12 of which were from CNAs, in violation of California minimum staffing levels.

b) **Multiple patients developed skin breakdown after being left in soaked diapers by staff over night shifts when facility was understaffed**: At YUCCA VALLEY NURSING in June 2021, multiple patients issued complaints because of insufficient staffing at night. Patient B complained of untimely diaper changes because staffing at night is "horrible" resulting in irritation and redness in her groin area, and Patient C reported the facility is "short of staff" at night, which affected staff's attitudes. Staffing data submitted for YUCCA VALLEY NURSING showed that the facility was staffed below California's minimum CNA staffing level of 2.4 hours on 30 out of 30 days in June 2021, and below California's overall staffing requirement of 3.5 direct hours per patient day on 30 out of 30 days in June 2021. The staffing issues were not resolved as of June the following year. In June of 2022, a witness made two reports of suspected neglect after Patient D reported complaints that she did not get changed during the nighttime and that CNA staff were getting "worse and worse." Patient D was taking antibiotics for an infection, which resulted in diarrhea and required frequent diaper changes. Because Patient D was left without diaper changes overnight, she developed a reddened area of skin breakdown over her buttocks, perianal area, and thighs. Patient E reported that night shift staff refused to provide help to change her into a clean, dry brief all night leading to pain, discomfort, and redness and irritation to her buttocks. Patient D and Patient E reported that night shift staff refused to apply barrier cream (a product applied directly to the skin surface to help maintain the skin's physical barrier and protect from irritants and dermatitis). Staffing data submitted by YUCCA VALLEY NURSING for the month of June 2022 indicates the facility was staffed below California's overall 3.5 minimum staffing level, and 2.4 CNA minimum staffing level, on 30 out of 30 days.

c) **Facility had insufficient staff to respond to an ongoing change in condition:** On

June 12, 2022, at YUCCA VALLEY NURSING, Patient F began to exhibit signs of a change in condition evidenced by restlessness and moaning. A CNA reported these issues to an LVN at approximately 11:00 p.m. However, the LVN did not assess Patient F's condition at any time during the remainder of the night shift because she was "the only nurse on the floor." When the CNA returned to work the following morning at 6:40 a.m., Patient F was on the floor with an altered level of consciousness and was hospitalized and required admission to the intensive care unit. On June 12, 2022, the facility had no registered nurse present, had only one LVN instead of the three LVNs who were scheduled to work, and had an overall staffing level of 2.83, below California's minimum staffing level of 3.5 direct care hours per patient day. According to staffing data submitted for YUCCA VALLEY NURSING for the week leading up to Patient F's emergency transfer to the hospital, the facility was staffed below California's overall minimum staffing level and CNA minimum on each day of the whole week.

d) **Lack of nursing supervision to protect patient from sexual abuse:** At BROOKSIDE CARE CENTER, Patient G was a male in his 60s with a BIMS[7] score of 15/15. Patient H was a female in her early 20s with a traumatic brain injury, schizophrenia, and a BIMS score of 3/15. Facility leadership was aware that Patient G's behavior was progressively escalating and no longer redirectable, and that he had a history of sexual interest in younger individuals. However, on August 19, 2022, Patient G and Patient H were left outside without supervision of staff, and a CNA who was passing trays inside the facility looked out the window and observed Patient G touching Patient H's breast. According to staffing data submitted for BROOKSIDE CARE CENTER, the facility was staffed below California's overall and CNA minimum staffing levels on the date of this incident.

e) **Lack of nursing supervision to protect patient from physical abuse:** At FOWLER

[7] "BIMS Score" refers to the "Brief Interview for Mental Status," a screening tool used in nursing homes to assess cognition. A score of 0-7 suggests severe cognitive impairment, 8-12 points suggests moderate cognitive impairment, and 13-15 points indicates cognition is intact.

CARE CENTER, Patient I had a history of resident-to-resident altercations and did not like sharing a room with other patients. For the relevant time period, there was no director of nursing or full-time registered nurse on staff to oversee assessments. Staff did not evaluate the risk of patient-to-patient abuse from Patient I when they inserted Patient J as a roommate. They also did not provide supervision. Patient J was found by staff on January 21, 2022, in pain with facial injuries including bruising and swelling. On this date, the facility was staffed at 3.23 overall nursing hours, 2.23 of which from CNA hours, in violation of California minimum staffing levels. According to FOWLER CARE CENTER's Social Services Director, the facility's lack of sufficient staffing played a role in Patient I's aggressive behavior. At VALLEY CARE CENTER, Patient K was placed under an order for 1:1 supervision due to aggressive behavior after an altercation incident on May 17, 2022. The May 17, 2022, incident occurred on a date when VALLEY CARE CENTER was staffed at 2.34 overall nursing hours, 1.34 of which were from CNA hours, in violation of California minimum staffing levels according to staffing data. However, the VALLEY CARE CENTER did not provide 1:1 supervision as ordered in the days that followed, and Patient K initiated another physical incident against another patient without provocation on June 4, 2022. On that date, VALLEY CARE CENTER was staffed at 2.11 overall hours, 1.41 of which were from CNA hours, in violation of California minimum staffing levels, according to staffing data.

f) **Lack of nursing care to prevent the development and worsening of pressure ulcers:** At FOWLER CARE CENTER, Patient L, Patient M, and Patient N suffered deterioration of their pressure ulcers and the development of new pressure ulcers due to failures of nursing staff to provide skin and pressure ulcer care in accordance with professional standards. Patient L was admitted to FOWLER CARE CENTER on March 9, 2022, with two stage 2 pressure ulcers, and two unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered with slough or eschar). However, nursing assessments and services to promote wound healing were

not provided by nursing staff at FOWLER CARE CENTER over the course of Patient L's admission, resulting in the development of two additional pressure ulcers. The two pressure ulcers which were at stage 2 on admission worsened to unstageable within six days after admission. Nursing staff did not assess and measure Patient L's wounds weekly in accordance with facility policy, and nursing staff failed to comply with physician orders for wound treatment. Nurses were not trained to assess patient skin to stage pressure ulcers, and did not have interdisciplinary team meetings to evaluate the effectiveness of Patient L's treatment. As a result, Patient L then developed two stage 3 pressure ulcers to the left foot, a stage 4 pressure ulcer to the right hip, and worsening of other pressure ulcers. Over time, Patient L developed eight pressure ulcers with necrotic tissue, slough, and foul-smelling purulent drainage which required antibiotic therapy. Staff stated a foul odor was detectable through their facemask and face shield immediately upon entering the door to Patient L's room. Patient L transferred to the hospital on May 19, 2022, where Patient L was assessed to have visible exposed metal of the hip joint through a pressure ulcer. Of the 71 days of Patient L's admission, the facility's overall staffing fell below California's overall staffing minimum of 3.5 hours on 58 out of 71 days, and below the 2.4 minimum CNA staffing level on 42 out of 71 days. FOWLER CARE CENTER's Director of Nursing indicated Patient L's treatments were not consistently being done, and with short staffing she did not see how one nurse could pass medications and perform wound care for 42 residents. Patients M and N were also present in the facility in the same approximate time period as Patient L. Patient M developed a stage 3 pressure ulcer to the foot which worsened to a stage 4 ulcer at the facility. FOWLER CARE CENTER nursing staff did not perform accurate skin assessments, and Patient M experienced a severe unplanned weight loss of 22 pounds over four months, which negatively affected her nutritional status for wound healing. Patient N developed a deep tissue injury to her right outer heel, and a care plan developed for Patient N required nursing staff to provide her with daily skin assessments. However, nursing

staff of FOWLER CARE CENTER did not provide the daily skin assessments required by her care plan, and Patient N suffered an unplanned weight loss of 18.3 pounds, however nursing staff did not ensure she received a nutritional assessment to prevent further pressure ulcer development due to the nutritional deficiency.

g) **Failures to protect patients from elopements and injuries:** At YUCCA VALLEY NURSING, Patient O, who had cognitive impairment, eloped from the facility on February 5, 2022, and was found outside by a "Good Samaritan" down the street and returned to the facility. Patient O had dried blood on the back of his head and dirt in the wound, with complaints of headache. He was transferred to the hospital and found to have a subdural hematoma. On this date, according to staffing data, the facility had overall staffing of 1.97 hours, 1.61 of which were from CNA hours, in violation of California minimum staffing levels. At RANCHO SECO CARE CENTER, Patient P had a medical history of severe cognitive impairment and a BIMS score of 5. Patient P eloped from the facility on his wheelchair on multiple occasions and crossed a busy road to go to a convenience store to purchase alcohol. He was observed drinking beer from the convenience store on April 6, 2023, and was seen outside of the facility on his wheelchair near the road on the corner without supervision of staff on April 20, 2023. According to staffing data, on April 6, 2023, the facility had overall staffing of 2.95 hours, 1.69 of which was from CNAs, and on April 20, 2023, the facility had 3.15 overall staffing hours, 1.84 of which was from CNAs, in violation of California minimum staffing levels.

h) **Patient in pain for four days with an untreated hip fracture:** At ROLLING HILLS CARE CENTER, Patient Q suffered an unwitnessed fall on June 2, 2022, when the facility was operating below California's minimum CNA staffing level. Not only did the facility fail to ensure that an assessment was provided by an RN, its LVN who responded to the patient after the fall failed to notify Patient Q's family or physician for further intervention. Over the next four days, Patient Q continued to experience pain. An x-ray was not obtained until June 5, which revealed Patient Q had a hip

fracture. According to staffing data for ROLLING HILLS CARE CENTER from June 2 to June 5, the facility was staffed below California's 3.5 overall staffing minimum on two out of four days, and below the minimum CNA requirement on 3 out of 4 days. Patient Q was not transported to the hospital until June 6 -- five days after the fall.

i) **Failure to care plan[8] and implement interventions to prevent falls and injuries:** At VALLEY CARE CENTER, Patient R suffered two successive falls, one of which resulted in a hip fracture. Patient R's first fall occurred on January 7, 2021, when according to staffing data, VALLEY CARE CENTER was staffed at 2.30 overall staffing hours, 1.54 of which were CNA hours. Patient R's second fall occurred on January 11, 2021, when VALLEY CARE CENTER was staffed at 2.50 hours overall, 1.39 hours of which was from CNAs, in violation of California's minimum staffing requirements. Patient R's care plan was not re-evaluated in either instance and new interventions to prevent falls were not considered or implemented by nursing staff. At YUCCA VALLEY NURSING, on April 21, 2021, Patient S suffered a fall and subdural hematoma due to lack of supervision. Patient S had a fall care plan, dated March 22, 2021, which required a 1:1 sitter; however, on April 21, 2021, the patient was found face down on the floor with lacerations, skin tears, sluggish pupil response to light, and was unresponsive to touch or verbalization. Patient S was not provided the 1:1 supervision required by his care plan. At the hospital, Patient S was diagnosed with a subdural bleed as a result of the fall. On this date, according to staffing data submitted for YUCCA VALLEY NURSING, the facility was staffed at 1.88 hours overall, 0.89 of which was from CNA hours, in violation of California's minimum staffing levels.

j) **Employee reported staff are hiding call lights, yelling at patients, and withholding repositioning:** On November 29, 2021, an anonymous complainant

[8] A care plan is a formal nursing process that correctly identifies existing needs and recognizes a patient's potential needs or risks, and includes nursing interventions selected by a registered nurse to address the patient's needs and risks.

reported that staff at YUCCA VALLEY NURSING, especially on the night shift, were hiding call lights from residents and spending time on their phones instead of handling patients who were yelling for help. The staff member reported patients were slipping off their beds and staff were not helping them, and staff were not turning patients who were then getting bedsores. The reporter indicated staff were yelling at patients to shut up, patients were being denied water, and that the facility smelled like feces. In the 60 days preceding this complaint, according to staffing data submitted by Defendants, YUCCA VALLEY NURSING was staffed below and in violation of California's overall 3.5 staffing minimum on 60 out of 60 days, and below and in violation of California's 2.4 CNA staffing minimum on 60 out of 60 days.

k) **Resident with fractured left lower tibia and fibula was not assessed or treated for four days after staff observed swelling and pain complaints:** At RANCHO SECO CARE CENTER on May 23, 2023, a CNA observed Patient T had swelling to his left ankle and reported it to a licensed nurse. On May 25, 2023, a CNA observed Patient T's left leg was swollen, bruised, and purple and green in color. On May 26, 2023, a CNA reported to a licensed nurse that Patient T had bruising and pain to the leg. On May 27, 2023, the same CNA noticed Patient T's left lower leg was bruised, painful to the touch, painful when moved, had yellow and purple bruising with purple bruising close to the ankle, and reported these symptoms to the licensed nurse. Patient T was not assessed by a licensed nurse until early in the night shift on May 26, days after the injury was first observed. Even then, Patient T was not sent to the hospital. A licensed nurse assessed Patient T at approximately 3:00 p.m. on May 27, 2023, and observed the leg was bruised purple and pink with deformity above the ankle; however, Patient T was still not sent to the hospital. Patient T was not transferred to the hospital until shortly after 10:28 p.m. on May 27, 2023, after an x-ray showed fractures of the left tibia and fibula. The emergency department physician noted the leg had a makeshift support applied that was too tight, and that the injury was likely about one week old from a ground level fall. According to staffing data, on

each date between May 23, 2023, and May 28, 2023, RANCHO SECO CARE CENTER reported CNA hours of 1.87 or less, which were below the California minimum staffing levels. Likewise, in this time period, RANCHO SECO CARE CENTER reported overall staffing hours between 2.66 and 3.30, also below the California's minimum staffing requirement of 3.5 hours.

61. During the time that the SWEETWATER FACILITY DEFENDANTS have been licensed to operate, the CDPH has issued hundreds of deficiency findings, setting forth findings that each of the SWEETWATER FACILITY DEFENDANTS engaged in violations of laws and regulations applicable to the operation of SNFs in the State of California. CDPH surveys and complaint investigations are periodic, and do not represent a continuous assessment of the SWEETWATER FACILITY DEFENDANTS' compliance with California law on a daily basis.

62. Furthermore, pursuant to Welfare and Institutions Code section 15630, the SWEETWATER DEFENDANTS had a duty to report incidents that reasonably appear to be physical abuse, abandonment, isolation, financial abuse, or neglect, or reports by elder or dependent adults of such incidents. California law requires these reports to be made to local law enforcement, the local ombudsman, and licensing agency within a specified time period. However, according to incident reports maintained by the SWEETWATER FACILITIES, dozens of incidents which required reports of abuse or neglect were not reported in compliance with California law. (Welf. & Inst. Code, § 15600.)

63. The SWEETWATER DEFENDANTS had a duty to report actual nursing staff hours worked by direct care staff, including registered nurses, licensed vocational nurses, and certified nurse assistants on a quarterly basis to the Centers for Medicare and Medicaid Services (CMS). Regulations require staffing data be accurate, complete, and auditable and Defendants' own policies and practices mandated hours worked by employees that were reported to the government be supported by timecard documentation providing those individual employees indeed worked the hours reported to governmental agencies. However, in fact, the SWEETWATER DEFENDANTS reported over 248,000 hours purportedly worked by nursing staff at the SWEETWATER FACILITIES which were not documented or substantiated by payroll records to show these

nurses were actually in the building and working on the dates and times claimed.

**Extraction of Patient Revenues to Ownership**

64. While the SWEETWATER DEFENDANTS engaged in continuous violations of California laws and regulations, as discussed above, the SWEETWATER DEFENDANTS routinely chose to divert funds generated from operations to the ultimate beneficial owners through profits and related party[9] transactions.

65. According to Medi-Cal cost reports submitted by the SWEETWATER FACILITY DEFENDANTS between 2020-2022, Defendants reported $8,108,604 in profits from the operation of the SWEETWATER FACILITY DEFENDANTS. According to Home Office Cost Reports for the year 2023 alone, the SWEETWATER FACILITY DEFENDANTS reported a net income of $39,231,169.

66. The SWEETWATER DEFENDANTS have continued to generate increasing revenues from government payors year over year since 2020. For instance, in 2020, the SWEETWATER FACILITY Defendants were paid $7,046,397 in payments from Medi-Cal for nursing services and $697,145 from Medicare. By virtue of the chain's growth, in 2023, the SWEETWATER FACILITY DEFENDANTS received $92,822,673 in Medi-Cal payments for nursing services, and $60,820,000 in Medicare payments. In total, for nursing services rendered between 2020-2023 in the State of California, the SWEETWATER DEFENDANTS were paid $349,404,658. Out of those total revenues, 85.66% came from Government funds – specifically, $196,183,015 from the Medi-Cal program, and $103,109,161 from the Medicare program.

67. While the SWEETWATER DEFENDANT facilities continued to engage in violations of California minimum staffing levels as discussed *supra*, Defendants chose to direct

[9] A "Related Party" is "an organization that is related to the facility, as defined in 42 C.F.R. section 413.17(b), and means that the provider, to a significant extent, is associated or affiliated with or has control of or is controlled by the organization furnishing services, facilities, or supplies. Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or the organization serving the facility. Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the facility. An affiliate is defined as a person, entity, or organization controlling, controlled by, or under common control with another person, entity, or organization, including, but not limited to parent corporations, holding companies, related entities, joint ventures and partnerships. Factors to be considered include: common ownership of 50% or more, shared board of directors; purpose; and whether an entity operates for the benefit of others." Offices of Statewide Health Planning and Development "Accounting and Reporting Manual for California Long-Term Care Facilities," section 4020.3.1.

$22,985,245 in payments to related party entities that were owned directly and indirectly by the SWEETWATER OWNER DEFENDANTS. For instance, this includes $1,954,792 in 2023 alone paid to WILD HORSE STAFFING, a temporary staffing agency. Through this type of transaction, revenues generated from the provision of nursing services at the SWEETWATER FACILITY level – primarily generated from government payors like Medi-Cal – were then diverted to a SWEETWATER DEFENDANT related party entity for purported temporary nursing services. These revenues then flowed upwards to the SWEETWATER OWNER DEFENDANTS.

68. In addition, the SWEETWATER DEFENDANTS diverted tens of millions of dollars in revenues to the SWEETWATER MANAGEMENT DEFENDANTS through related party payments. As shown in **Table 2**, Defendants allocated $17,458,378 in management and administrative fees to the SWEETWATER MANAGEMENT DEFENDANTS from 2020-2023.

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**Table 2. Related Party Management/Administrative Service Transactions**

| Facility | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Almond View Care Center | | | $597,692 | $864,902 |
| Brookside Care Center | | $326,108 | $608,096 | $608,977 |
| Evergreen Care Center | | $224,899 | $303,845 | $331,976 |
| Feather River Care Center | | | $275,297 | $363,640 |
| Fowler Care Center | | $194,822 | $243,127 | $307,103 |
| Grand Oaks Care | | | $334,278 | $614,036 |
| Meadowood Nursing Center | | | | $729,236 |
| Noble Care Center | | $302,980 | $586,852 | $631,925 |
| Orchards at Tulare | | | $281,437 | $531,211 |
| Palms Care Center | | $307,647 | $346,054 | $370,148 |
| Rancho Seco Care Center | | $278,077 | $547,840 | $710,445 |
| River Walk Care Center | | | $322,252 | $568,117 |
| Rolling Hills Care Center | | $170,859 | $205,663 | $258,999 |
| Sequoia Vista | | | $319,737 | $560,439 |
| Shasta View Care Center | | | $23,652 | $51,857 |
| Valley Care Center | $211,872 | $178,833 | $143,153 | |
| Valley View Care Center | | $268,946 | $324,979 | $378,778 |
| Vineyards at Fowler | | $42,165 | $260,322 | $283,382 |
| Yucca Valley Nursing | $441,051 | $392,200 | $228,472 | |
| Total | $652,923 | $2,687,536 | $5,952,748 | $8,165,171 |

69. The SWEETWATER DEFENDANTS chose to allocate $8,797,319 in profits and $22,985,245 through related-party transactions to the SWEETWATER OWNER DEFENDANTS and the SWEETWATER MANAGEMENT DEFENDANTS between 2020-2023, instead of increasing nursing wages or allocating those funds to hire additional nursing staff to address the ongoing chain-wide violations of California's minimum staffing laws.

70. At all times, the SWEETWATER DEFENDANTS had the ability to select the hourly

wage rates they could offer to hire and retain appropriate levels of nursing staff to provide care and services at the SWEETWATER FACILITIES. Leadership of the SWEETWATER MANAGEMENT DEFENDANTS were aware that failures to pay competitive wages, sufficient wages, and/or wages that were commensurate with the local market would affect their ability to hire sufficient nursing staff and meet patient needs. Despite this knowledge, the SWEETWATER DEFENDANTS chose to offer salaries and wages in various SWEETWATER FACILITIES that were below market wages, thereby causing and contributing to the understaffing patterns which impacted patients of the SWEETWATER FACILITIES.

71. The business practices of the SWEETWATER DEFENDANTS, including the failures to hire and retain sufficient nursing staff to meet California minimum staffing levels, deprived SNF patients of sufficient nursing staff levels and impacted continuity of nursing care.

**Misleading 5-Star Ratings**

72. Each SNF is required to report its staffing hours to the CMS. In turn, CMS uses this information to calculate a 5-Star rating for each SNF. These 5-Star ratings include a component related to staffing levels, and these ratings are published to the general public on CMS's official website at Medicare.gov/care-compare. The website invites consumers to "[f]ind and compare Medicare-certified nursing homes based on a location, and [to] compare the quality of care they provide *and their staffing.*" (Emphasis added.)

73. The SWEETWATER DEFENDANTS made false and misleading statements to CMS in terms of staffing levels at the SWEETWATER FACILITIES when they reported hours worked by nursing staff that were not supported by payroll records to demonstrate that nursing staff actually worked on the claimed dates and times.

74. The SWEETWATER DEFENDANTS reported nursing staff hours to CMS which are not supported by payroll records that substantiate that these nurses actually worked the hours claimed. Those representations regarding the purported hours worked by nursing staff were taken into account in CMS' calculation of CMS 5-Star Ratings, which were then published for the public's use in selecting an appropriate SNF. The SWEETWATER DEFENDANTS' acts of falsely reporting worked nursing hours to CMS despite the lack of any evidence that staff were

actually paid to work on those dates constitute false or misleading statements in violation of Business and Professions Code section 17500.

**FIRST CAUSE OF ACTION**

[By Plaintiff against All Defendants]

VIOLATION OF BUSINESS AND PROFESSIONS CODE SECTION 17200 ET SEQ.

(Unlawful, Unfair, and/or Fraudulent Business Practices)

75. The People incorporate by reference paragraphs 1-74 as though fully set forth.

76. Defendants have engaged in acts or practices that are unlawful, unfair, or fraudulent and which constitute unfair competition within the meaning of Business and Professions Code section 17200 et seq., and as alleged *supra.* These include, but are not limited to, the following acts or practices:

a) Defendants have violated Business and Professions Code section 17500 et seq. as alleged in the Second Cause of Action.

b) Defendants engaged in unlawful and unfair business practices which violate the UCL by failing to provide overall nursing hours and certified nurse assistant hours, at or above the minimum levels established by California law, and by otherwise failing to provide nursing staff sufficient to meet the acuity needs of the patient populations of the SWEETWATER FACILITY DEFENDANTS.

c) Defendants engaged in unfair and fraudulent business practices which violate the UCL when Defendants promised the State of California they would comply with state and federal laws and regulations in order to become a Medi-Cal provider, and further promised not to permit fraud or abuse of patients, however breached those promises as more fully set forth at paragraphs 49-63, *supra*.

d) Defendants engaged in unfair and fraudulent business practices when Defendants promised patients to provide sufficient nursing staff and other rights guaranteed by California Code of Regulations, title 22, section 72527, however breached those promises as more fully set forth at paragraphs 49-63, *supra*.

e) Defendants engaged in unlawful and unfair business practices when they directed

funds paid to them by Medi-Cal or Medicare for nursing care to owners and/or related parties rather than prioritizing expenditures toward nursing achieving sufficient staff levels to comply with California law.

f) Defendants engaged in unlawful and unfair business practices in violation of the UCL by failing to provide nursing staffing, care, and services consistent with promises made to residents or their responsible parties at the time of admission as set forth in the California Standard Admission Agreement for Skilled Nursing Facilities.

g) Defendants engaged in unlawful and unfair business practices in violation of the UCL by violating laws and regulations in the provision of substandard nursing care to patients of the SWEETWATER FACILITY DEFENDANTS.

h) Defendants engaged in unfair and unlawful business practices when they failed to ensure sufficient nursing staff so as to ensure registered nurses, licensed vocational nurses, and certified nurse assistants only provided nursing care and services within the scope of their respective professional licensure as permitted by California law.

i) Defendants engaged in unlawful and fraudulent business practices in violation of the UCL by reporting nurses worked certain hours to a government agency, when payroll records do not demonstrate those nurses were actually paid to work at those times.

77. This cause of action is brought for the benefit of senior citizens and/or disabled persons residing within Defendants' facilities to redress Defendants unfair and deceptive acts and practices, and unfair methods of competition.

**SECOND CAUSE OF ACTION**

[By Plaintiff against All Defendants]

VIOLATION OF BUSINESS AND PROFESSIONS CODE SECTION 17500 ET SEQ.

(False and Misleading Statements)

78. The People incorporate by reference paragraphs 1-77 as through fully set forth.

79. The SWEETWATER DEFENDANTS' acts of falsely reporting worked nursing hours to CMS despite the lack of any evidence that staff were actually paid to work on those dates constitute false or misleading statements in violation of Business and Professions Code section

17500. The unlawful conduct, acts, and omissions of Defendants in violation of Business and Professions Code section 17500 demonstrates the necessity and legal basis for granting injunctive relief, disgorgement pursuant to Business and Professions Code section 17535, and the imposition of civil penalties pursuant to Business and Professions Code section 17536 for each violation, including but not limited to, each report of unsupported or falsely inflated nursing hours to governmental agencies.

80. This cause of action is brought for the benefit of senior citizens and/or disabled persons residing within Defendants' facilities to redress Defendants unfair and deceptive acts and practices, and unfair methods of competition.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiff prays for judgment as follows:

1. That the Court make such orders or judgments as may be necessary to prevent the use or employment by Defendants, their successors, agents, representatives, employees, and all persons who act in concert with them of any practice that constitutes unfair competition or false advertising, under the authority of Business and Professions Code sections 17203 and 17535, respectively;

2. That the Court make such orders or judgments as may be necessary to restore to any person in interest any money or property that Defendants may have acquired by violations of sections 17200 and 17500 in an amount according to proof, under the authority of Business and Professions Code sections 17203 and 17535;

3. That the Court assess a civil penalty of $2,500 against each Defendant for each violation of Business and Professions Code section 17200 in an amount according to proof, under the authority of Business and Professions Code section 17206;[10]

[10] The People exclude from the People's prayers for civil penalties any violations of Health & Safety Code section 1276.65, subdivisions (c)(1)(b)-(c), that occurred during the time period covered under a COVID-19 waiver issued by CDPH pursuant to AFL 20-32 effective between March 30, 2020 through June 30, 2020.

4. That the Court assess a civil penalty of $2,500 against each Defendant for each violation of Business and Professions Code section 17500 in an amount according to proof, under the authority of Business and Professions Code section 17536;

5. In addition to any penalties assessed under Business and Professions Code sections 17206 and 17536, that the Court assess a civil penalty of $2,500 against each Defendant for each violation of Business and Professions Code section 17200 perpetrated against a senior citizen or disabled person, in an amount according to proof, under the authority of Business and Professions Code section 17206.1;

6. For treble civil penalties pursuant to Civil Code section 3345;

7. That the Court award disgorgement in an amount according to proof, under the authority of Government Code section 12527.6;

8. For the appointment of a receiver / compliance monitor pursuant to Business and Professions Code section 17203;

9. For injunctive relief under Business and Professions Code section 17203 to prevent the violation of California law and regulations according to proof;

10. That the People recover their costs of suit;

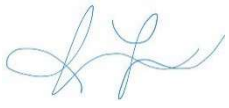
11. That the People receive all other relief to which they are legally entitled; and

12. For such other and further relief that the Court deems just and proper.

Dated: June 23, 2025

Respectfully Submitted,

ROB BONTA
Attorney General of California



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