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By: H. Larson Deputy

Edward P. Dudensing (Bar No. 182221)
Jay P. Renneisen (Bar No. 173531)
Matthew M. Chisholm (Bar No. 240896)

Dudensing Law

1610 R Street, Suite 220

Sacramento, CA 95811

Telephone: (916) 448-6400

Facsimile: (916) 448-6401

ServiceCharles@dudensinglaw.com

Attorney for Plaintiffs

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

KATHLEEN CHARLES, by and through
her successor-in-interest, ERIKA WRIGHT;
ERIKA WRIGHT, individually;
RAYMOND GREGORY CHARLES,
individually; and THOMAS WRIGHT,
individually,

Plaintiffs,

vs.

WELLQUEST ELK GROVE, LLC, a Utah
limited liability company; WELLQUEST
ELK GROVE TENANTCO LLC, a
California limited liability company;
WELLQUEST PROPERTIES, LLC, a
Delaware limited liability company;
FJM SENIOR LIVING, LLC, a Utah limited
liability company; FJ MANANGEMENT
INC., a Utah corporation;
WELLQUEST HOLDINGS, LLC, a Utah
limited liability company; WELLQUEST
LIVING, LLC, a Utah limited liability
company; STEVE SANDHOLTZ,
individually; DEAN MATTSSON,
individually; and DOES 1 through 50,
inclusive,

Defendants.

Case No. **25CV014386**

COMPLAINT FOR DAMAGES

1. Elder Neglect
2. Elder Neglect (Enhanced Remedies Sought)
3. Negligence (Custodial)
4. Fraud (Constructive)
5. Tort Per Se (Penal Code § 368)
6. Negligent Infliction of Emotional Distress
7. Wrongful Death

1 Plaintiffs allege as follows:

2 **PARTIES**

3 1. Plaintiff Kathleen Charles was at all relevant times over the age of 65 years
4 old and thus an “elder” within the meaning of Welfare and Institutions Code section 15600,
5 *et seq.* Ms. Charles suffered untold pain, suffering, injury, and death as a result of all named
6 defendants’ reckless neglect and abuse. At all relevant times, Ms. Charles was a resident at
7 WellQuest Elk Grove, LLC, which is a residential care facility for the elderly as defined in
8 section 1569(2)(o)(1) of the Health and Safety Code and is and was subject to the
9 requirements of federal and state law for such facilities.
10

11 2. Plaintiff Erika Wright is the niece of and successor-in-interest to Kathleen
12 Charles. Ms. Wright has complied with Welfare and Institutions Code section 15657.3(d) by
13 filing a successor-in-interest affidavit pursuant to Code of Civil Procedure section 377.32.
14 At all relevant times, Erika Wright was and is a resident of Louisiana.
15

16 3. Plaintiff Raymond Gregory Charles is the brother of Kathleen Charles. At all
17 relevant times, Raymond Gregory Charles was and is a resident of California.

18 4. Plaintiff Thomas Wright is the nephew of Kathleen Charles. At all relevant
19 times, Thomas Wright was and is a resident of California.
20

21 5. At all relevant times, defendant WellQuest Elk Grove, LLC, a Utah limited
22 liability company (hereafter “WellQuest EG” or “facility”), was and is in the business of
23 providing residential care for the elderly as a residential facility as defined in section 1502 of
24 the Health and Safety Code and was subject to the requirements of federal and state law.
25 WellQuest EG is registered with the California Secretary of State at 185 S. State Street, Suite

1 1300 Salt Lake City, UT 84111. At all times relevant to this action, WellQuest EG did
2 business at 8871 East Stockton Boulevard, Elk Grove, CA 95624, located in the County of
3 Sacramento.

4 6. At all relevant times, defendant WellQuest Elk Grove TenantCo LLC, a
5 California limited liability company, owned, managed, controlled, maintained, and/or
6 operated WellQuest EG and was and is a limited liability company with its principal office
7 address located at 185 S. State Street, Suite 1300 Salt Lake City, UT 84111.
8

9 7. At all relevant times, defendant WellQuest Properties, LLC, a Delaware
10 limited liability company, owned, managed, controlled, maintained, and/or operated
11 WellQuest EG and was and is a limited liability company with its principal office address
12 located at 185 S. State Street, Suite 1300 Salt Lake City, UT 84111.
13

14 8. At all relevant times, defendant FJM Senior Living, LLC, a Utah limited
15 liability company, owned, managed, controlled, maintained, and/or operated WellQuest EG
16 and was and is a limited liability company with its principal office address located at 185 S.
17 State Street, Suite 1300 Salt Lake City, UT 84111.

18 9. At all relevant times, defendant FJ Management Inc., a Utah corporation,
19 owned, managed, controlled, maintained, and/or operated WellQuest EG and was and is a
20 corporation with its principal office address located at 185 S. State Street, Suite 1300 Salt
21 Lake City, UT 84111.
22

23 10. At all relevant times, defendant WellQuest Holdings, LLC, a Utah limited
24 liability company, owned, managed, controlled, maintained, and/or operated WellQuest EG
25

1 and was and is a limited liability company with its principal office address located at 185 S.
2 State Street, Suite 1300 Salt Lake City, UT 84111.

3 11. At all relevant times, defendant WellQuest Living, LLC, a Utah limited
4 liability company, owned, managed, controlled, maintained, and/or operated WellQuest EG
5 and was and is a limited liability company with its principal office address located at 185 S.
6 State Street, Suite 1300 Salt Lake City, UT 84111.
7

8 12. At all relevant times, defendant Steve Sandholtz owned, managed, controlled,
9 maintained, and/or operated WellQuest EG. Mr. Sandholtz controlled the operations of
10 WellQuest EG from his office located at 11864 North Atlas Drive, Highland, Utah 84003.

11 13. At all relevant times, defendant Dean Mattsson owned, managed, controlled,
12 maintained, and/or operated WellQuest EG. Mr. Mattsson controlled the operations of
13 WellQuest EG from his office located at 11864 North Atlas Drive, Highland, Utah 84003.
14

15 14. Plaintiffs are ignorant of the true names and capacities of those defendants
16 named as Does 1 through 50 (hereafter “Doe Defendants”), and for that reason have sued
17 these defendants by fictitious names. Plaintiffs allege that each of the fictitiously named
18 Doe Defendants is in some way liable and legally responsible for the damages and injuries
19 set forth in this complaint. Plaintiffs will seek leave of the Court to amend this complaint to
20 identify these Doe Defendants when their identities are determined.
21

22 15. In this complaint, plaintiffs refer to defendants WellQuest EG; WellQuest
23 Elk Grove TenantCo LLC, a California limited liability company; WellQuest Properties,
24 LLC, a Delaware limited liability company; FJM Senior Living, LLC, a Utah limited liability
25 company; FJ Management Inc., a Utah corporation; WellQuest Holdings, LLC, a Utah

1 limited liability company; WellQuest Living, LLC, a Utah limited liability company; Steve
2 Sandholtz, individually; Dean Mattsson, individually; and Doe Defendants 1 through 50
3 collectively as “defendants.” Whenever plaintiffs refer to “defendants,” plaintiffs are
4 referring to defendants WellQuest EG; WellQuest Elk Grove TenantCo LLC, a California
5 limited liability company; WellQuest Properties, LLC, a Delaware limited liability company;
6 FJM Senior Living, LLC, a Utah limited liability company; FJ Management Inc., a Utah
7 corporation; WellQuest Holdings, LLC, a Utah limited liability company; WellQuest Living,
8 LLC, a Utah limited liability company; Steve Sandholtz, individually; Dean Mattsson,
9 individually; and Doe Defendants 1 through 50 as if each defendant had been identified
10 individually.
11

12 16. In this complaint, plaintiffs refer to defendants WellQuest Elk Grove
13 TenantCo LLC, a California limited liability company; WellQuest Properties, LLC, a
14 Delaware limited liability company; FJM Senior Living, LLC, a Utah limited liability
15 company; FJ Management Inc., a Utah corporation; WellQuest Holdings, LLC, a Utah
16 limited liability company; WellQuest Living, LLC, a Utah limited liability company; Steve
17 Sandholtz, individually; Dean Mattsson, individually; and Doe Defendants 1 through 30 as
18 the “Corporate Defendants.” Whenever plaintiffs refer to the “Corporate Defendants,”
19 plaintiffs are referring to defendants WellQuest Elk Grove TenantCo LLC, a California
20 limited liability company; WellQuest Properties, LLC, a Delaware limited liability company;
21 FJM Senior Living, LLC, a Utah limited liability company; FJ Management Inc., a Utah
22 corporation; WellQuest Holdings, LLC, a Utah limited liability company; WellQuest Living,
23 LLC, a Utah limited liability company; Steve Sandholtz, individually; Dean Mattsson,
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1 individually; and Doe Defendants 1 through 30 as if each of these defendants had been
2 identified individually.

3 17. At all relevant times, the Corporate Defendants owned, operated, and
4 controlled WellQuest EG and the other facilities within the WellQuest Living chain of
5 assisted living facilities. The Corporate Defendants controlled all critical aspects of the
6 operation of WellQuest EG to such a degree that they are directly liable for the wrongdoing
7 that WellQuest EG perpetrated upon Ms. Charles. Specifically, as further set forth below,
8 the Corporate Defendants controlled staffing decisions at WellQuest EG; received and
9 controlled all revenues generated by WellQuest EG; knowingly and deliberately
10 understaffed and underfunded WellQuest EG despite knowing it posed a serious danger to
11 its residents; and, more generally, created the overall plan to maximize profits at the expense
12 of resident care. Part and parcel of the Corporate Defendants' plan was to cut staffing at
13 their facilities, including WellQuest EG, despite knowing full well that it did not have
14 enough staff in terms of numbers, qualifications, and supervision to take care of the
15 residents in their facilities, including WellQuest EG.

16 18. Numerous red flags put the Corporate Defendants on notice of serious
17 problems at their facilities, including WellQuest EG. The Corporate Defendants' facilities
18 have been the target of multiple civil lawsuits as well as state regulatory actions arising from
19 resident injuries and deaths resulting from their deliberate and habitual understaffing of
20 their facilities, including WellQuest EG. The Corporate Defendants were aware of
21 numerous complaints that the level of staffing was inadequate and that staff were so
22 overburdened that they could not comply with state or federal mandates or the standard of
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1 care. The Corporate Defendants knew that their facilities, including WellQuest EG, were
2 troubled (inadequate staff, insufficient training, DSS visits, fines, civil lawsuits, staff
3 turnover, etc.), but the Corporate Defendants kept admitting new residents without
4 increasing staffing and hid the problems from prospective families, including Ms. Charles
5 and her family, as well as from other persons involved in placing residents in residential care
6 facilities for the elderly. Despite their knowledge, the Corporate Defendants continued their
7 profit-maximizing strategy and jeopardized resident health and safety because profits were
8 prioritized above resident well-being.
9

10 19. In addition to the foregoing direct liability of the Corporate Defendants,
11 plaintiffs maintain that the Corporate Defendants are liable for the wrongdoing of
12 WellQuest EG because WellQuest EG is an alter ego of the Corporate Defendants. In that
13 connection, the Corporate Defendants ostensibly operate as a service organization that
14 performs all services for affiliated facilities, including WellQuest EG, but in reality, they
15 directly control the facilities. The Corporate Defendants own and have the ability to directly
16 control all affiliated facilities in their chain, including WellQuest EG.
17

18 20. The allegations supporting the Corporate Defendants' alter ego relationship
19 with WellQuest EG include the following, among others. The officers, directors, managers,
20 shareholders, and members of the board of directors of the Corporate Defendants and their
21 various facilities, including WellQuest EG, are believed to be substantially identical. The
22 Corporate Defendants perform all accounting functions for WellQuest EG and entirely
23 control its finances. The agent for service of process between these entities is the same. The
24 corporate headquarters for the entities are the same. In addition, WellQuest EG has limited
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1 assets with all profits reaped from its operations flowing to its parent corporations, the
2 Corporate Defendants. As alter egos, the Corporate Defendants and WellQuest EG operate
3 as care custodians over the residents at WellQuest EG and are fully subject to liability based
4 on the reckless neglect that Kathleen Charles suffered at WellQuest EG. WellQuest EG has
5 intentionally been undercapitalized as a way of avoiding liability for the wrongdoing of its
6 employees. WellQuest EG's executive director directly reports to individuals from the
7 Corporate Defendants.
8

9 21. Given the alter ego relationship between and among the Corporate
10 Defendants and WellQuest EG, as a matter of law, each of the acts attributable to
11 WellQuest EG are also legally attributable to the Corporate Defendants.
12

13 22. In addition, the Corporate Defendants and WellQuest EG are engaged in a
14 joint venture such that each of these entities is legally responsible for the wrongful conduct
15 of the other. Specifically, the Corporate Defendants and WellQuest EG have combined
16 their property, skill and knowledge with the intent of carrying out a single business
17 undertaking -- to wit, the operation of a residential care facility for the elderly in a manner
18 that maximizes profit at the expense of resident care. The entities have overlapping
19 ownership. Joint control over the businesses exists as detailed in the foregoing paragraphs.
20 The profits and losses of the businesses are shared and commingled. Given the joint control
21 and operation of the Corporate Defendants and WellQuest EG, they constitute a joint
22 venture such that the Corporate Defendants are legally liable for the fraudulent and
23 otherwise wrongful conduct of WellQuest EG and vice versa.
24
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1 23. In addition, the Corporate Defendants are liable for the wrongdoing of
2 WellQuest EG as to Ms. Charles because they acted as aiders and abettors of WellQuest
3 EG's egregious plan to maximize profits at the expense of resident care. Specifically, the
4 Corporate Defendants knew that their facility WellQuest EG was engaged in a plan to
5 maximize profits at the expense of resident care by, among other things, drawing in high
6 acuity residents and then severely understaffing the facility. The Corporate Defendants
7 knew that such a plan was substantially likely to result in significant harm to the facility's
8 vulnerable residents including Ms. Charles. The Corporate Defendants gave substantial
9 assistance to this egregious plan by, among other things, controlling the budget that led to
10 the execution of the plan, giving financial incentives to facility personnel to carry out the
11 plan, and otherwise creating a culture that encouraged and condoned this egregiously
12 dangerous plan. WellQuest EG's conduct and the Corporate Defendants' conduct were
13 substantial factors in causing harm to plaintiffs.
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16 24. In addition, the Corporate Defendants are liable for the wrongdoing of
17 WellQuest EG as to Ms. Charles because the entities were co-conspirators in an egregious
18 plan to maximize profits at the expense of resident care. Specifically, the Corporate
19 Defendants knew that WellQuest EG was engaged in a plan to maximize profits at the
20 expense of resident care by, among other things, drawing in high acuity residents and then
21 severely understaffing the facility. The Corporate Defendants knew that such a plan was
22 substantially likely to result in significant harm to the facility's vulnerable residents including
23 Ms. Charles. The Corporate Defendants agreed with the egregious plan described above
24 and intended that it be carried out. Indeed, the Corporate Defendants gave substantial
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1 assistance to this egregious plan by, among other things, controlling the budget that led to
2 the execution of the plan, giving financial incentives to facility personnel to carry out the
3 plan, and otherwise creating a culture that encouraged and condoned this egregiously
4 dangerous plan. WellQuest EG's conduct and the Corporate Defendants' conduct were
5 substantial factors in causing harm to Ms. Charles.
6

7 25. In addition, the Corporate Defendants are liable for the harm that Kathleen
8 Charles suffered while at WellQuest EG because at all relevant times WellQuest EG acted
9 as a mere agent of the Corporate Defendants. WellQuest EG was a mere agent of the
10 Corporate Defendants because the Corporate Defendants designated WellQuest EG as
11 their agent and at all relevant times the Corporate Defendants controlled all material aspects
12 of the operation of WellQuest EG including but not limited to the flow of money to and
13 from WellQuest EG, staffing, and the overall budget. As such, the Corporate Defendants
14 not only gave WellQuest EG authority to act on their behalf but commanded that
15 WellQuest EG act as it did on behalf of, and for the benefit of, the Corporate Defendants.
16 At all relevant times, WellQuest EG was acting within the scope of its agent role and the
17 harm that Ms. Charles suffered was a foreseeable consequence of the nature of the agency
18 relationship between WellQuest EG and the Corporate Defendants. Further, the Corporate
19 Defendants ultimately ratified their agent's conduct by, among other things, continuing to
20 approve budgets that caused understaffing at WellQuest EG, electing to give financial
21 incentives to reward facility personnel for the understaffing that harmed Ms. Charles,
22 choosing not to take any action to hold anyone accountable for the neglect of Ms. Charles,
23 and failing to otherwise repudiate the neglect of Ms. Charles in any way.
24
25

1 **FACTUAL ALLEGATIONS**

2 26. All of the acts described herein constituted an ongoing practice and pattern
3 of neglect and abuse committed by defendants.

4 27. Prior to Kathleen Charles' admission to defendants' WellQuest EG facility,
5 she resided at home with her live-in partner in Sacramento, California. Ms. Charles had a
6 confirmed diagnosis of dementia and consequently, her family had three home health
7 nurses that, between them, provided care 8 hours a day, 7 days a week. Despite their effort,
8 and after considering several options, Ms. Charles and her family decided to move her into
9 the memory care wing of WellQuest EG on September 29, 2024. This move was made to
10 obtain a higher level of care, in an environment that would provide both the support and
11 constant supervision that Ms. Charles needed to protect her from the foreseeable dangers
12 of living with her cognitive disabilities. Ms. Charles was 74 years of age and, in spite of her
13 cognitive limitations, in general good health.

14 28. Staff at WellQuest EG conducted a pre-admission appraisal of Ms. Charles
15 prior to accepting her as a resident. That appraisal included consultation with both her
16 family and her doctors. In the preplacement appraisal dated September 9, 2024, Raymond
17 Gregory Charles provided Ms. Charles' diagnosis (i.e. - frontotemporal dementia) and noted
18 that she needed assistance for most activities. Mr. Charles specifically noted that Ms.
19 Charles needed "special observation/night supervision (due to confusion, forgetfulness,
20 wandering)." WellQuest EG noted in their service plan for Ms. Charles her "severe
21 impairment . . . requires frequent supervision and oversight." In addition to Mr. Charles'
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1 requests, facility policies and state regulations required defendants to check in on Ms.
2 Charles, and every other resident, regularly to ensure their safety.

3 29. After her admission to the facility, the family continued to highlight the need
4 for close supervision of Ms. Charles due to her cognitive limitations. Just six hours after
5 admission, her family told staff that Kathleen is a wanderer and needed to be monitored or
6 she would attempt to leave the facility. On her second day in the facility, staff again noted
7 that Ms. Charles is a “wanderer” and had a tendency to enter other residents’ rooms.
8 Despite defendants’ documented awareness of Kathleen’s condition, her proclivity to
9 wander, and her need for greater supervision and assistance, defendants did not implement
10 any additional precautionary efforts to protect her. As a result of defendants’ failure,
11 Ms. Charles entered the unmonitored courtyard and was left unattended for hours.
12

13 30. Official historical records show that the ambient high temperature in Elk
14 Grove, California on October 2, 2024 was 102 degrees Fahrenheit.
15

16 31. On October 2, 2024 at approximately 3:25 p.m., just three days after her
17 admission to WellQuest EG, Ms. Charles was found by staff seated, unresponsive and
18 unattended, in a chair in direct sun in the memory care courtyard. It is unknown how long
19 she was exposed to these unhealthy temperatures or how long she was unconscious.
20

21 32. Upon finding her, staff tried to communicate with Ms. Charles but had no
22 success; she was completely unresponsive. Staff then moved Kathleen indoors and took her
23 vitals. Realizing Ms. Charles was likely suffering heat stroke, staff called 9-1-1. The
24 Cosumnes Fire Department arrived on scene at 3:29 p.m. and took their own vitals. Ms.
25 Charles’ internal temperature was 105 degrees and paramedics began administering cooling

1 treatments, including ice packs and water-soaked towels applied all over her body.

2 Paramedics transported Kathleen to a Kaiser Permanente hospital “Code 3” immediately,
3 arriving at the facility at 3:50 p.m.

4 33. At Kaiser, doctors examined Ms. Charles and noted horrific burns, mostly
5 first degree and covering 23 to 25% of her body’s surface area. Kathleen had burns on her
6 face, her abdomen, both of her arms, and both of her legs. Despite the treatment by
7 paramedics, her temperature remained near 105 degrees and she persisted in a comatose
8 state. The admitting doctor diagnosed Ms. Charles with heatstroke and she was admitted to
9 the Intensive Care Unit (ICU).
10

11 34. Over the next four days, Ms. Charles suffered significant pain and discomfort
12 in her struggle to live, enduring at least three Tonic-Clonic (Grand Mal) seizures. Ms.
13 Charles’ burns resulted in extensive raised blisters on her skin and several of those blisters
14 eventually ruptured. Ms. Charles’ family, including her brother Raymond Gregory, was at
15 her bedside at Kaiser to comfort her during her treatment. They were traumatized by
16 witnessing her dire condition and abject suffering, after they had just placed Kathleen in the
17 care and custody of Wellquest EG just three days prior. Ms. Charles never regained
18 consciousness after leaving WellQuest EG and never said goodbye to her loved ones. Ms.
19 Charles died from defendants’ reckless neglect on October 6, 2024.
20
21

22 **COUNT ONE**
23 **[Elder Neglect**
 Plaintiff Kathleen Charles vs. Defendants]

24 35. Plaintiffs hereby incorporate by reference each and every allegation set forth
25 in all of the preceding paragraphs of this complaint as though these paragraphs were

1 individually alleged and repeated in connection with this cause of action.

2 36. Defendants had care or custody over Ms. Charles during her entire admission
3 at their WellQuest EG facility. Defendants, and each of them, had a substantial caretaking
4 and custodial relationship with Ms. Charles with responsibility for her basic needs while she
5 was a resident in their residential care facility for the elderly. At the time of her admission,
6 Ms. Charles was over the age of 65 and thus an “elder” and within the class of persons
7 protected by Welfare and Institutions Code section 15600, et seq.
8

9 37. Defendants neglected Ms. Charles within the meaning of Welfare and
10 Institutions Code section 15610.57 by entirely ignoring their obligation to provide custodial
11 care with respect to monitoring her location and environment in light of her cognitive
12 limitations. Upon admission to WellQuest EG, the defendants were put on notice of
13 Ms. Charles’ cognitive disability, verbally at the time of her assessment, in a letter from her
14 physician and in writing by her family. In both preadmission forms and direct comments to
15 staff on the day of her admission, Ms. Charles’ family warned WellQuest EG that Kathleen
16 was a wanderer and needed assistance in all activities. Furthermore, Kathleen’s wandering
17 behavior manifested immediately and WellQuest EG noted it in their charting. Despite the
18 defendants’ awareness of Ms. Charles’ cognitive impairment and proclivity for wandering,
19 defendants chose to rely on the limited default supervision of their staff to monitor and care
20 for a woman who was repeatedly identified as having severe mental impairment and the
21 inability to care for her own needs. This level of care was utterly unacceptable for someone
22 who, because of her cognitive impairment, did not even know whose room she was in or
23 when to get out of the sun. This was unconscionable neglect with a foreseeable result.
24
25

1 Tragically, Kathleen Charles cooked to death in the courtyard of WellQuest EG, suffering
2 unrecoverable heat stroke and burns on 23-25% of her body in just her third day in the
3 facility. As a result of defendants' failures, Ms. Charles suffered untold pain, suffering and
4 death.

5
6 38. The conduct of defendants, and each of them, as detailed above resulted in
7 enormous physical harm to Ms. Charles and ultimately killed her. In addition to the physical
8 harm caused by defendants' neglect of Ms. Charles, defendants' conduct caused Ms. Charles
9 to suffer substantial mental pain and suffering.

10 Wherefore, plaintiffs are entitled to recover for all pre-death harm, pain and
11 suffering that Ms. Charles experienced as a result of defendants' elder neglect of Ms.
12 Charles as well as all other damages prayed for as set forth below.

13
14 **COUNT TWO**
15 **[Elder Neglect (Enhanced Remedies Sought)**
Plaintiff Kathleen Charles vs. Defendants]

16 39. Plaintiffs hereby incorporate by reference each and every allegation set forth
17 in all of the preceding paragraphs of this complaint as though these paragraphs were
18 individually alleged and repeated in connection with this cause of action.

19 40. Defendants' neglect of Ms. Charles outlined in the preceding cause of action
20 – which plaintiffs hereby incorporate by reference as if these paragraphs were fully stated in
21 this cause of action – was reckless, oppressive and malicious. Specifically, the individuals
22 who cared for Ms. Charles knew that ignoring their obligations to (1) provide custodial care
23 with respect to her cognitive disabilities; (2) not abandon Ms. Charles; (3) protect Ms.
24 Charles from enduring first and second degree burns; (4) protect Ms. Charles from suffering
25

1 heatstroke; and (5) ensure Ms. Charles was free from unnecessary pain and was being
2 maintained at her highest practicable level of physical, emotional and psychosocial
3 functioning, among other things, would endanger Ms. Charles immediately and that there
4 was a high probability that she would suffer severe injuries or death. Further, defendants
5 knew that monitoring Ms. Charles' location and environment was critical to maintaining her
6 health, well-being, and prognosis. Despite their knowledge of the primary risk to Ms.
7 Charles' life, defendants ignored this resident care issue, and each of them, provided
8 abysmal care that fell far below how reasonable persons in their position would have
9 performed. By failing to maintain a safe environment for Ms. Charles, defendants knew that
10 it was highly probable that their conduct would cause her harm or death or both, and they
11 knowingly disregarded this risk.
12

13
14 41. Further, defendants, and each of them, are legally responsible for the reckless
15 neglect Ms. Charles suffered for numerous independent reasons. First, the managing agents
16 of defendants, and each of them, directly participated in the neglect of Ms. Charles.
17 Personnel whom defendants, and each of them, vested with discretionary decision-making
18 authority relating to resident care issues involving Ms. Charles were part of the team that
19 ignored their obligations to perform basic assessments and to provide custodial care with
20 respect to preventing heat stroke and skin burns by ensuring that Ms. Charles was
21 supervised, her well-being was properly monitored, and ensuring Ms. Charles was free from
22 unnecessary pain and was being maintained at her highest practicable level of physical,
23 emotional and psychosocial functioning, among other things. Such individuals were officers,
24 directors, and/or managing agents of defendants and each of them. The direct participation
25

1 of these individuals in the abysmal care provided to Ms. Charles and the withholding of care
2 to Ms. Charles, subjects defendants, and each of them, to liability under the Elder Abuse
3 and Dependent Adult Civil Protection Act (hereafter “Elder Abuse Act”).

4 42. Further, defendants, and each of them, are legally responsible for the
5 egregious neglect Ms. Charles suffered, because their officers, directors and/or managing
6 agents both directly and indirectly authorized the reckless neglect that Ms. Charles suffered.
7 These officers, directors and/or managing agents directly authorized the reckless neglect at
8 issue by specifically knowing that Ms. Charles was being neglected by WellQuest EG
9 personnel, allowing such neglect to continue to occur, and failing to take any action to
10 prevent the reckless neglect from further occurring.

11
12 43. Further, the Corporate Defendants, and each of them, are legally responsible
13 for the reckless neglect Ms. Charles suffered because their officers, directors and/or
14 managing agents were responsible for creating the resident care environment that inevitably
15 led to the reckless neglect of Ms. Charles and other similarly situated residential care facility
16 residents under the care of defendants. Specifically, defendants and their officers, directors
17 and managing agents purposely used insufficient staff, underpaid staff, insufficiently
18 supervised staff, and untrained staff as part of an overall plan, design, and scheme to
19 maximum their profits at the expense of resident care and well-being.

20
21 44. The Corporate Defendants owned, operated and controlled the 24-hour
22 health facility that had care and custody over Ms. Charles at all relevant times. The
23 Corporate Defendants are legally responsible for the widespread neglect of Ms. Charles
24 because the personnel who they vested with discretionary decision-making authority relating
25

1 to resident care issues involving Ms. Charles were part of the team at the facility that
2 ignored their obligations to perform basic assessments and to provide custodial care. Such
3 individuals had first-hand knowledge of the failures with respect to preventing dehydration,
4 preventing the development of pressure injuries, ensuring Ms. Charles was supervised and
5 her well-being was properly monitored, and ensuring Ms. Charles was free from
6 unnecessary pain and was being maintained at her highest practicable level of physical,
7 emotional and psychosocial functioning, among other things, yet allowed such neglect to
8 continue to occur, failed to take any action to prevent the reckless neglect from further
9 occurring, and otherwise purposely utilized insufficient staff, underpaid staff, and
10 insufficiently supervised staff as part of an overall plan, design, and scheme to maximum
11 their profits at the expense of resident care and well-being.
12

13
14 45. Defendants and their staff also recklessly neglected Ms. Charles by
15 intentionally understaffing the facility at expense of and risk to the health and safety of its
16 residents, including Ms. Charles. In choosing to maximize profits at the expense of resident
17 care, defendants knew their plan posed a substantial and imminent danger to the health,
18 safety and well-being of the residents they provided services to.
19

20 46. Defendants engaged in a significant pattern and practice of understaffing the
21 facility in knowing violation of applicable state statutes governing residential care facilities
22 for the elderly. Defendants and their managing agents were aware of applicable state
23 statutes and yet they had a significant pattern of knowingly violating them prior to and at
24 the time Ms. Charles was at the facility.
25

1 47. The Corporate Defendants, and their officers, directors and managing agents
2 had specifically been put on notice of the egregious failures of their personnel to provide
3 adequate resident care by, among other things, the numerous deficiencies and citations
4 imposed by the California Department of Social Services, the public entity statutorily
5 entrusted with providing regulatory oversight of these facilities. Further, plaintiffs are
6 informed and believe that defendants have been subjected to numerous civil lawsuits for
7 which they have been forced to pay millions of dollars in settlements relating specifically to
8 the abysmal resident care provided by defendants. Despite being placed on specific notice
9 of the repeated and significant shortcomings of resident care at WellQuest EG, defendants
10 have continued to operate WellQuest EG without making the necessary changes to address
11 identified shortcomings in resident care.
12

13 48. The conduct of defendants, and each of them, caused Ms. Charles to suffer
14 untold pain, suffering and ultimately death.
15

16 49. Under Welfare and Institutions Code sections 15657(a) and (b), defendants
17 are liable to plaintiffs for damages for Ms. Charles' pain and suffering, injuries, medical
18 expenses, and attorneys' fees and costs.
19

20 50. Defendants' violations of the various provisions of the Elder Abuse Act,
21 which provisions embody a substantial public interest to protect the health and welfare of
22 elderly and dependent persons, was despicable and in conscious disregard of Ms. Charles'
23 rights, health and welfare.

24 51. As is discussed more fully above, defendants acted with fraud, malice,
25 oppression and recklessness in doing so, thereby entitling plaintiffs to punitive damages in

1 connection with defendants' conduct.

2 Wherefore, plaintiffs pray for damages as set forth below.

3 **COUNT THREE**
4 **[Negligence (Custodial)**
5 **Plaintiff Kathleen Charles vs. Defendants]**

6 52. Plaintiffs hereby incorporate by reference each and every allegation set forth
7 in all of the preceding paragraphs of this complaint as though these paragraphs were
8 individually alleged and repeated in connection with this cause of action.

9 53. From September 29, 2022 to October 2, 2022, Plaintiff Kathleen Charles was
10 admitted to WellQuest EG, which was controlled and operated by defendants, and each of
11 them. Defendants owed Ms. Charles a duty to act reasonably in caring for her basic needs
12 by, among other things, regularly checking on her, ensuring that she was free from danger,
13 ensuring that she was adequately protected from the environment, ensuring that she did not
14 endure avoidable skin burns, assuring that she did not endure heat stroke, and ensuring that
15 she did not suffer unneeded and unwarranted pain and suffering.

16 54. Defendants failed to meet their duty of care to Ms. Charles.

17 55. As a proximate result of defendants' failure to meet their duty of care as to
18 Ms. Charles, she suffered enormous physical harm, mental harm, pain and suffering, and
19 death.
20

21 Wherefore, Plaintiffs are entitled to recover for all pre-death harm, pain and
22 suffering that Ms. Charles experienced as a result of defendants' breaches of their duties to
23 Ms. Charles as well as all other damages prayed for as set forth below.
24
25

COUNT FOUR
[Fraud (Constructive)
Plaintiff Kathleen Charles vs. Defendants]

56. Plaintiffs hereby incorporate by reference each and every allegation set forth in all of the preceding paragraphs of this complaint as though these paragraphs were individually alleged and repeated in connection with this cause of action.

57. Ms. Charles was dependent upon defendants for custodial care and assistance in meeting her basic daily living and health and safety needs when she resided at WellQuest EG from September 29, 2022 to October 2, 2022. Plaintiffs trusted defendants to faithfully fulfill and observe their custodial duties and to act on Ms. Charles' behalf for purposes of providing her with care and assistance to meet her daily living and health and safety needs.

58. Defendants accepted Ms. Charles as a resident, accepted her trust and confidence, and accepted the fiduciary relationship which was then and there created.

59. By virtue of the relationship between Ms. Charles and defendants, a fiduciary duty existed relating to the care, comfort, safety, and health of Ms. Charles and the disposition and use of money paid on behalf of Ms. Charles for her proper care. Pursuant to their duty, defendants owed the utmost good faith and fairness to Ms. Charles in all matters pertaining to her health, care, and comfort, and relating to use of the money paid on her behalf for her proper care. Ms. Charles relied on this fiduciary relationship, and defendants accepted her reliance.

60. Defendants breached their fiduciary duty to Ms. Charles by being aware of, but concealing from plaintiffs, that defendants were managing WellQuest EG in a manner that was focused on maximizing the profits of WellQuest EG to the fullest possible extent

1 even when doing so was to the detriment of the care to be provided. Defendants knew, but
2 concealed from plaintiffs, that because of this plan to prioritize profits over resident care
3 that residents at WellQuest EG, including Ms. Charles, would not receive the care they
4 wanted or needed. Defendants misled plaintiffs by failing to disclose this information.

5
6 61. Defendants further breached their fiduciary duty to Ms. Charles by being
7 aware, but concealing from plaintiffs, that the facility was not capable of properly caring for
8 Ms. Charles because its staff lacked the numbers, training and supervision to ensure that the
9 very high acuity resident population it was serving was cared for in a way so as to ensure
10 that their residents attained and maintained their highest practicable physical, mental, and
11 psychosocial well-being. Defendants knew but concealed that there were numerous
12 complaints that the level of staffing at WellQuest EG was inadequate, and that staff were so
13 overburdened and inadequate that they could not comply with state regulations relating to
14 staffing or the standard of care governing staffing. Defendants misled plaintiffs by failing to
15 disclose this information.
16

17 62. Had Ms. Charles known of the facts described in either of the above two
18 paragraphs she would not have agreed to reside at WellQuest EG and/or would have
19 promptly sought a discharge from the facility upon arrival. As a result of defendants' failure
20 to disclose this crucial information, defendants were able to secure and subsequently retain
21 Ms. Charles as a resident and to continue to collect monies for her care.
22

23 63. As a direct and proximate result of the acts alleged above, Ms. Charles
24 sustained physical and emotional injuries, including pain, suffering and ultimately death, the
25 damages of which will be established according to proof at trial.

Wherefore, Plaintiffs are entitled to recover for all pre-death harm, pain and suffering that Ms. Charles experienced as a result of defendants' breaches of their duties to Ms. Charles as well as all other damages prayed for as set forth below.

COUNT FIVE
[Tort Per Se (Penal Code § 368)
Plaintiff Kathleen Charles v. Defendants]

64. Plaintiffs hereby incorporate by reference each and every allegation set forth in all of the preceding paragraphs of this complaint as though these paragraphs were individually alleged and repeated in connection with this cause of action.

65. During all times relevant to this lawsuit, Ms. Charles was an elder within the meaning of Welfare and Institutions Code section 15600, et seq. Ms. Charles suffered untold pain, suffering, and serious injury as a result of all named defendants' reckless neglect and abuse.

66. Each of the defendants was an entity having the care or custody of Kathleen Charles, within the meaning of Penal Code section 368. Each of the defendants had the care, custody, and control of, or stood in a position of trust with, Ms. Charles. The defendants, and each of them, as care custodians, willfully caused or permitted the person or health of Ms. Charles to be injured or willfully caused or permitted Ms. Charles to be placed into a situation such that her person or health was in danger.

67. Defendants willfully caused or permitted Kathleen Charles, an elder whom they knew to be an elder, to suffer unjustifiable physical pain or mental suffering, within the meaning of Welfare and Institutions Code section 15610.53.

68. As a direct and proximate result of defendants' conduct toward Kathleen Charles, which includes but is not limited to defendants' neglect, abuse, and infliction of mental suffering, Ms. Charles suffered unspeakable physical and mental pain, suffering and injury.

69. Kathleen Charles's physical and mental pain, suffering and injury resulted from an occurrence of that nature which Penal Code section 368 is designed to prevent. Ms. Charles was one of the class of persons for whose protection Penal Code section 368 was adopted.

70. Defendants' violations of the various provisions of Penal Code section 368, which provisions embody a substantial public interest to protect the health and welfare of elderly and dependent persons, were despicable and in conscious disregard of Kathleen Charles's rights, health and welfare.

71. As is discussed more fully above, defendants acted with fraud, malice, oppression and recklessness in doing so, thereby entitling Plaintiffs to punitive damages in connection with this cause of action.

Wherefore, Plaintiffs pray for damages as set forth below.

COUNT SIX
[Negligent Infliction Of Emotional Distress
Plaintiff Raymond Gregory Charles vs. Defendants]

72. Plaintiffs hereby incorporate by reference each and every allegation set forth in all of the preceding paragraphs of this complaint as though these paragraphs were individually alleged and repeated in connection with this cause of action.

1 73. Raymond Gregory Charles is the brother of Kathleen Charles and was
2 extremely close to his sister. As Ms. Charles' brother, he was very much attuned to Ms.
3 Charles' needs and to defendants' utter failure to attend to those needs. After Kathleen
4 Charles was admitted to WellQuest EG, he visited her regularly.

5 74. Raymond Gregory Charles directly witnessed the maltreatment and neglect of
6 Ms. Charles by defendants, including but not limited to, defendants' utter failure to ensure
7 Ms. Charles was supervised and her well-being was properly monitored, among other
8 things. During this time, Mr. Charles continued to witness Ms. Charles' worsening physical
9 condition due to defendants' failures to ensure Ms. Charles was supervised and her well-
10 being was properly monitored. Through these direct observations, Mr. Charles gained
11 enough of an understanding of the maltreatment and neglect of Ms. Charles at the time it
12 was occurring to have contemporary sensory awareness that defendants' conduct was in fact
13 maltreatment and neglect and that it was causing Ms. Charles injury.

14 75. As a result of being present and observing defendants' reckless neglect of Ms.
15 Charles, Raymond Gregory Charles experienced anguish, shock, disgust, horror, anxiety and
16 grief. He suffered and continues to suffer severe and substantial emotional distress, beyond
17 that which would be anticipated in a disinterested witness. Defendants' neglect and
18 maltreatment of Ms. Charles directly caused the emotional distress suffered by Mr. Charles
19 which continues to this day. Mr. Charles had enough understanding of defendants'
20 maltreatment and neglect, and its effect on Ms. Charles, to have a contemporary sensory
21 awareness that defendants' conduct caused Ms. Charles' pain, suffering and injuries. This
22 realization led Mr. Charles to suffer severe emotional distress.

Wherefore, plaintiffs pray for damages as set forth below.

COUNT SEVEN
[Wrongful Death
Plaintiffs Erika Wright, Raymond Gregory Charles,
and Thomas Wright vs. Defendants]

76. Plaintiffs hereby incorporate by reference each and every allegation set forth in all of the preceding paragraphs of this complaint as though these paragraphs were individually alleged and repeated in connection with this cause of action.

77. As set forth more fully above, defendants recklessly neglected Kathleen Charles in many ways, including but not limited to failing to properly assess Ms. Charles and undertake basic interventions necessary to protect her, ignoring their obligations to not abandon Kathleen Charles, to keep her free from first degree skin burns, to keep Ms. Charles protected from heat stroke, to keep her in a safe and hospitable environment, and to keep Ms. Charles free from unnecessary pain and suffering. As a result of defendants' neglect as alleged more specifically above, Ms. Charles was transported to the hospital on October 2, 2022, in a comatose state, with first and second degree burns on 23-25% of her body, a temperature of 105 degrees, and heat stroke. After four painful days in the hospital, Ms. Charles died on October 6, 2022 from defendants' neglect.

78. Prior to the death of Kathleen Charles, Erika Wright, Raymond Gregory Charles, and Thomas Wright enjoyed the love, society, comfort, and attention of their sister/aunt. As a proximate result of the reckless neglect and abuse perpetrated by defendants, and each of them, Erika Wright, Raymond Gregory Charles and Thomas

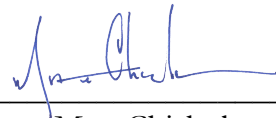
1 Wright are no longer able to enjoy the love, society, comfort and attention of Kathleen
2 Charles.

3 **WHEREFORE**, plaintiffs pray for judgment as follows:

- 4 1. For general damages according to proof;
- 5 2. For special damages according to proof;
- 6 3. For attorneys' fees against defendants pursuant to Welfare and Institutions
7 Code section 15657(a), and Code of Civil Procedure section 1021.5;
- 8 4. For punitive damages against all defendants;
- 9 5. For disgorgement of benefits and return of profits;
- 10 6. For costs of suit against all defendants, and
- 11 7. For such other and further relief as the Court deems just and proper.

12 Dated: June 17, 2025

Dudensing Law

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17 Matt Chisholm
18 Attorney for Plaintiffs
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