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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

GINGER CONGI, ANGIE RUBINO, CHANDRA PETERSON-CHASTAIN AND JESSIE PETERSON via her estate, individually,

Plaintiffs,

v.

DIGNITY HEALTH, d/b/a MERCY SAN JUAN MEDICAL CENTER; a division of COMMONSPIRIT; MORTUARY SUPPORT SERVICES OF NORTHERN CALIFORNIA (DOE #1), LLC; DOCTOR NADEEM MUKHTAR (DOE #2), and DOES 3-50, inclusive,

Defendants.

Case No. 24CV015815

SECOND AMENDED VERIFIED COMPLAINT FOR:

1. **NEGLIGENT HANDLING OF A CORPSE;**
2. **NEGLIGENCE;**
3. **NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS;**
4. **NEGLIGENT MISREPRESENTATION;**
5. **NEGLIGENT HIRING AND SUPERVISION;**
6. **VIOLATION OF CALIFORNIA HEALTH AND SAFETY CODE § 7100;**
7. **VIOLATION OF CALIFORNIA HEALTH AND SAFETY CODE § 7104;**
8. **GROSS NEGLIGENCE;**
9. **INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS;**
10. **INTENTIONAL MISREPRESENTATION; and**
11. **CONCEALMENT.**

Plaintiffs Ginger Congi ("Ginger"), Angie Rubino ("Angie"), Chandra Peterson-Chastain ("Chandra") and Jessie Peterson ("Jessie") (collectively the "Plaintiffs") complain and allege causes of action collectively and individually against Defendants Dignity Health, d/b/a Mercy San Juan Medical Center, CommonSpirit (hereinafter, the hospital defendants, Dignity Health, doing business as Mercy San Juan Medical Center, and CommonSpirit are referred to as "Dignity Health"), Mortuary Support Services

of Northern California ("Cremations Only"), Dr. Nadeem Mukhtar ("Dr. Mukhtar") (collectively the "Defendants") and Does 3-50 as follows:

INTRODUCTION

"The hospital failed to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures relating to family notification of patient death, timely completion of death certificates, and processing of patient remains . . . which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage."[1]

"On 10/4/2024, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from death in 2023, and 19 patient remains from deaths in the first half of 2024."[2]

"We assumed the remains being stored did not have families."[3]

* * *

Jessie Peterson had a family, and

Jessie Peterson deserved dignity, even in death.

[1] Audit Report findings of the California Department of Health and Human Services on behalf of CMS dated 10/04/2024. (Exhibit 3.) See: Nearly identical findings in the 2022 Audit Report (Exhibit 1) and 2023 Audit Report (Exhibit 2).

[2] *Id*.

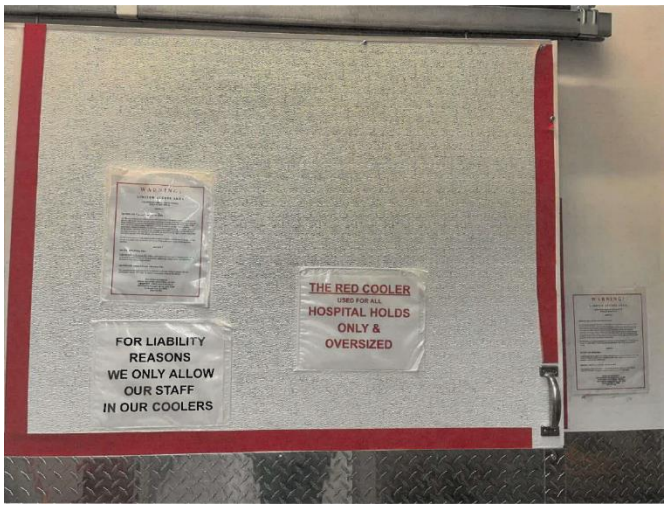
[3] Mercy San Juan Hospital President, Michael Korpiel's quoted response to the scathing findings of the California Department of Health and Human Services, as quoted in Exhibit 3, page 6. After the press coverage regarding this case Mr. Korpiel announced his retirement.

1. Jessie Marie Peterson (hereinafter "Jessie") was born on August 15, 1991. Jessie grew up in Sacramento, California along with her sisters Angie and Chandra. Jessie was a very loving and energetic person. Jessie was diagnosed with Type I diabetes at the early age of ten. This affected her energy and participation in gymnastics when she was younger. Jessie was a member of the High School Water polo team, High School Dance team, and was a prosecuting attorney for the Placer County Peer Court. She graduated from Roseville High School and attended Sierra College. Since the onset of her diabetes Jessie had been in an out of Dignity Health hospital numerous times.

2. On April 6, 2023, Jessie suffered a diabetic episode and was admitted to Mercy San Juan Medical Center in Sacramento, California. Jessie's medical records indicate a discharge date of April 8, 2023. Jessie's family was told that Jessie had been discharged against medical advice. In truth, Jessie had died while in the care of Dignity Health. Jessie's Certificate of Death, not completed until nearly a year after her passing, states that she died from cardiopulmonary arrest at age 31. Because Jessie's death was not reported by the Defendants to her family for a year after her death, an autopsy to determine the extent to which medical malpractice may have played a role in her death was rendered impossible.

3. Unaware that Jessie had died on **April 8, 2023**, Jessie's family tirelessly tried to locate Jessie. The Plaintiffs also filed a Missing Person's report with the Sacramento County Sheriff's Office. They also posted information about Jessie on the Department of Justice website for missing persons. Jessie's family searched and searched for Jessie. It was not until **April 2024**, that Dr. Mukhtar completed the physician certification portion of the death certificate enabling the Funeral Director at Cremations Only to issue Jessie's Death Certificate on April 5, 2024. (Exhibit 4.) Just one week later, on April 12, 2024, the Sacramento County Detective's Office was able to locate Jessie's remains and notified Jessie's family that Jessie had been found in "cold storage" and had been there since April 8, 2023. Cold storage

is essentially a large storage warehouse where Dignity Health has contracted to store bodies.



4. Finally, Jessie's family could lay Jessie to rest after a year in the Defendants' version of purgatory. But because of the passage of time Jessie's body was so decomposed that an open casket funeral was not feasible, and Jessie's fingerprints were not even obtainable for any keepsake. Because the hospital failed to notify Jessie's family of her death, they were unable to see Jessie's body to say goodbye and will forever live with their last image of Jessie coming from Jessie's medical records, as being ***confused and "curled up in a ball on a stretcher" and completely alone***. (Exhibit 5 at 5:12-13.) This image has and forever will cause Plaintiffs severe emotional distress.

5. Dignity Health advertises on its website that it changed its name to "*Dignity Health to better describe what we stand for. Dignity is something everyone is born with. 'Dignity' means showing respect for all people*."[4] In this case, no "dignity" or respect was afforded to Jessie Peterson or her family. Dignity Health, Dr. Mukhtar, and Cremations Only (collectively the "Defendants") failed in its most fundamental statutory, ethical, and required standard of care for Jessie and her family. Defendants callously stored Jessie in an off-site warehouse where she was left to decompose for nearly a year while her family relentlessly inquired about her whereabouts.

6. While a patient that doesn't survive may be just another lifeless body to the Defendants, Jessie was a family member, a daughter, and a sister and her family deserved the dignity and respect the Defendants so grossly failed to provide. Even to this day, the Defendants have not apologized to Jessie's

[4] "In 2012, we changed our name to Dignity Health to better describe what we stand for. Dignity is something that everyone is born with. To us, "dignity" means showing respect for all people by providing excellent care and helping them lead healthy, meaningful lives." (https://www.dignityhealth.org/about-us/press-center/about-dh)

family members, nor will Jessie's family ever know what really caused Jessie's death.

7. Dignity Health's callous disregard of their statutory and moral obligations with respect to Jessie Peterson was not an accident or an act of negligence, it was a pattern and practice and was known at the highest levels of Dignity Health's leadership. Dignity Health's gross misconduct and statutory violations were known to management as early as 2022 when it was documented by the California Department of Health in an Audit Report. (Exhibit 1.)

8. The Department of Public Health's demand for a Plan of Correction was sent to Michael Korpiel on April 8, 2022. (*Id.*) In the letter Mr. Korpiel and Dignity Health were directed that "The deficient practices should be corrected immediately. The date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance." (*Id.*)

9. Dignity Health disingenuously promised to implement a "Plan of Correction". (*Id.*) The Department of Public Health's 2024 audit report documents that as stated by Dignity Health's Quality Director, the promised Plan of Correction were **never implemented**. (Exhibit 3 at pp. 12-13.) Had Dignity Health and its staff implemented the promised corrective measures Jessie Peterson may not have died, we will never know for certain because an autopsy couldn't be conducted once her death certificate was issued eleven months late. Had Dignity Health and its management implemented corrective measures it promised in 2022, Jessie Peterson's family could have been timely informed of her death and the family could have laid her to rest rather than spending months looking for Jessie while she was in a body bag on a shelf at Cremations Only for eleven months, in a locker with other Dignity Health patients that lacked a death certificate or proper notification of next of kin.

10. In the 2024 CMS Audit the president of Mercy San Juan Medical Center, Michael Korpiel, is quoted as saying that that compliance with the statutory and procedural care for a deceased patient, including Jessie Peterson, is his "legal and moral obligation." (Exhibit 3 at p. 6.) He and his staff knowingly and intentionally failed Jessie Peterson and her family. As discussed below, Mr. Korpiel and his management team failed tens of other deceased patients and their families from 2021 through 2024. It was only in response to this and related lawsuits, along with the involvement of the District Attorney that

Dignity Health reluctantly started a process to allow more than sixty deceased Dignity Health patients to finally be laid to rest.[5] The facts detailed in this complaint document the Defendants' wrongful intentional conduct. The history, documented by the California Department of Public Health, was known to management of Dignity Health. (See: Exhibit 3.) Dignity Health hid the continuation of its misconduct by promising to implement a "Plan of Correction" in 2022 and 2023 which, in truth, were never implemented, as a matter of choice and financial saving by under staffing. The knowing, intentional, and repeated misconduct by the Defendants shocks the conscious and is deserving of substantial punitive damages.

PARTIES, JURISDICTION, AND VENUE

11. Plaintiffs are all natural persons residing in the Counties of Sacramento and Placer, California. Ginger Congi is Jessie's mother, Angie Rubino and Chandra Peterson-Chastain are Jessie's sisters. Jessie resided in Sacramento and her body was stored in Sacramento for a year after her death.

12. Defendant Dignity Health, doing business as San Juan Medical Center (hereinafter "Mercy San Juan"), is a not-for-profit public-benefit corporation incorporated in 1986 in California with its principal place of business in San Francisco, California. Dignity Health is "one of the largest health systems in the nation, with more than 400 care centers, including 41 hospitals, urgent and occupational care, imaging and surgery centers, home health, and primary care clinics in 22 states." In Northern California alone, Dignity Health operates six hospitals — Mercy General Hospital, Mercy Hospital of Folsom, Mercy San Juan Medical Center, Methodist Hospital of Sacramento, Sierra Nevada Memorial Hospital and Woodland Memorial Hospital. Dignity Health is a defendant in a related case alleging yet another "dignity" failure of the same defendants. (See: *Walker v. CommonSprirt Health/Dignity Health*, Case No. 25CV009026, filed April 15, 2025, relating to the death of Tonya Walker on November 2, 2023, and the delay in issuing a death certificate or notifying Ms. Walker's family of her death.)

13. Dignity Health is a division of Defendant CommonSpirit ("CommonSpirit").

[5] "On 10/4/2024, the off-site morgue had 61 patients remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from death in 2023, and 19 patient remains from death in the first half of 2024." (10/04/2024 Audit Report, Exhibit 3, p. 2.)

CommonSpirit, based in Chicago, Illinois, operates 142 hospitals and more than 700 care sites in 21 states. CommonSpirit is a multi-billion-dollar system that includes Dignity Health and Mercy San Juan Hospital in Sacramento, California. In September 2024, CommonSpirit publicized that it generated Thirty Seven Billion Dollars ($37,000,000,000) in revenues for the 2024 fiscal year, which ended on June 30, 2024.[6] ProPublica reports that Dignity Health generated over Nine Billion Nine Hundred Million Dollars ($9,900,000,000) for the 2023 fiscal year.[7] CommonSpirit/Dignity Health pay their executives millions of dollars in yearly compensation, e.g. CommonSpirit's CEO is paid approximately thirty-five million dollars ($35,000,000) per year, Dignity Health's CEO is paid $28,000,000 per year, Dignity Health's Chief Operating Officer is paid $6,400,000 per year, and Dignity Health's Senior Chief Strategy Officer is paid $4,100,000 per year.[8] Common Sprit is vicariously liable for the negligence, gross negligence, and outrageous misconduct of Dignity Health, doing business as Mercy San Juan hospital.

14. Defendant Mortuary Support Services of Northern California, LLC, doing business as Sacramento Mortuary Transport ("SMT"), and All Seasons, and Cremations Only (collectively "Cremations Only") is a California limited liability company with an address of 35 Quinta Court Ste. C, Sacramento, CA 95823. Cremations only stored Jessie Peterson for more than a year on a shelf in their cold storage warehouse, along with other former "patients" of Dignity Health, including numerous "patients" of Dignity Health. Mortuary Support Services is alleged herein as the true name of DOE 1. SMT aided and abetted Dignity Health's misconduct.

15. Defendant Dr. Nadeem Mukhtar ("Dr. Mukhtar") is a natural person providing medical care to patients of Mercy San Juan, including Jessie Peterson. Dr. Mukhtar is alleged herein as the true name of DOE 2.

16. Plaintiffs are unaware of the true names and capacities of the Defendants sued herein as

[6]https://www.commonspirit.org/news-articles/commonspirit-health-releases-fy2024-year-end-results#:~:text=CommonSpirit%20Health%20reported%20revenues%20of,8.2%25%20over%20the%20prior%20year.
[7] https://projects.propublica.org/nonprofits/organizations/941196203.
[8] Ibid.

Does 3 through 50, inclusive, and therefore, pursuant to Code of Civil Procedure § 474, sue these Defendants by such fictitious names. Defendants Does 3 through 50, which may include employees or agents of Defendants who are responsible in some manner for the activities and conduct alleged herein and each was acting as an agent for the others. Plaintiffs will amend this Complaint to add the true names of Does 3 through 50 when their identities and capacities are ascertained and/or they are provided with an opportunity to resolve their liability prior to being named as a Defendant in this matter. Whenever reference is made to Defendants, such reference shall include all Defendants, including Does 3 through 50.

17. On information and belief, each Defendant transacts substantial and significant business and/or has agents within Sacramento County. The unlawful acts alleged herein took place in Carmichael within the County of Sacramento. The unlawful acts alleged herein have a direct effect on Plaintiffs' family who resides in the Counties of Sacramento and Placer.

18. Venue is proper in this Court pursuant to California Civil Procedure Sections 395 and 395.5 since the principal place of business of Dignity Health is in the County of San Francisco, California, and it operates multiple facilities in the County of Sacramento, California, including Defendants' joint and several misconduct which occurred at 6501 Coyle Avenue, in Carmichael, California, County of Sacramento.

19. At all relevant times, each of the Defendants acted as a principal, agent, representative or employee of each of the other Defendants, and acted within the course and scope of said agency, representation or employment, and with the permission and ratification of each of the other Defendants.

APPLICABLE CALIFORNIA LAWS

20. In 1939, the California legislature enacted the California Health and Safety Code ("Health & Safety Code") to consolidate and revise the law relating to the preservation of the public health and safety, including not only the health and safety of persons, but also the custody and disposition of dead bodies (hereafter "human remains").

California Death Certificate Laws

21. Division 102 of the Health & Safety Code establishes the laws regarding the preparation and issuance of vital records, including death certificates. Specifically, Chapter 6 of Division 102 of the Health & Safety Code establishes the law for the preparation and issuance of death certificates, which the law requires to be completed within eight calendar days of an individual's death. (Cal. Health & Safety Code § 102775.)

22. Chapter 6 establishes what a hospital is required to do to assist in the completion of the death certification when a person dies in a hospital, which includes completing "the medical and health section data and the time of death," which must also be "attested to by the physician and surgeon last in attendance." (Health & Safety Code § 102795.) Notably, "the medical and health section data and the physician's or coroner's certification must be completed by the attending physician within 15 hours after the death." (Health & Safety Code § 102800.)

23. Additionally, once the hospital completes the required information in the death certificate, the hospital is required to provide it to the "funeral director, or a person acting in lieu thereof," who is then required to "prepare the certificate and register it with the local registrar." (Cal. Health & Safety Code §§ 102800, 102780.) The term "funeral director" is broadly defined under California law to include anyone "preparing for transportation, burial or disposal" of human remains. (Cal. Business & Professions Code § 7615.) To facilitate registering a death certificate, the funeral director is also required to complete other affirmative steps, including "obtain[ing] the required information other than medical and health section data from the person or source best qualified to supply the information." (Cal. Health & Safety Code § 102790.) Once the death certificate is registered with the local registrar, the police department or sheriff's department can then assist with finding and notifying the family of the deceased, to any extent the hospital has not already done so pursuant to the hospital's separate notice requirement as described in Paragraph 21 below.

Law Requiring Notification To Families Of Decedents

24. Division 7 of the Health & Safety Code, Sections 7000-8030, establishes the law regarding the notification requirements for those holding human remains prior to final disposition. As a threshold matter, the person or entity holding the remains is required to use reasonable diligence to notify the family of the decedent about the death. (Cal. Health & Safety Code § 7104.) This allows the family of the decedent to control the disposition of the remains, which is their legal right. (Cal. Health & Safety Code § 7100.)

25. Additionally, pursuant to the American Medical Association's (AMA) Principles of Ethics, "informing a patient's family that the patient has died is a duty that is fundamental to the patient-physician relationship … ordinarily, the treating physician should take responsibility for informing the family. However, it may be appropriate to delegate the task of informing the family to another physician if the other physician has a previous close relationship with the patient or family and the appropriate skill." (Exhibit 6.) Moreover, the physician has the duty to "disclose the death in a timely manner." (*Id*.)

Law Related To The Storage Human Remains Prior To Final Disposition

26. To legally hold human remains for more than eight calendar days, an entity holding the remains must obtain a permit for disposition from the local registrar in the district where the death occurred. (Cal. Health & Safety Code § 103070.)

Law Related To Controlling The Disposition Of Human Remains

27. The parents and siblings of the deceased have a right to control the manner in which human remains are disposed. (Cal. Health & Safety Code § 7100.)

DIGNITY HEALTH KNOWINGLY VIOLATED ITS LEGAL AND MORAL DUTIES TO (1) NOTIFY FAMILIES OF DEATHS AND (2) COMPLETE DEATH CERTIFICATES

Dignity Health's Disregard Of Statutory And Moral Obligations With Respect To Jessie Peterson Was Willful, Wanton, And Reckless

28. On December 1, 2022, Ginger Congi (hereinafter "Ginger") received a phone message from Teresa, a social worker at Dignity Health. Teresa left a callback number. On the same day, Ginger

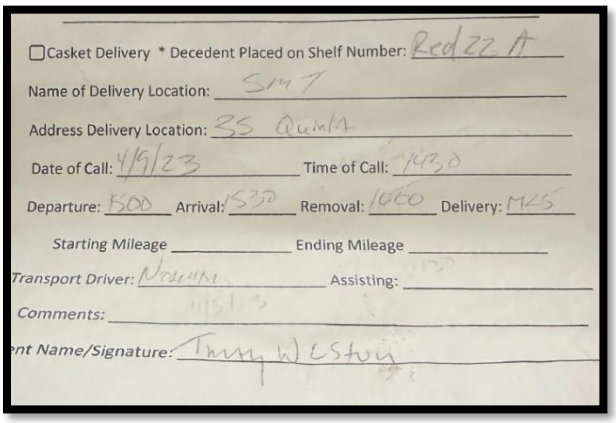
also received a phone message from Gail, a case manager at Dignity Health. Gail also left a callback number for Ginger. These phone calls concerned the hospitalization of Ginger's daughter, Jessie.

29. On January 10, 2023, Jessie had a diabetic episode and was picked up by an ambulance. She was admitted to Dignity Health. Jessie needed surgery due to an infection in her right foot. Jessie eventually underwent surgery on January 14, 2023, and she was under the care of medical staff at the hospital.

30. Jessie had suffered with Type 1 Diabetes since she was 10 years old. She had been in and out of Dignity Health many, many times, they knew her well.

31. Jessie was readmitted to Dignity Health on April 6, 2023 and placed in the Intensive Care Unit (ICU) due to the risk of death in her precarious condition. However, she was released from the ICU on the morning of April 8, 2023, at substantial cost savings to the hospital.

32. On April 8, 2023 at 2:50 p.m., Jessie called her mother asking to be picked up because she wanted to leave the hospital. Ginger responded that Jessie needed more time to heal. This turned out to be the last time that Ginger spoke with her daughter. Approximately two hours later, at 4:27 p.m., Jessie was pronounced dead by the staff of Dignity Health.


Casket Delivery * Decedent Placed on Shelf Number: Red 22 A
Name of Delivery Location: SMT
Address Delivery Location: 35 Quinn
Date of Call: 4/9/23 Time of Call: 1430
Departure: 1500 Arrival: 1530 Removal: 1660 Delivery: 1625
Starting Mileage _____ Ending Mileage _____
Transport Driver: Marcus Assisting: _____
Comments: _____
nt Name/Signature: Tracy Weston

33. The very next day Dignity Health transferred Jessie to an off-site cold storage facility. Jessie was placed on Shelf Number Red 22 A and not a second thought was given to her or her family.

34. Jessie's family was not notified of Jessie's passing, despite extensive previous contact between the hospital and Jessie's family, as well as the fact that Ginger was listed as Jessie's next of kin. Unlike prior unsuccessful calls, after Jessie died the hospital did not leave Ginger a voicemail requesting a callback. In fact, Ginger's phone records reveal zero incoming calls from Dignity Health after Jessie's passing on April 8, 2023. This is especially shocking because the hospital was aware of Ginger's phone number and had communicated with her on

numerous occasions and even admitted that "Ms. Peterson's emergency contact and which had been used successfully to speak with Ms. Congi just eight days earlier." (Exhibit 5 at pp. 10, 14.) It is outrageous that despite having contact information for at least three emergency contacts, the hospital also failed to notify or even leave a message for any of them. (*Id*. at p. 4; Exhibit 7 at pp. 3-4.)

35. Dignity Health was also required to report Jessie's death in the Electronic Death Registration System ("EDRS"). Dignity Health failed to do so.

36. Dignity Health was also obligated to notify Jessie's next of kin. Dignity Health failed to do so.

37. On April 11, 2023, unaware that Jessie had died, Jessie's mother, Ginger Congi, called Dignity Health on April 11, 2023, requesting to be transferred to Jessie's room. Hospital staff responded by saying that "there is no one here by that name." After inquiring further, Ginger was then informed that her daughter left the hospital against medical advice. This was not true. Jessie had died three days earlier while in the care of Dignity Health and her body had been quickly transferred to cold storage.

38. After not hearing from Jessie, Jessie's family began a relentless search campaign over the next several months. Ginger contacted Taylor Haggerty and Robert Baldwin, both places of which Jessie resided, and Angie filed a missing person report on behalf of the family with the Sacramento County Sheriff's Office (Report #23-234756). (Exhibit 8.)

39. Jessie's sister, Angie, then arranged for Jessie's information to be posted on the Department of Justice's website for missing persons. Jessie's information was posted on August 28, 2023.

40. Angie Rubino also posted flyers of Jessie. She talked to houseless individuals in the area to ascertain whether Jessie was recently spotted.

41. On October 12, 2023, Ginger contacted the County of Sacramento Coroners' office. Despite leaving several messages and speaking to a person regarding the possibility of the Coroner's office having Jessie's body, Ginger could not locate Jessie. Albeit, Ginger was relieved that Jessie was not with the County Coroner and was not registered with the Coroner. Jessie's family members drove around the area and handed out photos to Citrus Heights Police, Fire department, and security personnel, still looking

for Jessie. Because the Defendants never submitted the required reports to the Coroner, the Coroner was unaware that Jessie was dead.

42. Finally, on April 3, 2024, nearly a year after Jessie's death, Cremations Only sent an email to Dignity Health advising that there was still no death certificate for Jessie, it stated, "I did a spot check on the hospital holds that are approaching one year from death that we do not have a record of filling on your behalf; patients still in our care." Jessie was not the only person for whom death certificates had not been issued for one year, which again shows the hospital's reckless disregard for completing this duty and heartless behavior towards the prolonged grief and suffering it causes families. (Exhibit 9 at CRE000005.)

43. A Death Certificate was not issued for Jessie by Defendants, until **April 5, 2024**, three hundred and sixty-three (363) days after Jessie's passing. (Exhibit 4.) The death was not formally reported to the Coroner until April 5, 2024, (No. 24-016669). The Defendants' gross negligence is evident on the face of the Death Certificate, attached hereto as Exhibit 4. The date of issuance is a year after Jessie's death. The designation of "24" at the beginning of the Coroner's registration number in box 108 confirms that the registration with the Coroner did not occur until 2024. The Defendants' failure to comply with their statutory, ethical, moral and common law obligations is inexcusable.

44. The search for Jessie continued for months, until one day a detective with the Sacramento County Sheriff's Office called on April 12, 2024, and informed the family that Jessie was found, but she had died a year earlier. Following the call, Angie drove to the Sacramento County Coroner's office, where a staff member informed Angie that Jessie was not housed in their office. He then directed Angie to call Dignity Health to ascertain Jessie's whereabouts. Angie left a message to Dignity Health's mortuary department inquiring about her sister.

45. On April 15, 2024, Ginger called the hospital's Decedent Affairs and spoke with an individual who answered immediately. When Ginger inquired about the circumstances surrounding her daughter's death, the responding woman asked for Ginger's number stating that she will call her from a quieter place. Ginger never received that call. Ginger then contacted Dignity Health's Security regarding any belongings the hospital may have that belonged to Jessie. Security stated that there were none still

available. Finally, that same day at 11:50 a.m., East Lawn Mortuary contacted Ginger Congi to inform her that they had located Jessie in one of Dignity Health's off-site storage warehouses.

46. On April 18, 2024, the family spoke with Dr. Mukhtar by phone. Dr. Mukhtar stated that he did not remember Jessie's death specifically because it had been too long ago. He stated that there was a lot going on with Jessie, but it did not seem anything was life threatening. He refused to explain why it took him and Dignity Health so long to notify them of the death of Jessie. His refusal to answer the family's question is documented in his own entry in Jessie's medical records, dated April 18, 2024.

47. Because Dignity Health failed to notify Jessie's family of her death, the family members were unable to see Jessie's body to say goodbye. Jessie's family will forever live with their last image of Jessie, coming from Jessie's medical records, and as being awake, severely confused, and "curled in a ball on the stretcher". (Exhibit 5 at 5:12-13.)

48. Even after hiding Jessie's death for over a year, Dignity Health's extreme and outrageous conduct continues. Dignity Health takes no accountability for failing its duties to complete death certificates and notify families of deaths, but instead blames Jessie's family for Dignity Health's misconduct. According to Dignity Health, Dignity Health failed to perform these moral and legal duties owed to Jessie and her family, because, according to Dignity Health, Ginger didn't answer her phone. (Exhibit 5 at p. 18.) And if that weren't enough, throwing salt on a wound, the hospital alleges all this was again Ginger's fault because her relationship with Jessie was fractured due to Jessie's drug use. (*Id.*) And while staff of Dignity Health believed it wasn't a HIPPA violation to leave voice messages in December 2022 requesting Ginger to call back, now after Jessie had died, the Hospital claims that it did not leave a message with Ginger requesting a call back because doing so would have been a violation of Jessie's HIPPA rights. (Exhibit 7 at p. 3-4.) However, Dignity Health's Laura Lukin has testified under oath in reference to other deceased patients that a phone message was left for family members. (See e.g. Exhibit 10 at p. 3.)[9]

[9] Exhibit 10 contains excerpts of records filed with the Probate Court by Dignity Health. The documents filed by Dignity Health were not redacted.

49. And if blaming the family of the deceased weren't enough, the hospital further claims that now years after the COVID-19 pandemic, the hospital is still unable to perform its duties at the time of Jessie's death in April 2023 because of COVID. (Exhibit 5 at p. 19.)

50. On information and belief, notwithstanding CommonSpirit and Dignity Health's billions of dollars of revenue and having enough money to pay executives compensation in the tens of millions annually, they have engaged in a long-standing pattern and practice of skimping on patient-centered outcomes. Dignity Health has failed to institute procedures to ensure families are given timely notice of patient deaths and failed to ensure death certificates are completed within the statutorily required timeframe. While Dignity Health can pay tens of millions to executives, it claims "staffing challenges within the defendant's organization" contributes to the backlog in timely caring for the deceased. (Exhibit 5 at pp. 14, 19-20.)

51. Finally, for Jessie's family, the discovery of the government's 2022-2024 audits has only compounded their extreme grief. In addition to the audit finding that the hospital was failing its duty to notify families of deaths, there was another audit finding relevant to Jessie's death. An audit finding from June 2023, in order to reduce adverse health results, required a plan of correction be implemented related to the removal of central lines, which is a line inserted into a vein and guided to an area near the heart. (Exhibit 3 at pp. 8-9, 11.) Jessie's medical records revealed that Jessie's death in April 2023 was immediately preceded by a nurse's removal of a central line. (Exhibit 5 at 8:9-12.)

52. On information and belief, because the hospital negligently, caused Jessie's body to be left in cold storage for one year prior to notifying Jessie's family of her death, there could be no autopsy performed to determine whether the removal of the central line from near Jessie's heart had any role in triggering the heart attack that preceded Jessie's death.

Since At Least 2022, Government Audits Have Demanded That Dignity Health To Correct Failures to Provide Timely Notice of Death And Complete Death Certificates

53. On information and belief, as documented by the California Department of Public Health, and Probate Court Records, Dignity Health's denial of respect and dignity to Jessie and her family is not an isolated incident.

54. Dignity Health's callous, reckless, and outrageous failure of its duty to complete death certificates and notify families of deaths has been going on for years. At least as early as April 2022, one year before Jessie's death, an audit by the California Department of Health found Dignity Health had breached its duty to give timely notification of death. (Exhibit 1.)

55. The 2022 Audit found that "the facility failed to ensure a physician implemented a policy and procedure for notifying a next-of-kin of a patient's (Patient 1) death. The failure resulted in Patient 1's family not being notified of Patient 1's death for 6 weeks." (*Id*. at p. 1.) Patient 1 died on 9/21/16. (*Id*. at p. 4.) The CMO [Chief Medical Officer] confirmed the physician completed the Discharge Summary note on 10/30/16, and stated 'that was well over the 14-day period.'" (*Id*.)

56. In the 2022 Audit, the Chief Medical Officer is cited as saying it is "the responsibility of the attending physician to notify family of a patient's death." (*Id*. at p. 3.) The 2022 Audit, further found that the 2015 Medial Staff Rules and Responsibilities stated "Notifying the Next of Kin … The Attending Physician or his or her representative is responsible for notifying the next of kin in all cases of death." (*Id*.)

57. The plan of correction from 2022 required Dignity Health provide education to members of the medical staff by email about (1) the location of contact information, (2) the requirement to notify family about a death, and (3) the requirement to document notifications to family. (*Id*. at (adobe) p. 8.) The plan of correction claimed these plans were completed and implemented by April 11, 2022. (*Id*.)

58. The plan of correction from 2022 also required Dignity Health to develop an auditing and reporting process to evaluate the accuracy of telephone numbers listed as contacts in the medical record and schedule a semiannual reporting of the results with a goal of 100% accuracy. (*Id*.) The plan of

correction from 2022 also required Dignity Health schedule semiannual reporting of audit results with the goal of 100%. (*Id.*) The plan of correction claimed these plans were completed and implemented by April 11, 2022. (*Id.*)

59. The Audit Report documents that top management of Dignity Health was aware of this dereliction of duty, at the latest, from its receipt of the Department of Health 2022 Audit Report.

60. Dignity Health's Plan of Correction was submitted to the Department of Health on April 5, 2022. The Plan of Correction was approved April 8, 2022, precisely one year before the death of Jessie Peterson.

61. Dignity Health's Plan of Correction was to be completed by no later than April 12, 2022.

62. On information and belief, but for Dignity Health's admitted failure to implement any part of the 2022 Plan of Correction a timely death certificate would have been issued for patients: *Jessie Peterson*, James T., Michael I., Charles H., Herman G., Stephen O., William S.; Dianna E.; Anthony David J., Michael W., Marc N., Brenda S., Eula R., and others. Each of these individuals are identified fully in Probate Court filings wherein Dignity Health had to request a court ordered death certificate because Dignity Health had failed to issue a death certificate within one year of the patient's death. (The patient's last name has been redacted out of respect for the privacy of the patient's family.)

63. Despite Dignity Health's promise to correct it misconduct in April 2022, an additional audit in May 2023, found Dignity Health was still failing in its duty to notify families of patient deaths. The 2023 Audit found, "The Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow their morgue (place where the deceased are kept temporarily) policy when Patient 1 expired and documentation of the location of the body was unknown. This failure resulted in Patient 1's son being unaware of his mother's body whereabouts and caused family emotional distress." (Exhibit 2 at p. 1.)

64. In addition to failing to ensure death certificates are completed and families are notified of patient deaths, Dignity Health also failed in numerous instances to timely complete required documentation of the storage and transportation of Jessie's remains. This paperwork is significant because

it would assist the morgue in having information to contact families of the deceased. The GSD (Greater Sacramento District) Laboratories Morgue Policy And Procedure requires that "If a funeral home comes to pick-up the body during business hours, the Pathology Department releases the body", and "The coroner or the funeral home representative calls the number indicated on the phone by the morgue." The ANS completes the Release of Body Form and the coroner or the funeral home representative will sign the book (Log)." (*Id*. at p. 2.) "Prior to releasing the body to a funeral home, a completed Authorized Release and original Release of Remains form must be presented." (*Id*. at p. 3.) The Morgue Policy further requires Dignity Health "Document in the NOD (Notification of Death) form, the date of transfer, and the name of the storage facility. In the Morgue Log, document: the date, time and signature of the representative from the storage facility." (*Id*.)

65. Corrective action taken in 2023 stated that an education module was distributed to all Pathology Laboratory and Administrative Nursing Supervisor staff that instructed of the requirement to place copies of Notice of Death Forms on the shroud, locker, and be forwarded to the morgue. (*Id*. at p. 17.) Moreover, family contact information is routinely noted on the Notice of Death Forms that would accompany the body from the hospital to the morgue. (See e.g. Exhibit 10 at p. 5.)

66. Two years after the 2022 audit, in 2024, another Department of Health audit, this one was mandated by CMS. (Exhibit 3.) The Department of Health issued a scathing Report. Dignity Health was found to continue its failure to complete death certificates and provide families timely notification of deaths. (Exhibit 3 at pp. 1-3.) This audit specifically noted that the hospital's breaching this duty can "***result in family distress*** over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage" and these failures can "***prolong distress and grief for families***." (*Id*. [emphasis added]) This is precisely what the hospital did with respect to Jessie Peterson. Despite two years passing since the 2022 audit, in 2024 the hospital's heartless and reckless attitude was shown by the lack of any documentation showing the hospital had implemented any of the plans of correction to ensure families are notified of deaths. (*Id*. at pp. 12-13.) Incredibly, the Quality Director openly admitted to the

Department of Health that Dignity Health didn't bother to implement any part of the 2022 promised Plan of Correction. (*Id*.)

67. The 2024 Report including findings that as of October 3, 2024, "11 bodies have been in storage since 2022, 15 bodies have been in storage since 2023, and 19 bodies have remained in storage from 1/1/2024 to 6/30/2024." In total there were "61 patient remains in the off-site morgue." (*Id*. at pp. 2, 7.) These bodies were from Dignity Health's Greater Sacramento Division. (*Id*. at p. 3.) Obviously, Dignity Health continued its "out of sight out of mind" disregard for patients it shipped off to Cremations Only for storage well into 2024. It was not until Dignity Health's dirty little secret became a matter of public news reporting that it began to correct its statutory, ethical, and moral failures.

68. The Audit Report documents that the Sacramento Market Leader of Laboratory Services: Lab, Cardiopulmonary, & Rehabilitation, stated that the "RMO [Regional Morgue Office] was responsible for making three attempts to contact family once patient remains left the local hospital" and that if the family is unable to be contacted, "the case should be forwarded to the County Public Administrator, who would attempt to find family, and if none could be found after a diligent search, contact the coroner to pick up the body." (*Id*. at p. 4.)

69. The critical findings of the 2024 Audit is nearly identical to the findings in the 2022 Audit Report:

> a. Based on interview and document review, the hospital **failed** to ensure an effective governing body legally responsible for the conduct of the hospital for a census of 367 patients out of a hospital bed capacity of 384 when:
>
> b. The hospital **failed** to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures relating to family notification of patient death, timely completion of death certificates, and processing of patient remains . . .
>
> c. These **failures** contributed to ongoing delays in processing death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they

> were deceased and in storage: On 10/4/2024, the off-site morgue had 11 patients remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first have of 2024.

(2024 Audit Report, emphasis added.)

70. The Audit Report documents that Dignity Health's staff were aware of Dignity Health's and its morgue's failures related to timely processing of remains. The "Supervisor of Lab Support Services (SLSS), SLSS stated she was aware the RMO was failing to timely process patient remains and complete death certificate worksheets beginning in April 2023." The SLSS also "reported [the backlog] to the Regional Laboratory Director and Hospital President (HP) in September 2023" but "[i]t went nowhere". (*Id*. at p. 5.)

71. Dignity Health's Quality Director ("QD") in October 3, 2024 stated, "I have not been able to locate data for either POC." The QD stated, "**No one was working on these [POCs], there is no data to provide implementation and tracking.**" The QD further confirmed, "there was no documented evidence the interventions in the POCs, that were dated April 2022 and July 2023 respectively, were monitored for success and sustained compliance per hospital QAPI plan and regulatory requirements." (*Id*. at pp. 12-13.) This is incredible. Dignity Health did nothing to meet its promises to the California Department of Health and Human Services – Nothing. In response to a scathing audit, it did nothing.

72. On information and belief, Dignity Health negligently or intentionally hid information regarding its regulatory failures related to timely processing of human remains from its oversight board. The "Patient Safety Program Annual Summary and Evaluation for Fiscal Year 2023, which details categories of adverse events reported during the year, any regulatory findings, and active and completed plans of correction submitted September 2023 to the Community Board […] did not include documentation of the gaps in patient notification, death certificate processing according to legal requirements, or delay in handling patient remains. (*Id*. at p. 7.) Additionally, the board meeting minutes from January-August 2024 "did not reference any concerns regarding processing patient remains. There was no information regarding untimely completion of death certificates or lack of notification of next of

kin of the death of a patient." (*Id*. at p. 5.) Indeed, the Community Board was not aware of prior hospital regulatory violations for failure to process patient remains. (*Id*. at pp. 4-5.)

73. While the Hospital President is quoted in the 2024 Audit Report that "I'm legally and morally responsible for those in the morgue", he also denied knowing of the problem despite the 2022 audit findings. (*Id*. at p. 6.) Meanwhile, the Supervisor of Lab Support Services is quoted as saying that she reported the issue to the Regional Laboratory Director and the Hospital President, but "It went nowhere" and no log or documents were kept for the Morgue processing until April 2024, the same month that Dignity Health finally issued a death certificate for Jessie Peterson. (2024 Audit Report, Exhibit 3, p. 5.)

74. On information and belief, a series of embarrassing news stories beginning in August 2024 has done what years of audit findings apparently couldn't, Dignity Health finally vowed to make resolving the dereliction of its duty to provide timely notification to families of the deceased and complete timely death certificates a priority for the Chief Operating Officer. (*Id*. at pp. 5-6.)

Dignity Health's Callous Disregard For Jessie Peterson And Her Family Was Part Of A Pattern And Practice Of Disregard For Certain Patients After Their Death At A Dignity Health

75. Dignity Health has so far refused discovery requests to produce copies of death certificates it issued after the statutory requirement of no later than eight days. However, Plaintiffs are aware of several examples.

76. On information and belief, Dignity Health patient Phillip Cross died at Dignity Health on May 27, 2023. Dignity Health didn't issue a death certificate until January 2, 2024. Mr. Cross was stored on a shelf at Cremations Only for "temporary envaultment" for over eight months.

77. On information and belief, Dignity Health Patient Tonya Walker died at Dignity Health on November 2, 2023. Dignity Health didn't issue a death certificate until April 16, 2024. Ms. Walker was stored on a shelf at Cremations Only for "temporary envaultment" for over five months. (See: Civil Complaint, *Walker v. CommonSpirit/Dignity Health*, Case No. 25CV009026.)

78. Because Dignity Health Hospital was so flagrant in failing to prepare a death certificate, in 2024 the hospital had to seek obtain Court orders to establish the fact of death. For example, on January 9, 2025, Dignity Health/ Dignity Health Hospital filed a request for an Order Establishing Fact of Death for Almeza Demby who had died at the hospital on December 24, 2022. The Court's Order acknowledges that "said death has not been registered in conformity with the provisions of law in effect at the time." (Exhibit 11.)

79. On information and belief, the same is true for Dignity Health Hospital patients listed below, all of which a court ordered death certificate was necessary because Dignity Health "had not registered the death in conformity with the provisions of law in effect at the time":

a. Mr. James T. died at Dignity Health on May 30, 2022. A court ordered death certificate had to be issued on or about July 19, 2024, due to Dignity Health's failure to timely issue a death certificate;

b. Mr. Michael I. died at Dignity Health on June 18, 2022. A court ordered death certificate had to be issued on or about July 10, 2024, due to Dignity Health's failure to timely issue a death certificate;

c. Mr. Charles H. died at Dignity Health on June 2, 2022. A court ordered death certificate had to be issued on or about September 6, 2024 due to Dignity Health's failure to timely issue a death certificate;

d. Mr. Herman G. died at Dignity Health on July 9, 2022. A court ordered death certificate had to be issued on or about July 2, 2024, due to Dignity Health's failure to timely issue a death certificate;

e. Mr. Stephen O. died at Dignity Health on October 21, 2022. A court ordered death certificate had to be issued on or about July 13, 2024, due to Dignity Health's failure to timely issue a death certificate;

f. Mr. William S. died at Dignity Health on December 28, 2022. A court ordered death certificate had to be issued on or about August 27, 2024, due

to Dignity Health's failure to timely issue a death certificate;

g. Ms. Dianna E. died at Dignity Health on March 4, 2023. A court ordered death certificate had to be issued on or about July 19, 2024, due to Dignity Health's failure to timely issue a death certificate;

h. Mr. Anthony J. died at Dignity Health on March 14, 2023. A court ordered death certificate had to be issued on or about October 31, 2024, due to Dignity Health's failure to timely issue a death certificate;

i. Michael W. died at Dignity Health on March 25, 2023. A court ordered death certificate had to be issued on or about October 23, 2024, due to Dignity Health's failure to timely issue a death certificate;

j. Marc N. died at Dignity Health on March 26, 2023. A court ordered death certificate had to be issued on or about September 20, 2024, due to Dignity Health's failure to timely issue a death certificate;

k. Brenda S. died at Dignity Health on March 28, 2023. A court ordered death certificate had to be issued on or about September 30, 2024, due to Dignity Health's failure to timely issue a death certificate; and,

l. Eula R., died at Dignity Health on March 28, 2023. A court ordered death certificate had to be issued on or about October 7, 2024, due to Dignity Health's failure to timely issue a death certificate.

80. With each of the above Probate Court filings Dignity Health submitted a declaration of Laura Lukin, Dignity Health's Regional Laboratory Support Supervisor for Pathology Services and the Supervisor of Decedent Affairs, since 2022. (The patient's last name has been abbreviated out of respect for the patient's family. The complete file was downloaded from the Probate Court's publicly available website.)

81. Ms. Lukin stated, in each and every declaration, under penalty of perjury, stating: "I am responsible for obtaining death certificates for deceased CommonSpirit / Dignity Health patients . . ."

Further, Ms. Lukin declares that the "deceased patients who have been moved to SMT's facility (Cremations Only) are still considered 'patients' of CommonSpirit / Dignity Heath and remain within the system's custody and controls."

82. Ms. Lukin's excuse for failing to timely perform her duty to issue death certificates for, some but not all of Dignity Health's patients, is that there was a backlog and "associated staffing issues." A staffing issue is a euphemism for an unwillingness to spend money to properly staff the hospital. A "staffing issue" does not justify Dignity Health's pattern and practice of leaving deceased patients in cold storage for more than a year, in some cases more than three years. (Exhibit 10 at p. 3.)

83. This inexcusable conduct was a knowing and willful dereliction of duty. Worse yet, Dignity Health promised the Department of Public Health that it would cease its misconduct, but then did nothing to honor that promise. What happened to Jessie Peterson was not the result of negligence – it was the standard practice accepted by Dignity Health, Laura Lukin, Michael Korpiel.

84. On information and belief, the management of Dignity Health, including Ms. Lukin, were well aware of the large number of patients that they were storing at Cremations Only. At least as early as May 2023, Cremations Only sent monthly reports to Dignity Health listing the names of the people in storage and the date they were first placed in storage. Page one of the July 14, 2023 Report by Cremations Only to Dignity Health documents the continued storage of two patients from 2021, twenty-four patients from 2022, and twelve patients stored prior to Jessie Peterson on April 9, 2023. (Exhibit 12 at SNC001018-1020.)

07/14/2023 12:10 PM
Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
1	10/13/2021 16:28:20	Mercy San Juan Medical Center		
2	10/27/2021 15:20:52	Mercy San Juan Medical Center		
3	1/8/2022 19:24:04	Mercy San Juan Medical Center		
4	1/17/2022 16:07:06	Mercy San Juan Medical Center		
5	2/2/2022 13:45:03	Mercy San Juan Medical Center		
6	2/9/2022 3:30:43	Mercy San Juan Medical Center		
7	3/5/2022 15:28:09	Mercy San Juan Medical Center		
8	3/16/2022 13:01:39	Mercy San Juan Medical Center		
9	5/31/2022 14:55:22	Mercy San Juan Medical Center		
10	6/2/2022 19:12:25	Mercy San Juan Medical Center		
11	6/19/2022 14:39:17	Mercy San Juan Medical Center		
12	6/19/2022 14:40:16	Mercy San Juan Medical Center		
13	7/10/2022 1:42:52	Mercy San Juan Medical Center		
14	8/20/2022 20:36:02	Mercy San Juan Medical Center		
15	9/18/2022 1:02:36	Mercy San Juan Medical Center		
16	10/4/2022 12:12:52	Mercy San Juan Medical Center		
17	10/21/2022 18:12:00	Mercy San Juan Medical Center		
18	11/6/2022 23:14:35	Mercy San Juan Medical Center		
19	11/12/2022 11:59:39	Mercy San Juan Medical Center		
20	11/24/2022 11:51:38	Mercy San Juan Medical Center		
21	12/10/2022 9:02:49	Mercy San Juan Medical Center		
22	12/11/2022 17:35:27	Mercy San Juan Medical Center		
23	12/16/2022 11:07:15	Mercy San Juan Medical Center		
24	12/23/2022 15:21:20	Mercy San Juan Medical Center		
25	12/25/2022 6:02:14	Mercy San Juan Medical Center		
26	12/29/2022 19:36:06	Mercy San Juan Medical Center		
27	1/1/2023 18:20:38	Mercy San Juan Medical Center		
28	1/9/2023 0:10:45	Mercy San Juan Medical Center		
29	1/21/2023 15:25:06	Mercy San Juan Medical Center		
30	2/23/2023 13:38:16	Mercy San Juan Medical Center		
31	3/4/2023 20:09:27	Mercy San Juan Medical Center		
32	3/15/2023 11:43:25	Mercy San Juan Medical Center		
33	3/15/2023 12:47:28	Mercy San Juan Medical Center		
34	3/26/2023 13:16:16	Mercy San Juan Medical Center		
35	3/28/2023 12:50:12	Mercy San Juan Medical Center		
36	3/28/2023 12:53:17	Mercy San Juan Medical Center		
37	3/29/2023 12:21:29	Mercy San Juan Medical Center		
38	3/29/2023 15:43:47	Mercy San Juan Medical Center		
39	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
40	4/19/2023 12:13:09	Mercy San Juan Medical Center		

85. The monthly report to Dignity Health for January 24, 2025, shows the continued storage of nine patients from 2022, nine patients from 2023, and forty patients from 2024. (*Id*. at SNC001140-1141); a sampling of the reports sent to Dignity Health by Cremations Only are attached as Exhibit 12.)

86. The Monthly Reports showed that the extended storage of bodies by Dignity Health at Cremations Only included bodies from Dignity's Methodist Hospital of Sacrament (*Id*. at SNC000053), Mercy General Hospital (*Id*. at SNC000054) and Mercy Hospital of Folsom (*Id*. at SNC000055.) Dignity's mishandling of deceased patients was not limited to Mercy San Juan Medical Center, it was companywide under the supervision of the Greater Sacramento Division of Common Spirit and the coordination of Laura Lukin.

87. In addition to the monthly reports, Cremations Only would alert Laura Lukin at Dignity Health when the delay in issuing a death certificate was approaching the one-year anniversary of death. (See e.g. Exhibit 9 at CRE000005-7, a portion of which is also shown below.)

One Year Since DOD Approaching
4 messages

Jennifer Richards <jennifer@cremationsandburial.com> Wed, Apr 3, 2024 at 11:36 AM
To: Laura Lurkin <laura.lukin@commonspirit.org>
Cc: James Lofton <james@cremationsandburial.com>

Good morning Laura

I did a spot check on the hospital holds that are approaching one year from death that we do not have a record of filing on your behalf; patients still in our care.

I thought it would be helpful for you and your team - please let me know if you have any questions.

Methodist:
[redacted] DOD [redacted]

Mercy General
[redacted] DOD [redacted]

Mercy San Juan
Jessie Peterson DOD 4/8/2023
[redacted] DOD
[redacted] DOD

Thank you,
--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services
dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823

88. Ms. Lukin asked Cremations Only to prepare a death certificate for Jessie Peterson. (*Id*. at CRE000005.) Despite Dignity Health's vast familiarity with Jessie Peterson, the draft death certificate (especially as it relates to information on Jessie's family) is mostly blank because none of the pertinent information was shared with Cremations Only. (*Id*. at CRE000007-11.) On information and belief, Ms. Lukins wanted to avoid having to obtain a death certificate from the Court because it would cost legal fees and could expose the hospital's, and her personal, dereliction of duty.

89. On information and belief, Ms. Lukin also had Cremations Only prepare a fraudulent Application and Permit for Disposition of Human Remains. (*Id*. at CRE000011.) Before a deceased person can be transported from one location to another a Permit must be obtained so that there is a record of the location of the person. In this case, the transfer was from Dignity Health to Cremations Only, for "temporary envaultment." However, that transfer took place the day after Jessie Peterson died, April 9, 2023, the Application, signed by the owner of Cremations Only, falsely states that the transfer took place on April 5, 2024. (Exhibit 12 at SNC001156.)

90. On information and belief, those who come in contact with the bereaved should show the greatest solicitude because they have assumed a position of special trust towards the family. Dignity Health callously over a period of years denied the family of Jessie Peterson and the families of many other people listed above, consolation, consideration, dignity and peace of mind they deserved.

91. On information and belief, Dignity Health's misconduct, disregard for the care of its patients, disregard for the harm it was causing to patients' families, and false promises to the Department of Health are worthy of substantial punitive damages and injunctive relief. It is time that "Dignity" Health lives up to its self-described level of integrity and care: "*In 2012, we changed our name to Dignity Health to better describe what we stand for. Dignity is something that everyone is born with. To us, "dignity" means showing respect for all people by providing excellent care and helping them lead healthy, meaningful lives*. (www.dignityhealth.org/about-us/press-center/about-dh)

Dignity Health's Violations Related To The Electronic Death Registration System

92. On information and belief, Dignity Health has also violated its statutory obligations with respect to the Electronic Death Registration System for patients that have died in its care. Dignity Health has repeatedly violated statutory reporting obligations that are separate and distinct from the rendering of medical diagnosis and treatment, i.e., violation of California Health and Safety Code section 102775. Dignity Health failed to maintain an accurate Internet-based electronic death registration system (EDRS) for the creation, storage, and transfer of death registration information. The flagrant failure to maintain the hospital's EDRS system is evidence by the facts set forth in this case as well as Dignity Health's failure to report deaths in a timely manner, including the following examples:

a. Mr. Michael Gray died while in the care of Dignity Health Hospital/Dignity Health on July 10, 2021, but the Death Certificate was not issued until August 13, 2021, (See: Case No. 34-2022-00315771, Exhibit 13 at ¶ 17);

b. Mr. Phillip Coss died while in the care of Mercy Hospital of Folsom/Dignity Health on May 27, 2023, but the Death Certificate was not issued until December 29, 2023 (See: Death Certificate, Exhibit 14);

c. Ms. Tanya Walker died while in the care of Mercy General Hospital/Dignity Health on November 2, 2023, but the Death Certificate was not issued until April 15, 2024 (See: Death Certificate, Exhibit 15); and

d. Research is ongoing with respect to the scope and time frame that this misconduct has occurred. Dignity Health has so far refused to produce copies of death certificates that were filed after the required statutorily mandated time deadline. (Exhibit 5 at pp. 16-17).

93. On information and belief, with respect to the death of Michael Gray, Dignity Health was named as a defendant in a lawsuit filed on March 23, 2022, in Sacramento County Superior Court, Case No. 34-2022-00315771, relating to the failure to report the death of Michael Gray or inform Mr. Gray's family. At the time of Jessie Peterson's death a year later, Dignity Health was clearly on notice that it was

failing to accurately and timely perform statutory obligations, failing to maintain an accurate EDRS, failing to timely inform next of kin of the death of their family member, and failing to supervise doctors in a manner that would accomplish the timely filing of a Death Certificate. Yet the pattern of gross negligence and repeated malfeasance continued, ultimately resulting in the failure to report the death of Jessie Peterson.

94. On information and belief, with respect to the death of Tonya Walker, Dignity Health is named as a defendant in a lawsuit filed on April 15, 2025, in Sacramento County Superior Court, Case No. 25CV009026, relating to the failure to timely issue a death certificate for Ms. Walker or inform Ms. Walker's family.

95. On information and belief, Dignity Health has repeatedly caused harm to families of patients that die while under their care, denying families the ability to obtain an autopsy, preventing the families from adherence to their religious obligations in laying a family member to rest, denying the families the option to see their family member to say goodbye or allow for an open-casket funeral and exacerbating the families' pain and suffering, including the recurring pain of thinking about their loved one being held in storage for months. Dignity Health's repeated violations of their statutory, legal, and ethical obligations is so outrageous, egregious, repetitive, and malicious to shock the conscious.

DR. MUKHTAR'S FAILURES TO COMPLETE JESSIE'S DEATH CERTIFICATE AND NOTIFY JESSIE'S FAMILY OF HER DEATH

96. California Health & Safety Code sections 102795 and 102800 require the attending physician to complete the medical and health section and physician certification of a death record within fifteen (15) hours after the person's death.

97. In violation of Health & Safety Code sections 102795 and 102800, Dr. Mukhtar completed the medical and health and physician certification sections of Jessie's death record on April 4, 2024. (Exhibit 4 at Boxes 107-118.)

98. California Health & Safety Code section 102775 requires death certificates be completed within eight (8) days of a person's death. Health & Safety Code sections 102780 and 102800 require the

death certificate be provided to the local registrar. Health and Safety Code section 103785 makes it a misdemeanor for failing to complete and register a death certificate.

99. In violation of Health & Safety Code sections 102775, 102780, and 102800, Jessie's death certificate was not completed and provided to the local registrar until April 5, 2024, three hundred and sixty-three days (363) after Jessie's passing while under Dr. Mukhtar's care. (Exhibit 4 at Box 47.) The Defendants' gross negligence is evident on the face of the Death Certificate, which shows that Jessie's death was not reported to the Coroner until April 5, 2024 (No. 24-01669). (*Id.* at Box 108.) The Defendants' failure to comply with their statutory, ethical, moral and common law obligations is inexcusable.

100. California Health & Safety Code section 7104 requires reasonable diligence be exercised in notifying family of a person's death. This enables the family to control the disposition of the remains, a right established in Health & Safety Code section 7100.

101. On information and belief, the AMA's Principles of Ethics, "informing a patient's family that the patient has died is a duty that is fundamental to the patient-physician relationship … ordinarily, the treating physician should take responsibility for informing the family." (Exhibit 6.) Moreover, the physician has the duty to "disclose the death in a timely manner." (*Id*.)

102. In the 2022 Audit of Dignity Health, the Chief Medical Officer is cited as saying it is "the responsibility of the attending physician to notify family of a patient's death." The 2022 Audit, further found that the 2015 Medical Staff Rules and Responsibilities stated "Notifying the Next of Kin … The Attending Physician or his or her representative is responsible for notifying the next of kin in all cases of death." (Exhibit 1 at p 1.)

103. In violation of Health & Safety Code section 7104, AMA Ethics, and Dignity Health's medical staff rules, although Jessie died on April 8, 2023, Dr. Mukhtar did not notify Jessie's family of her death until more than one year later on April 18, 2024. When Dr. Mukhtar finally called the number the hospital had all along for Jessie's sister Angela Rubino, Dr. Mukhtar stated that he did not remember Jessie's death specifically because it had been too long ago. He stated that there was a lot going on with

Jessie, but it did not seem that anything was life threatening. He refused to explain why it took him and the hospital Defendants so long to notify them of Jessie's death.

104. On information and belief, Dr. Mukhtar also failed to sign off on death certificates for two other patients that died under his care during the same time frame of the death of Jessie Peterson, one death occurring on March 14, 2023 and another on March 28, 2023 at Dignity Health. Dignity Health waited so long to prepare a death certificate that it had to ask the Probate Court, more than a year later to issue it for these two patients of Dr. Mukhtar. (Exhibit 16 (Patient Brenda S., Probate Case No. 24PR002912); Exhibit 17 (Patient Anthony J., Probate Case No. 24PR003135).)[10]

CREMATIONS ONLY'S FAILURES TO COMPLETE JESSIE'S DEATH CERTIFICATE AND NOTIFY JESSIE'S FAMILY OF HER DEATH

105. On information and belief, Cremations Only has contracted with Dignity Health to transport and store the bodies of individuals who die while in the care of Dignity Health. Under the contract, Cremations Only is paid $100-$185 to transport a body and $15/day for the first 60 days to store a body. The contract does not contain any costs to Dignity Health to store bodies at Cremations Only beyond 60 days. (Exhibit 18 at p. 6.)

106. California Health & Safety Code section 102775 requires death certificates be completed within eight (8) days of a person's death. Health & Safety Code sections 102780 and 102800 require the death certificate be provided to the local registrar. California Health & Safety Code section 102790 requires Cremations Only and its funeral director to complete other affirmative steps in preparing the death certificate including "obtain[ing] the required information other than medical and health section data from the person or source best qualified to supply the information." (Cal. Health & Safety Code § 102790.) Health and Safety Code section 103785 makes it a misdemeanor for failing to complete and register a death certificate.

[10] Exhibits 16 and 17 contain excerpts of records filed with the Probate Court by Dignity Health. The documents filed by Dignity Health were not redacted.

107. In violation of Health & Safety Code sections 102775, 102780, 102790, and 102800, Jessie's death certificate was not completed and provided to the local registrar until April 5, 2024, three hundred and sixty-three days (363) after Jessie's death. (Exhibit 4 at Box 47.) The Defendants' gross negligence is evident on the face of the Death Certificate, which shows that Jessie's death was not reported to the Coroner until April 5, 2024 (No. 24-01669). (Exhibit 4 at Box 108.) The Defendants' failure to comply with their statutory, ethical, moral and common law obligations is inexcusable. Had Cremations Only registered Jessie's death record within eight days, Jessie's family would not have searched for her for nearly a full year.

108. Health & Safety Code section 102775 establishes that a person's body cannot be held more than eight (8) calendar days after death without a permit being issued by the local registrar. (Health & Safety Code § 103070.)

109. In violation of Health & Safety Code section 102775, Dignity Health and Cremations Only failed to obtain this permit. As a result, Jessie's body was lost in physical purgatory, she was no longer a patient of Dignity Health, and without the registration of a death certificate she was not found on state vital records.

110. California Health & Safety Code section 7104 requires the person or entity holding human remains use exercise reasonable diligence in notifying family of a person's death. This enables the family to control the disposition of the remains, a right established in Health & Safety Code section 7100. Jessie's remains were required to remain in cold storage at Cremations Only because pursuant to Health and Safety Code 103050, human remains cannot be disposed of until after a death certificate is registered.

111. In violation of California Health & Safety Code section 7104, Cremations Only never notified Jessie's family of her death. Finding the contact information for Jessies family and providing this notification should have been easy as the information should have been located on Dignity Health's "Notification of Death" form which should have accompanied Jessie's body wherever her body was located. (Exhibit 2 (at adobe page 9) [Notification of Death form to be placed on the shroud, locker, and provided to the morgue]; Exhibit 19 at p. 2.) Family contact information is routinely noted on the Notice

of Death Forms that would accompany the body from the hospital to the morgue. (See e.g. Exhibit 10 at p. 5.)

112. On information and belief, after one year, Cremations Only cannot dispose of human remains in its possession without a court order. On April 3, 2024 Cremations Only employee Jennifer Richards emailed Laura Lukin, Dignity Health's supervisor of decedent affairs, and advised that Jessie's one year was approaching. (Exhibit 9 at CRE000005.) This required Dignity Health complete Jessie's death record because pursuant to Health and Safety Code 103050, human remains cannot be disposed of until after a death certificate is registered. That is when Dignity Health finally provided the information for Cremations only to complete Jessie's death record. (*Id*.)

113. Laura Lukin asked Cremations Only to complete Jessie's death record "ASAP" because "it will be 1 year in 5 days****". (*Id*.) With the limited information provided, this death record stated any information for Jessie's family members, which Dignity Health had but had never provided to Cremations Only. (*Id*. at CRE000007-10; Exhibit 4.)

114. On information and belief, Jessie's death certificate was later amended to include information for her family members.

115. Cremations Only violated H&S Code Section 103780 by submitting a false Permit, stating that they had the right to control the body of Jessie Peterson when in fact, under Section 7100, they did not. (Exhibit 12 at SNC001156.)

116. On information and belief, Cremations Only's contract with Dignity Health states, the bodies will be stored at Cremations Only are merely stored for Dignity Health at "Contractor's licensed storage facility." According to declaration's signed by Lukin, the bodies remain in the custody and control of Dignity Health. Cremations Only agreed, stating, "Laura Lukin is correct that the bodies in question were in the custody and control of the hospital and were being held at SMT's facility because the hospital's own morgue has limited capacity." (See e.g. Exhibit 20 at p. 1.) Accordingly, Phil Manning should not have signed the affirmation on the April 9, 2023 permit stating he has the right to control disposition pursuant to Health and Safety Code Section 7100. Phil Manning, who is a licensed funeral director of

Cremations Only, also should not have been identified as the "Informant" in box 7A of the death record. The informant should have been listed as Laura Lukin or someone else at Dignity Health since Dignity Health retained custody and control of the remains. Therefore, Dignity Health, should have, but failed to file the permit for temporary envaultment as required under section 103050 within eight days of Jessie's death. It was only months later, after Dignity Health informed Cremations Only that it had not done so for Jessie and some other decedents it was holding at Cremations Only, that Cremations Only first became aware of this and agreed to have Cremations Only file the permits and death certificates for Dignity Health. (*Id*. at p. 2.)

117. On information and belief, according to the declaration of Larua Lukin, all of the deceased patients listed above in paragraphs 77 and 78, were held at Cremations Only. Neither Dignity Health nor Cremations Only made any effort to allow Dignity Health's patients to be laid to rest until the filing of the complaint in this matter and the television and newspaper coverage that followed.

ALLEGATIONS COMMON TO ALL DEFENDANTS

118. On information and belief, failure to notify Jessie's family of her death requires not merely systemic failures, but collaborated breaches of duties, legal obligations, moral obligations, hospital regulations, and human decency.

119. First, Dr. Mukhtar (the attending physician) failed to complete the medical and health sections of Jessie's death record and failed to notify Jessie's family of her death in violation of legal obligations, medical ethics, and hospital standards.

120. Second, Dignity Health failed to ensure its medical staff followed its policies despite years of audit findings pointing out failures to complete death records and notify families of deaths. In connection with this, Dignity Health hid from its oversight board year after year audit findings of these violations.

121. Third, Dignity Health failed to ensure its staff followed its Notification of Death policy and documentation, a process supposedly in place to ensure compliance with the violations identified in the audits.

122. Fourth, Dignity Health failed to include this Notification of Death record, which would have included the contact information for Jessie's family with her body as it was transferred to the custody of Cremations Only.

123. Fifth, Cremations Only failed to complete Jessie's death record in violation of state law.

124. Sixth, Cremations Only failed to make reasonably diligent efforts to contact Jessie's family in violation of state law and their own policies.

125. On information and belief, not until the one-year anniversary of Jessie's death approached, was any effort made to complete Jessie's death record, and this was only made to avoid having to obtain court approval for disposing of Jessie's remains. Cremations Only didn't care about identifying Jessie's family during the first 60 days of holding her body because Dignity Health pays a daily rate for storing Jessie's remains. Dignity Health doesn't care about identifying Jessie's family after these 60 days because it costs them nothing to keep Jessie's remains at Cremations Only after the initial 60 days.

126. On information and belief, meanwhile, every month, Dignity Health callously disregarded monthly reminders about Jessie Peterson and numerous others, when Cremations Only sent them emails listing all of Dignity Health's patients that were in body-bags in storage on shelves at Cremations Only. For example, Dignity Health received written inventory reports that mentioned patient Jessie Peterson more than seven times. Dignity received written inventory reports that mentioned patient William S. on more than fifty occasions between May 2, 2023 and January 27, 2025.

127. On information and belief, the allegations described herein were directed at Plaintiffs and were done intentionally or in reckless disregard to the probability of causing emotional distress.

128. Discovery is continuing and, so far, Dignity Health has failed to produce documents in response to written discovery requests. As such, further amendments to the complaint are likely, as well as the identification of additional plaintiffs.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

Negligent Handling of a Corpse

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, and Does 3-50)

129. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

130. Defendants owed a duty to Plaintiffs to exercise reasonable and ordinary care when handling the decedent's remains. That duty arose from, among other things, federal, state, and local laws that require Defendants to properly and adequately handle an individual's remains as to preserve their dignity and honoring the right of Jessie's family to control the disposition of Jessie's remains.

131. Defendants breached that duty to Plaintiffs by failing to properly care for Jessie's remains. Indeed, while in Defendants' possession, Jessie was left decomposing for over a year. As a result, Jessie's body was so discolored that her tattoos could not be identified. Moreover, Jessie's fingerprints were not obtainable for any keepsake, and Jessie's family could not say goodbye or hold an open casket funeral. The mishandling also denied the family the option of an autopsy.

132. As a direct and proximate result of Defendants' failing to appropriately handle Jessie's body after her death, Plaintiffs were induced to believe that Jessie was still alive and searched for Jessie for several months even though Jessie's body was located in Dignity Health's cold storage and have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

SECOND CAUSE OF ACTION

Negligence

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, Dr. Mukhtar, and Does 3-50)

133. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

134. Defendants owed a duty to Plaintiffs to exercise reasonable and ordinary care. That duty arose from, among other things, federal, state, or local laws that require Defendants to notify decedent's next of kin of their death.

135. Defendants breached that duty when they failed to notify Jessie's family of her death for a year. Defendants had extensive contact with Jessie's mother, and she was also listed as her next of kin on hospital records.

136. Defendants failure to issue a timely Certificate of Death, failure to notify Jessie's next of kin, failure to allow an autopsy, and mishandling of Jessie's remains was negligent, careless, and heartless. Defendants violated their own promise of dignity and respect for the people in their care.

137. Defendants interfered with Plaintiffs rights under California Health & Safety Code § 7100 which states that the control of a deceased individual's remains vests in "the surviving competent parent or parents of the decedent." Defendants wrongfully retained control over Jessie's remains for over a year and failed to relinquish control of Jessie's body to her family.

138. Defendants violated California Health & Safety Code § 7104 which states "When no provision is made by the decedent, or where the estate is insufficient to provide for interment and the duty of interment does not devolve upon any other person residing in the state or if such person cannot after reasonable diligence be found within the state the person who has custody of the remains may require the coroner of the county where the decedent resided at time of death to take possession of the remains and the coroner shall inter the remains in the manner provided for the interment of indigent dead." Defendants failed to make reasonable efforts to contact Jessie's next of kin, including any of the Plaintiffs, to inform them of Jessie's death.

139. The negligence per se doctrine applies because (1) the defendants violated a statute, ordinance, or regulation of a public entity; (2) the violation proximately caused injury to a person or property; (3) the injury resulted from an occurrence of the nature of which the statute, ordinance or regulation was designed to prevent; and (4) the person suffering the injury to his person or property was one of the class of persons for whose protection the statute, ordinance, or regulation was adopted.

140. As a direct and proximate result of Defendants' negligence, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

THIRD CAUSE OF ACTION

Negligent Infliction of Emotional Distress

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, Dr. Mukhtar, and Does 3-50)

141. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

142. Defendants owed a duty to Plaintiffs to act as reasonable, prudent persons. This duty includes an obligation to act in a careful, lawful, and prudent manner and in full compliance with applicable federal, state, and local laws.

143. Defendants' conduct toward Plaintiffs resulted in a breach of Defendants' duties to act as reasonable, prudent persons.

144. Defendants should reasonably have anticipated that their conduct would have resulted in emotional distress. Because they failed to notify Jessie's mother about her death, Jessie's family continued the search for Jessie for over a year, while suffering emotional and mental anguish for Jessie during their search.

145. Defendants also denied Plaintiffs the ability to have an autopsy completed to determine the actual cause of death.

146. As a result of Defendants breach of their duties, Plaintiffs suffered legally compensable emotional distress damages.

147. Defendants' conduct towards Plaintiffs was malicious and outrageous. Defendants acted with complete disregard for the probability that Plaintiffs would suffer severe or extreme emotional distress by mishandling Jessie's remains and letting her corpse decompose for a year thus rendering an open casket funeral to be impossible, and by failing to notify Plaintiffs of her death and allowing for the search for Jessie to continue causing emotional and mental anguish for Jessie's family. Only the imposition

of significant damages will deter similar mistreatment of a corpse and disregard of the rights and emotional needs of a decedent's family.

148. As a direct and proximate result of Defendants' negligent infliction of emotional distress, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

FOURTH CAUSE OF ACTION

Negligent Misrepresentation

(Against Defendants Dignity Health and Does 3-50)

149. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

150. On or about April 11, 2023, Dignity Health falsely represented to Plaintiff Ginger Congi that Jessie had left Mercy San Juan Hospital against medical advice. In truth, Jessie had died at the Mercy San Juan Hospital on April 8, 2023.

151. The material assertions made by Dignity Health were made with no reasonable ground for believing them to be true, and Dignity Health knew or should have known that the statements were untrue.

152. Plaintiffs, at the time the misrepresentations were made, were unaware of the truth and that Dignity Health's misrepresentations were false. Plaintiffs, in the exercise of reasonable diligence, could not have discovered the truth at the time the false statements were made.

153. In making the misrepresentations, Dignity Health knew that Plaintiffs would act in reliance on the misrepresentations.

154. Plaintiffs justifiably relied on the representations made to them by Dignity Health.

155. As a proximate result of the misrepresentations by Dignity Health, as alleged herein, Plaintiffs were induced to believe that Jessie was still alive and searched for Jessie for several months even though Jessie's body was located in Dignity Health's cold storage and have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

156. As a direct and proximate result of Dignity Health's negligent misrepresentation, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

FIFTH CAUSE OF ACTION

Negligent Hiring and Supervision

(Against Defendants Dignity Health and Does 3-50)

157. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

158. Dignity Health failed to use reasonable case in the hiring and supervision of Dr. Mukhtar, the staff of Mercy San Juan and Does 3 through 10 to ensure that they adequately maintained an EDRS, timely prepared death certificates upon the death of a patient, and used reasonable diligence in contacting next of kin to inform them of a family member's death.

159. Dignity Health knew of Dr. Mukhtar and its employees incompetent performance of legal obligations, moral obligations, and hospital policies and procedures in maintaining an EDRS, timely prepared death certificates upon the death of a patient, and used reasonable diligence in contacting next of kin to inform them of a family member's death based on several years of audit findings directing Dignity Health to correct these errors. Additionally, Dignity Health knew of these systemic failures based on monthly communications from Cremations Only advising Dignity Health of human remains Cremations Only was storing for Dignity Health.

160. Plaintiffs were harmed as a direct and proximate result of Dignity Health's failure to supervise its employees and ensure they fulfilled legal obligations, moral obligations, and hospital policies and procedures in maintaining an EDRS, timely prepared death certificates upon the death of a patient, and used reasonable diligence in contacting next of kin to inform them of a family member's death.

161. As a direct and proximate result of Defendants Dignity Health dba Mercy San Juan, Common Spirit, and Does 3 through 50's negligent hiring, training, retention, discipline and supervision of Dr. Mukhtar and Does 3 through 50, Plaintiffs suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

SIXTH CAUSE OF ACTION

Violation of California Health & Safety Code § 7100

(Against Defendants Dignity Health dba Mercy San Juan, Common Spirit, and Does 3-50)

162. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

163. California Health & Safety Code § 7100 states that the control of a deceased individual's remains vests in "the surviving competent parent or parents of the decedent."

164. Defendants violated the section above by retaining control over Jessie's remains for over a year and failing to relinquish control of Jessie's corpse to her family.

165. As a direct and proximate result of Defendants Dignity Health dba Mercy San Juan, Common Spirit, and Does 3 through 50's violation of California Health & Safety Code § 7100, Plaintiffs suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

SEVENTH CAUSE OF ACTION

Violation of California Health & Safety Code § 7104

(Against Defendants Dignity Health dba Mercy San Juan, Common Spirit, and Does 3-50)

166. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

167. California Health & Safety Code § 7104 states "When no provision is made by the decedent, or where the estate is insufficient to provide for interment and the duty of interment does not devolve upon any other person residing in the state or if such person cannot after reasonable diligence be found within the state the person who has custody of the remains may require the coroner of the county where the decedent resided at time of death to take possession of the remains and the coroner shall inter the remains in the manner provided for the interment of indigent dead."

168. Defendants violated the section above by failing to make a reasonable attempt to contact Jessie's next of kin, including any of the Plaintiffs, to inform them of Jessie's death.

169. As a direct and proximate result of Defendants Dignity Health dba Mercy San Juan, Common Spirit, and Does 3 through 50's violation of California Health & Safety Code § 7104, Plaintiffs suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

EIGHTH CAUSE OF ACTION

Gross Negligence

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, Dr. Mukhtar, and Does 3-50)

170. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

171. Defendants owed a duty to Plaintiffs to exercise reasonable and ordinary care. That duty arose from, among other things, federal, state, or local laws that require Defendants to notify decedent's next of kin of their death.

172. Defendants' breach of that duty was due to a lack of any care or an extreme departure from what a reasonably careful person would do in order to prevent harm to Jessie's family. Dignity Health had extensive contact with Jessie's mother, and she was also listed as Jessie's next of kin on hospital records. Dignity Health also had contact information for Jessie's sister who had also been listed as an emergency contact in Jessie's medical records. This contact information was readily available to all other Defendants.

173. Defendants' failure to issue a timely Certificate of Death, failure to notify Jessie's next of kin, failure to allow an autopsy, and mishandling of Jessie's remains was negligent, careless, and heartless. Defendants violated their promise of dignity and respect for the people in their care.

174. Defendants' conduct as described herein was oppressive and/or malicious, in that it was despicable conduct that subjected the family to cruel and unjust hardship in conscious disregard for Plaintiffs rights and/or was carried out with a willful and conscious disregard to the rights of the Plaintiffs.

175. As a direct and proximate result of Defendants' gross negligence, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

NINTH CAUSE OF ACTION

Intentional Infliction of Emotional Distress

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, Dr. Mukhtar, and Does 3-50)

176. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

177. Defendants owed a duty to Plaintiffs to act as reasonable, prudent persons. This duty includes an obligation to act in a careful, lawful, and prudent manner and in full compliance with applicable federal, state, and local laws.

178. Defendants' conduct toward Plaintiffs resulted in a breach of Defendants' duties to act as reasonable, prudent person.

179. Defendants should reasonably have anticipated that their conduct would have resulted in emotional distress because Audit findings beginning at least as early as 2022 and continuing through 2024 have directed Dignity Health to provide timely notification of death to family members and to timely complete death certificates. These audits had further informed Dignity Health that failure to timely notify families could cause emotional distress. Despite this knowledge and its promised "Plan of Correction" Dignity Health did nothing to correct its conduct.

180. Defendants' conduct was outrageous and exceeded the bounds of decency in a civilized community.

181. Defendants either intended to cause Plaintiffs emotional distress, or acted with reckless disregard of the probability that Plaintiffs would suffer emotional distress.

182. Because Defendants failed to notify Jessie's mother about her death, Jessie's family searched for Jessie for over a year, while suffering emotional and mental anguish for Jessie during their search. As a result of Defendants breach of their duties, Plaintiffs suffered legally compensable emotional distress damages.

183. Defendants' inactions also denied Plaintiffs the ability to have an autopsy completed to determine the actual cause of death.

184. Defendants' conduct towards Plaintiffs was malicious and outrageous. Defendant acted with complete disregard for the probability that Plaintiffs would suffer severe or extreme emotional distress by mishandling Jessie's remains and letting her corpse decompose for a year thus rendering an open casket funeral to be impossible, and by failing to notify Plaintiffs of her death and allowing for the search for Jessie to continue causing emotional and mental anguish for Jessie's family. Only the imposition of significant damages will deter similar mistreatment of a corpse and disregard of the rights and emotional needs of a decedent's family.

185. As a direct and proximate result of Defendants' intentional infliction of emotional distress, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

TENTH CAUSE OF ACTION

Intentional Misrepresentation

(Against Defendants Dignity Health and Does 3-50)

186. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

187. On or about April 11, 2023, Defendant Dignity Health falsely represented to Plaintiff Ginger Congi that Jessie had left Dignity Health Hospital against medical advice. In truth, Jessie had died at Dignity Health Hospital on April 8, 2023.

188. Dignity Health's representation to Ginger that Jessie had left the hospital against medical advice was made recklessly and without regard for the truth.

189. In making the misrepresentations, Dignity Health knew that Plaintiffs would act in reliance on the misrepresentations.

190. Plaintiffs justifiably relied on the representations made to them by Dignity Health and began their years long search for Jessie outside of Dignity Health.

191. As a proximate result of the misrepresentations by Dignity Health, as alleged herein, Plaintiffs were induced to believe that Jessie was still alive and searched for Jessie for several months even though Jessie's body was located in Dignity Health's cold storage and have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

192. As a direct and proximate result of Defendants' intentional misrepresentation, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

ELEVENTH CAUSE OF ACTION

Concealment

(Against Defendants Dignity Health, Mortuary Support Servies of Northern California, LLC, Dr. Mukhtar, and Does 3-50)

193. Plaintiffs reallege and incorporate by reference every allegation contained in this Complaint as if fully set forth herein.

194. Defendants have not only a legal, but also a moral obligation to notify families of deaths and complete death certificates. But instead of fulfilling these duties, Jessie Peterson's body was hidden away in cold storage where only the hospital and the cold storage facility knew Jessie was deceased.

195. Despite having the contact information in its records, Defendants failed to notify Jessie's (1) mom, (2) sister, or (3) friend of Jessie's death for one year.

196. Unaware of Jessie's death, her family endured a year of purgatory searching, hoping, and waiting. Days after Jessie's death Ginger called the hospital and was not informed that Jessie had died. The family searched for Jessie and filed missing person reports hoping the police would help locate her.

197. Defendants (a) failure to complete Jessie's death certificate and (b) failure to report Jessie's death on the Electronic Death Registration System prevented Jessie's family and the police from learning of Jessie's death. Even setting aside the fact that Defendants did not call Jessie's emergency contacts, had the Defendants completed the death certificate or Electronic Death Registration, Jessie's family would have learned of her death just as they did a mere days after Mukhtar finally completed Jessie's Death Certificate.

198. Defendants intentionally withheld information and misled Plaintiffs of information related to Jessie's death. The Defendants had the contact information to notify Plaintiffs of Jessie's death, but failed to call, failed to leave any messages requesting a return call, failed to send any letters; and even negligently and intentionally failed to inform Ginger of Jessie's having died when Ginger called the hospital three days after Jessie's death.

199. Had Plaintiffs known of Jessie's death, they would not have endured purgatory while they searched and waited for any information regarding their daughter, sister, and friend. The agony of the daily searching and waiting would not have been endured for one year.

200. Defendants' conduct towards Plaintiffs was malicious and outrageous. Dignity Health was well aware of the harm its negligence and knowing disregard for their statutory, moral, and procedural obligations was causing, but continued despite warnings from the Department of Health And Human Services. Defendants acted with complete disregard for the probability that Plaintiffs, would suffer severe or extreme emotional distress while searching and waiting for nearly a year for any news of Jessie. Defendants' concealment of Jessie's death was a substantial factor in causing Plaintiff's severe emotional distress. Dignity Health has known since at least 2022 that their conduct was causing harm and they promised various corrective measures – only to disregard its own promises to the Department of Health and Human Services. Dignity Health is guilty of knowingly, intentionally and repeatedly causing harm that was entirely avoidable had they complied with the law, their own policies, and their promises to the State of California and the people that end up at a Dignity Health hospital.

201. As a direct and proximate result of Defendants' concealment of Jessie's death, Plaintiffs have suffered damages according to proof, but in excess of the jurisdictional minimum of this Court.

202. Dignity Health and Dr. Mukhtar thinks that the worst that can result is an insurance claim for medical malpractice – they are wrong. Defendants' universal lack of respect for the dead and the feelings of the decedent's survivors cannot go unpunished.

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PRAYER FOR RELIEF

WHEREFORE, Plaintiffs prays for relief as follows:

1. A judgment in favor of Plaintiffs and against Defendants;
2. General damages against Defendants according to proof;
3. Special damages against Defendants according to proof;
4. Awarding reasonable attorney fees, interest and costs, to the full extent permitted by law; and
5. All such other and further relief as the Court may deem just, appropriate, and equitable.

DATED: June 4, 2025

TUCKER ELLIS LLP

By: _____
Marc R. Greenberg
Attorneys for Plaintiffs

DEMAND FOR JURY TRIAL

Plaintiffs demand a trial by jury on all issues triable of right by jury.

DATED: June 4, 2025

TUCKER ELLIS LLP

By: _____
Marc R. Greenberg
Attorneys for Plaintiffs

VERIFICATION

I, Ginger Congi, declare as follows:

I am the Plaintiff in this action. I have read the Second Amended Complaint. Each of the matters stated in the causes of action are true of my own knowledge except as to any matters where are stated on information and belief, and as to those matters, I am informed and believe that they are true. I have reviewed the California Department of Health And Human Services Audit Reports from 2022, 2023 and 2024, as well as Dignity Health's signed Plan of Correction which were received in reasons to a Public Records Act Request. I have also reviewed the Probate filings by Dignity Health seeking issuance of death certificates because Dignity Health had not issued a death certificate within one year of the patient's death. These court filings are publicly available on the Probate Court's website.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on May 30, 2025, at Rocklin, California.

Ginger J. Congi

Ginger Congi

EXHIBIT 1

Stat f California-Health and Human Serv s Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

April 8, 2022

Michael Korpiel, Administrator
Mercy San Juan Medical Center
6501 Coyle Ave
Carmichael, CA 95608

Dear Administrator:

FACILITY: Mercy San Juan Medical Center
COMPLAINT NUMBER: CA00511685

Enclosed is CMS 2567 Statement of Deficiencies and Plan of Correction Form, which resulted from a recent visit to your facility. Please prepare a plan of correction, sign and date the document, return the original to this department within ten (10) calendar days from receipt of this CMS 2567 Statement of Deficiencies, and retain a copy for your file.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.

b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.

c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.

d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.

e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing. You are ultimately accountable for compliance, and responsibility is not alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance.

If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the CMS 2567 Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Deborah Clifton, Health Facilities Evaluator Supervisor, at (916) 263-5800.

Sincerely,

Miriam Linares, Program Technician II

For: Lisa Bennefield
District Administrator

Enclosure *(CMS 2567)*

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	R-C 04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{E 000}	Initial Comments An off-site revisit survey was conducted on 04/12/2022 for all previous deficiencies cited on 04/05/2022. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed 04/11/2022.	{E 000}		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

acceptable POC BC 4/11/22 4/12/22

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00511685. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 38970 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the hospital.	E 000	See attached	
E 242	T22 DIV5 CH1 ART3-70203(a)(2) Medical Service General Requirements (2) Developing, maintaining and implementing written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician implemented a policy and procedure for notifying a next-of-kin of a patient's (Patient 1) death. This failure resulted in Patient 1's family not being notified of Patient1's death for 6 weeks. Findings: Review of a physician document titled History and Physical, dated 9/18/16, indicated Patient 1 was admitted to the facility for increased confusion.	E 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 242	Continued From page 1 Review of a physician note titled "Critical Event/Code Blue Note/Death Note," dated 9/21/16, indicated Patient 1 went into cardiac arrest and died at 4:34 a.m. The note included an addendum, which indicated the physician made an attempt to notify two family members (FM 1 and FM 2) of Patient 1's death. The addendum included the names and phone numbers of FM 1 and FM 2. The physician indicated the number for FM 1 was no longer in service, and the number for FM 2 was invalid. The addendum indicated the physician notified the Administrative Nursing Supervisor of the inability to reach FM 1 and FM 2. Review of Patient 1's electronic medical record indicated emergency contact information for FM 1 and FM 2. The phone number for FM 1 indicated a different phone number from the phone number indicated in the physician's addendum titled "Critical Event/Code Blue Note/Death Note." During an interview and concurrent record review with the Nursing Manager (NM) of the surgical intensive care unit (SICU) on 3/9/22, at 10:20 a.m., the NM confirmed Patient 1's medical record indicated he was in the SICU at the time of his death. When asked where a physician would locate the name and contact information of a next-of-kin, the NM stated the physician would locate the information in the patient information tab or on the patient's face sheet. The NM reviewed Patient 1's face sheet and confirmed there was no phone number for FM 1 on the facesheet. The NM reviewed the contact information for FM 1 in the patient's information tab and compared it to the number indicated in the physician addendum titled "Critical Event/Code Blue Note/Death Note," and confirmed the two phone numbers were different	E 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 242	Continued From page 2 In the order of digits. During an interview with the Chief Medical Officer (CMO) on 3/9/22, at 11:12 a.m., the CMO stated she believed it was the responsibility of the attending physician to notify family of a patient's death. Review of the 2015 Medical Staff Rules and Responsibilities indicated, "Notifying the Next of Kin...The Attending Physician or his or her representative is responsible for notifying the next of kin in all cases of death."	E 242		
E2247	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to promptly complete a medical record within the required two week period following a patient's (Patient 1) discharge. Findings: Review of a physician document titled History and Physical, dated 9/18/16, indicated Patient 1 admitted to the facility for increased confusion.	E2247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2247	Continued From page 3 Review of a physician note titled "Critical Event/Code Blue Note/Death Note," dated 9/21/16, indicated Patient 1 went into cardiac arrest and died at 4:34 a.m. that day. Review of a physician note for Patient 1 titled "Discharge Summary," indicated the author initiated the note on 10/21/16 and completed the note on 10/30/16, which was 39 days after Patient 1's discharge. Review of the 2015 Medical Staff Rules and Regulations indicated, "Medical records must be completed promptly and authenticated or signed by a Practitioner within fourteen (14) days following the patient's discharge." During an interview and concurrent record review with the Chief Medical Officer (CMO) on 3/9/22, at 11:12 a.m., the CMO confirmed Patient 1 died on 9/21/16. The CMO confirmed the physician completed the Discharge Summary note on 10/30/16, and stated "that was well over the 14-day period." During an interview with the Director of Medical Staff Administration (DMSA) on 3/9/22, at 11:33 a.m., the DMSA stated the Medical Staff Rules and Regulations indicated the physician was required to complete the medical record within 14 days of a patient discharge, and this included a Discharge Summary note.	E2247		

PLAN OF CORRECTION
CA00511685

Corrective Action	Complete Date
Response to Tag E242 Begins Here	
A. Verified the physician responsible for notifying the family following the patient death is no longer on staff. Completed by: Director Medical Staff Administration	4/5/22
B. Provided education to members of the medical staff by email about: • Location of contact information. • The requirement to notify family about a death. • The requirement to document notifications to family. Completed by: Chief Medical Officer	4/11/22
C. Instructed department managers to provided education in department huddles to hospital staff about: • A description of the deficiency cited CA00511685 • The importance of accuracy of information in the medical record including contact phone numbers. • To achieve timely notification of death to family/next of kin, the information in the medical record including contact phone numbers, must be accurate. Completed by: Quality Director	4/622
D. Developed an auditing and reporting process to evaluate accuracy of telephone numbers listed as contacts in the medical record. • Numerator = Number of contacts telephone numbers listed in progress notes or other documented entered into the electronic medical record by hospital staff, physicians, or advanced practice providers that accurately match the contact information in the section of the electronic medical record titled "Patient Information". • Denominator = Number of medical records reviewed with a contact and a contact phone number listed in the electronic health record. • Sample: 10 per month. • Case selection: Patients with a stay in an intensive care unit. • Goal = 100% Completed by: Quality Program Manager	4/11/22
E. Scheduled semiannual reporting of audit results to the Quality Management Committee of the Medical Staff for integration into the established QAPI process. Reporting will continue until four consecutive audit results are 100% excluding months with no cases. Completed by: Quality Program Manager	4/10/22
Response to Tag E242 Ends Here	

Corrective Action	Complete Date
Response to Tag E2247 Begins Here	
F. Provided one-on-one education about the requirement for completion of a discharge summary within 14 days after discharge to the physician responsible for the completion of the discharge. Completed by: Chief Medical Officer	4/11/22
G. Provided education to members of the medical staff by email about: • A description of the deficiency cited CA00511685 • A final summary regarding the patient's hospital course and outcome must be written or dictated by the Attending Physician on all patients who expire. • The discharge summary completed within fourteen (14) days after the patient's discharge for all patients hospitalized over forty-eight (48) hours. Completed by: Chief Medical Officer	4/11/22
H. Verified a mechanism is in place to: • Notify a physician within 7 days of discharge that a medical record will become delinquent if not completed within 7 days. • Terminate medical staff membership if a physician is suspended for a continuous period greater than 24 days for failure to complete medical records. Completed by: Quality Director	4/12/22
I. Verified the auditing and reporting process to evaluate the timeliness of discharge summaries. • Numerator = Number of discharge summaries completed within 14 days. • Denominator = Number discharge summaries completed evaluated. • Sample: 10 per month. • Case selection: Patients assigned to the Hospital Medicine service. • Goal = 100% Completed by: Quality Program Manager	4/11/22
J. Scheduled semiannual reporting of audit results to the Quality Management Committee of the Medical Staff for integration into the established QAPI process. Reporting will continue until four consecutive audit results are 100% excluding months with no cases. Completed by: Quality Program Manager	4/10/22
Response to Tag E2247 Ends Here	

EXHIBIT 2

State of California—Health and Human Service Agency
California Department of Public Health

TOMAS J. ARAGON, M.D., Dr P.H
Director and State Public Health Officer

GAVIN NEWSOM
Governor

April 8, 2022

Michael Korpiel, Administrator
Mercy San Juan Medical Center
6501 Coyle Ave
Carmichael, CA 95608

Dear Administrator,

Your plan of correction from the abbreviated survey completed on 04/05/2022 for complaint #CA00511685 has been accepted and you have corrected all deficiencies noted during the survey.

If you have any questions concerning this letter, please contact Deborah Clifton, Health Facilities Evaluator Supervisor, at (916) 263-5800.

Sincerely,

Miriam Linares, Program Technician II

For: Lisa Bennefield
District Administrator

Licensing and Certification Program, Sacramento District Office
3901 Lennane Drive, Suite 210, Sacramento, CA 95834
PHONE (916) 263-5800 • (916) 263-5840 FAX
Internet Address: www.cdph.ca.gov

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

June 30, 2023

Mr.. Michael Korpiel, Administrator
Mercy San Juan Medical Center
6501 Coyle Ave
Carmichael, CA 95608

Dear Administrator:

FACILITY: Mercy San Juan Medical Center
COMPLAINT NUMBER: CA00747251

Enclosed is CMS 2567 Statement of Deficiencies and Plan of Correction Form, which resulted from a recent visit to your facility. Please prepare a plan of correction, sign and date the document, return the original to this department within ten (10) calendar days from receipt of this CMS 2567 Statement of Deficiencies, and retain a copy for your file.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.

b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.

c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.

d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.

e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing. You are ultimately accountable for compliance, and responsibility is not alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance.

If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the CMS 2567 Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Amber Boobar, Health Facilities Evaluator Supervisor, at (916) 263-5800.

Sincerely,

Emily Lim Program Technician II

For- Daniel Schut
District Manager

Enclosure *(CMS 2567)*

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	R-C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{E 000}	Initial Comments An off-site revisit survey was conducted on 07/24/2023 for all previous deficiencies cited on 05/16/2023. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed 07/31/2023. CA00747251	{E 000}		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00747251. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 42291 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the hospital.	E 000	POC rec'd 7/12/23 POC approved 7/24/23 Provider BC 7/31/2023 Amber Booher HFES	
E 269	T22 DIV5 CH1 ART3-70213(b) Nursing Service Policies and Procedures. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow their morgue (place where the deceased are kept temporarily) policy when Patient 1 expired and documentation of the location of the body was unknown. This failure resulted in Patient 1's son being unaware of his mother's body whereabouts and caused family emotional distress. Findings: During a review of Patient 1's "Death Note", dated August 3, 2021, the "Death Note" indicated, Patient 1's diagnoses included COVID 19,	E 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 269	Continued From page 1 worsening shortness of breath, pneumonia, and a cardiopulmonary arrest (heart stops). During an interview with the Emergency Department Registered Nurse (EDRN), on 5/4/23 at 09:40 a.m., EDRN explained, bodies are taken to the morgue by an ED Technician (EDT)... if needed, a nurse goes. During the off hours (after 5 p.m.), the Administrative Nurse Supervisor (ANS) is notified and the ANS opens the morgue. The log is completed by the EDT. The EDRN stated during the COVID epidemic there was an Auxiliary Morgue used. During an interview with the ANS, on 5/4/23 at 10:35 a.m., ANS stated the following information regarding body disposition: "During business hours the Pathology Department is responsible for the ins and outs of the morgue", and, "during off hours, the EDT takes the body to the morgue and brings the paperwork to the ANS office. The ANS places the paperwork in a folder". "If a funeral home comes to pick-up the body during business hours, the Pathology Department releases the body", and, "The coroner or the funeral home representative calls the number indicated on the phone by the morgue." The ANS completes the Release of Body Form and the coroner or the funeral home representative will sign the book (Log). The ANS confirmed this information is in the Morgue Policy. During a concurrent interview and record review with the Emergency Department Educator (EDE) on 5/2/23 at 11:10 a.m., EDE confirmed, the morgue signature page did not have a signature or the location where Patient 1's body was taken, it was left blank, and the person picking up the body did not sign.	E 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000127	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 269	Continued From page 2 Review of the facility policy titled "XXX Laboratories Morgue Policy and Procedure", dated 7/27/2018 indicated, ..."3. Pathology will facilitate the release of the deceased to the appropriate destination. Pathology shall document the status of morgue activities, which includes delivery of deceased to the morgue, or release directly to a Mortuary ...6. Prior to releasing the body to a funeral home, a completed Authorized Release and original Release of Remains form must be presented." Continued review of the facility policy titled "XXX Laboratories Morgue Policy and Procedure", dated 7/27/2018 indicated, ..."9. In the event the morgue cannot accommodate the number of deceased, the outside storage ..., will be contacted ...and a request will be made to transport the deceased to their off-site storage facility. Document in the NOD (Notification of Death) form, the date of transfer, and the name of the storage facility. In the Morgue Log, document: the date, time and signature of the representative from the storage facility."	E 269		

PLAN OF CORRECTION
CA00747251

Corrective Action	Complete Date
§70213. Nursing Service Policies and Procedure (ID Prefix Tag E 264) (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing services. Was not met by the facility not being able to locate a patient's family member. Response to Tag E 269 Begins Here	
A. An education module was developed and submitted for distribution to all Pathology Laboratory and Administrative Nursing Supervisor staff via stand-up education. Key points in the module included: 1. At the time of death, the patient will continue to be cared for with dignity and respect for his/her wishes and in accordance with federal and state regulatory requirements. 2. Print a copy of Notification of Death Form and face sheet and place them on the outside of the shroud. 3. Staff will attach Notice of Death Form and Face Sheet outside of the locker, and place copies in the pathology lab to be forwarded to the regional morgue coordinator. 4. All deposits are documented in the morgue log book. 5. Access to the Morgue shall only be provided by the Pathology Department or the ANS Completed by: Director - Laboratory Services	06/30/2023- 07/31/2023
B. Retrospective auditing was used to verify that patients were deposited in the morgue with the appropriate documentation. a. Numerator = Number of expired patients documented in the morgue log book. b. Denominator = Number of patient mortalities. c. Performance goal = 100%. d. Sample = 100% of patient mortalities e. Monitoring continued until three consecutive months of goal performance was achieved. Completed by: Quality and Patient Safety Program Manager Response to Tag E 269 Ends Here	Ongoing

EXHIBIT 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a complaint validation survey conducted on 9/30/2024 through 10/4/2024 for CMS Control #CA00918214, #CA00914497, and #CA00916965. The investigation was limited to the specific complaints investigated and authorized conditions of participation, and does not represent the findings of a full inspection of the hospital. The census on date of entry was 367 and the sample size was 27.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview, and document review, the hospital failed to ensure an effective governing body legally responsible for the conduct of the hospital for a census of 367 patients out of a hospital bed capacity of 384 when: A. The hospital failed to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures related to family notification of patient death, timely completion of death certificates, and	A 043		11/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 043	Continued From page 1 processing of patient remains for a sample of three out of 61 hospital deceased patients (Patient 2, Patient 3, Patient 4) stored at an off-site morgue. Refer to A-0083. These failures contributed to ongoing delays in processing death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage; On 10/4/2024, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first half of 2024. The cumulative effect of these systemic problems resulted in the inability of the hospital to comply with the statutorily mandated Condition of Participation for Governing Body.	A 043		
A 083	CONTRACTED SERVICES CFR(s): 482.12(e) The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on interview and document review, the	A 083		11/25/24

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A 083	Continued From page 2 hospital failed to demonstrate the governing body was responsible for services furnished by the Regional Morgue Office (RMO), in the Greater Sacramento Division (GSD), for a sample of three out of 61 deceased patients (Patient 2, Patient 3, and Patient 4) stored in an off-site morgue at time of survey. The Regional Morgue Office failed to: 1. Notify the families of Patient 2, Patient 3, and Patient 4 of their deaths, and complete death certificates per regulatory requirements, 2. Resolve a known back-log of 61 deceased patients stored in an off-site morgue according to the GSD Laboratory Morgue Policy and Procedure. These failures resulted in a delay in completion of death certificates, in notification to families of patient deaths, and in handling the patients' bodies after death. These failures had the potential to prolong distress and grief for families. Findings: 1. During a review of a log kept by the RMO of patient remains in an off-site morgue, the log indicated: a. Patient 2 died on 10/3/2022, family had not been found as of 9/5/2024 per the Public Administrator (PA), the death certificate had not been completed, and Patient 2's remains continued to be stored at the off-site morgue; b. Patient 3 died on 10/21/2022, on 5/23/2024 the PA spoke with Patient 3's family member who requested disposal of remains under county indigent (suffering from extreme poverty) plan,	A 083		

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A 083	Continued From page 3	A 083		

the death certificate had not been completed, and Patient 3's remains continue to be stored at the off-site morgue; and

c. Patient 4 died on 12/28/2022, a note indicated Spanish interpreter needed to proceed, the death certificate had not been completed, and Patient 4's remains continue to be stored at the off-site morgue.

During an interview on 10/1/2024 at 1:15 p.m. with the Sacramento Market Leader of Laboratory Services: Lab, Cardiopulmonary, & Rehabilitation (SMLLSLCR), SMLLSLCR stated the RMO was responsible for making three attempts to contact family once patient remains left the local hospital. SMLLSLCR stated there was no expected time frame for the contact attempts. SMLLSLCR stated, until recently there was no log to track the attempts. SMLLSLCR stated, if the process fails to yield results, the case should be forwarded to the County Public Administrator, who would attempt to find family, and if none could be found after a diligent search, contact the coroner to pick up the body. SMLLSLCR stated, the Office of the Coroner would attempt to contact family if known family could not be reached. SMLLSLCR stated, records of referrals to the PA and the Coroner's Office had not been kept until recently. SMLLSLCR could not provide documented evidence of referrals to the PA or Coroner.

During an interview on 10/2/2024 at 10:20 a.m. with Chairman of the Community Board (CCB) responsible for both the Community Board and the Quality Committee of the Community Board (QCCB), CCB stated the Community Board was comprised of the Chiefs of Staff and Presidents of the hospitals in the GSD, which included four

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hospitals. The Community Board reviewed reports from the QCCB Committee. CCB stated they were not aware of prior hospital regulatory violations for failure to process patient remains.

During review of the Community Board Meeting minutes for the period of January 2024 to August 2024 meetings, the minutes did not reference any concerns regarding processing patient remains. There was no information regarding untimely completion of death certificates or lack of notification of next of kin of the death of a patient.

2. During an interview on 10/2/2024 at 1:05 p.m. with Supervisor of Lab Support Services (SLSS), SLSS stated she was aware the RMO was failing to timely process patient remains and complete death certificate worksheets beginning in April 2023. SLSS stated, initially she tried to help more with the process in addition to her clinical laboratory duties. SLSS stated the backlog continued; she reported it to the Regional Laboratory Director and Hospital President (HP) in September 2023. SLSS stated "It went nowhere." SLSS stated no log or documents were kept for the Morgue processes until April 2024.

During an interview on 10/3/2024 at 3 p.m. with the Regional Director of Laboratory Services (RDLS), RDLS stated he had been aware of the RMO backlog shortly after starting his role three months ago.

During an interview on 10/3/2024 at 3:35 p.m. with the Chief Operating Officer (COO), the COO stated he started in his role three and half months ago and the lab reports to him. He was not aware of the back-log of processing human remains within RMO until it was a news story, in August

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2024. COO stated resolving the issues became a priority then.

During an interview on 10/3/2024 at 4:15 p.m. with the Hospital President (HP), the HP stated he was legally responsible for all hospital services. HP stated he reports to a GSD Hospital President, but the Healthcare Organization Governing Body had delegated the responsibility of hospital services to him. HP stated he was aware of the failures of the RMO to timely process patient remains and complete the death certificate worksheets in September 2023. HP referred the issues to the GSD President in September 2023. HP stated the GSD President and legal department were working to resolve the issue. HP stated he had not received, nor asked for any updates on solutions. When asked to explain this lack of oversight, HP stated the problem would be addressed at the divisional level; HP stated, "It is not my scope." HP stated he was not aware of the failure to notify families. HP stated, "We assumed the remains being stored did not have families." HP explained the patient populations at the hospital included high numbers of homeless persons. HP stated he never reported the backlog of patient remains processing or family notifications to the Community Board. HP stated that National Board is only notified of regional issues from the Community Board. HP stated "I'm legally and morally responsible for those in the morgue". HP stated he was not aware of previous facility regulatory violations and plans of correction for failure to notify families of patient deaths. HP stated the previous QD notified him that all plans of corrections were completed. HP stated the previous plans of corrections did not have ongoing monitoring. HP stated QD does not have

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A 083	Continued From page 6 a direct line of reporting to him. In a concurrent interview and document review of the GSD Laboratory Morgue Policy and Procedure, approved 3/1/2022, with the SLSS on 10/3/2024 at 1 p.m., the document indicated processes for handling abandoned bodies and bodies with no next of kin. The document indicated the RMO should contact the public administrator and coroner when family could not be reached, or found, or the next of kin did not have resources to cremate or bury the body. The SLSS stated there was no documented evidence these agencies were contacted for assistance. In a document review of the Patient Safety Program Annual Summary and Evaluation for Fiscal Year 2023, which details categories of adverse events reported during the year, any regulatory findings, and active and completed plans of correction, submitted September 2023 to the Community Board, the document did not include documentation of the gaps in patient notification, death certificate processing according to legal requirements, or delay in handling patient remains. In a concurrent interview and record review of the newly created log of patient remains in off-site morgue storage, last updated 10/3/2024, with the QD on 10/3/2024 at 4:45 p.m., the QD confirmed the log indicated 11 bodies have been in storage since 2022, 15 bodies have been in storage since 2023, and 19 bodies have remained in storage from 1/1/2024 to 6/30/2024. The log indicated there were 61 patient remains in the off-site morgue on 10/3/2024.	A 083		
A 263	QAPI	A 263		11/25/24

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A 263	Continued From page 7 CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program that reflected the complexity of the hospital's organization and services for a census of 367 patients in a hospital bed capacity of 384, as evidenced by: A. The hospital QAPI program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations related in part to family notification of patient death and processing of the bodies of deceased patients, and the implementation of a process change for central venous catheter (a thin flexible tube that is	A 263		

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A 263	Continued From page 8 inserted into a vein and guided into a large vein above the right side of the heart) removal. Refer to A0283. These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement andf ongoing failures. The cumulative effect of these systemic problems resulted in the inability of the Hospital to comply with the statutorily mandated Condition of Participation for QAPI.	A 263		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		11/25/24

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A 283	Continued From page 9	A 283		

This STANDARD is not met as evidenced by:
Based on observation, interviews, and record reviews, the hospital Quality Assessment and Performance Improvement (QAPI) Program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained when there was no documented evidence of implementation and completion for:

1. The Plan of Correction (POC, an action plan submitted by a hospital to a State Agency to correct a cited regulatory violation) for intake CA00511685, dated April 2022, indicated plans to educate staff regarding accuracy of family contact information in chart, timely notification of death to next of kin by physician and physician's timely completion of deceased patient's charts including the summary of hospital course and discharge summary. Additionally, the Quality Program Manager (QPM) was responsible for verification through chart audits and providing semiannual reporting of audit for integration into the QAPI process. The timeframe indicated on the POC stated "reporting will continue until four consecutive audit results are 100% excluding months with no cases".

2. The POC for intake CA00747251, dated July 2023, indicated the development of an education module for the Pathology (study of disease) Laboratory and Administrative Nursing Supervisor staff covering the steps to take after the death of a patient to ensure dignity and respect, following federal and state regulatory requirements and including responsible staff tasks. This POC would be verified by Quality and Patient Safety Program

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Manager (QPSPM) with chart audits meeting measurable goals until "three consecutive months of goal performance was achieved".

3. A performance improvement project, dated 6/8/2023, identified by the Quality Management Committee (QMC) as a targeted area for improvement, focused on the removal of central venous catheters (CVC, a thin flexible tube that is inserted into a vein and guided into a large vein above the right side of the heart) prior to transfer to lower level of care (intensive care unit to medical or surgical units) to reduce the risk of CVC related patient adverse events.

These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement.

Findings:

1. During a review of the POC for intake CA00511685, dated April 2022, the POC included the following corrective actions, in part:
a. Education provided to medical staff on contacting and documenting family notification of death.
b. Department managers provided education to hospital staff about the importance of accuracy of information in the medical record, including contact numbers.
c. Developed an auditing and reporting process to evaluate the accuracy of telephone numbers listed as contacts in the medical record.
d. Scheduled semiannual reporting and of audit results to the QMC of the medical staff for integration into the established QAPI process.

2. During a review of the POC for intake

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CA00747251, dated July 2023, the POC included the following corrective actions, in part:
a. Development of an education module for Pathology Laboratory and Administrative Nursing Supervisors to include at time of death the patient will be cared for with dignity and respect, in accordance with federal and state regulatory requirements, the location of Notifications of Death Form, the documentation of deceased patient in morgue logbook and identify who is provided access to the morgue.
b. Retrospective chart audits performed by QPSM to verified that patients were deposited in the morgue with the appropriate documentation. This audit was to continue until 3 consecutive months of goal performance of 100% compliance was achieved.

During a review of the hospital QAPI plans, dated fiscal year 2023 and fiscal year 2024, the QAPI plans did not include any documented evidence of implementation of corrective actions identified in the POCs or evidence of tracking of performance improvement.

During a concurrent interview and record review on 10/1/24, at 11:05 a.m., with the Quality Director (QD), the QD was provided a copy of the POCs for intakes CA00511685 and CA00747251. After reviewing the POCs, the QD stated, "I am not familiar with these POCs ...will research ...these were before I started and there was no handoff to me [from previous staff]".

During an interview on 10/3/24, at 1:20 p.m., with the QD, the QD stated, "I have not been able to locate data for either POC". The QD stated, "No one was working on these [POCs], there is no data to provide implementation and tracking." The

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QD confirmed there was no documented evidence the interventions in the POCs, that were dated April 2022 and July 2023 respectively, were monitored for success and sustained compliance per hospital QAPI plan and regulatory requirements.

3. During an interview on 10/3/24, at 11:45 a.m., with Critical Care Nurse Educator (CCNE), the CCNE stated, they are working on a performance improvement project (PIP) to remove CVC before the patient is transferred to the medical or surgical floor. The CCNE stated, starting in February of 2023, the QMC started to investigate CVC line removal before transfer to a lower level of care as a quality indicator. The CCNE stated the nursing staff had been educated via Pathways (an online learning module the hospital utilizes to educate nurses) to a new vascular (vein) access policy, which included a skills module for vascular access care and removal. This module was assigned on 3/9/23 with a due date of 4/30/23. When asked about how many patients were being sent to the medical/surgical floor with CVC for this PIP the CCNE stated, "We are not tracking the data."

During a review of QMC minutes, dated June 2023, the QMC indicated the need to remove CVCs prior to transfer to a lower level of care.

During a concurrent observation and interview of the 5C Trauma medical surgical and telemetry (continuous monitoring of heart activity) unit, on 10/3/24, at 10:20 a.m., with the QD, the QD stated the unit was focused on monthly report cards (an infographic that is posted on a bulletin board for all staff to see). The only PIP that was observed posted in the unit was for patient falls.

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A 283	Continued From page 13 The QD stated that she did not see evidence of a PIP for CVC removal.	A 283		

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a complaint validation survey conducted on 9/30/2024 through 10/4/2024 for CMS Control #CA00918214, #CA00914497, and #CA00916965. The investigation was limited to the specific complaints investigated and authorized conditions of participation, and does not represent the findings of a full inspection of the hospital. The census on date of entry was 367 and the sample size was 27.	A 000	To immediately correct CFR (s): 482.12, Governing Body, the Community Board of Directors: • Were informed of the events noted in this CMS investigation regarding the Regional Morgue Office (RMO) services, • Will be updated on the process improvement work and process changes being implemented by the Greater Sacramento Division (GSD) hospitals. These process improvements include documentation by RMO of at least 3 next of kin notification attempts if, upon transfer to the RMO, no initial contact from the hospital defined as (the next of kin has not been reachable by the hospital prior to transfer to RMO). Timely initiation of the death certificate processes upon transfer of the body defined as within 2 RMO business days from death, as well as the current and ongoing status updates of the remains at the off-site morgue.	08/20/2024 11/21/2024
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview, and document review, the hospital failed to ensure an effective governing body legally responsible for the conduct of the hospital for a census of 367 patients out of a hospital bed capacity of 384 when: A. The hospital failed to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures related to family notification of patient death, timely completion of death certificates, and	A 043	**Responsible Person:** Hospital President/CEO To ensure the deficient practice does not recur the Quality Department has created a tracker of all State self reported events, as well as regulatory and complaint surveys, that when surveyed, did not meet the statute and were substantiated and regulatory violations were cited dating back to 2021. This tracker includes a summary title of the event, CA number for reference, party responsible for the monitoring of the PoC metrics, details of the accepted PoC monitoring metrics, indication if compliance has been met, then if not yet met, the monitoring start date and metric tracking will be completed. This tracker will be reported per meeting (monthly unless canceled or deferred, staying within Bylaw requirements) to the local Quality Management Committee, Quality Community Board meeting, and Community Board of Directors meeting. The focus of the report is to provide a summary of current compliance and action taken if not meeting compliance. This reporting structure will ensure timely communication to the Community Board of Directors for effective oversight of the hospital. **Responsible Person:** Hospital President/CEO	Beginning 11/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vimal Mishra | TITLE: CMO | (X6) DATE: 11/13/2024

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	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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A 043	Continued From page 1 processing of patient remains for a sample of three out of 61 hospital deceased patients (Patient 2, Patient 3, Patient 4) stored at an off-site morgue. Refer to A-0083. These failures contributed to ongoing delays in processing death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage; On 10/4/2024, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first half of 2024. The cumulative effect of these systemic problems resulted in the inability of the hospital to comply with the statutorily mandated Condition of Participation for Governing Body.	A 043	In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date. **Responsible Person:** Director of Quality To immediately correct CFR(s): 482.12(e), regarding the governing body's responsibility for services furnished in the hospital, the Community Board of Directors: • Were informed of the events noted in this CMS investigation regarding the Regional Morgue Office (RMO) services. • Will be updated on the process improvement work and process changes being implemented by the Greater Sacramento Division (GSD) hospitals. These process improvements include documentation by RMO of at least 3 next of kin notification attempts if, upon transfer to the RMO, the next of kin has not been reachable by the hospital prior to transfer to RMO, timely initiation of the death certificate processes upon transfer of the body defined as within 2 business days of death, as well as the current and ongoing status updates of the remains at the off-site morgue. Additionally, the back-log of deceased patients stored at the off-site morgue were reviewed and added to the tracking process implemented for all deceased patients. **Responsible Person:** Hospital President/CEO	Beginning 11/14/2024 08/20/2024 11/21/2024 10/04/2024
A 083	CONTRACTED SERVICES CFR(s): 482.12(e) The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on interview and document review, the	A 083		

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A 083	Continued From page 2 hospital failed to demonstrate the governing body was responsible for services furnished by the Regional Morgue Office (RMO), in the Greater Sacramento Division (GSD), for a sample of three out of 61 deceased patients (Patient 2, Patient 3, and Patient 4) stored in an off-site morgue at time of survey. The Regional Morgue Office failed to: 1. Notify the families of Patient 2, Patient 3, and Patient 4 of their deaths, and complete death certificates per regulatory requirements, 2. Resolve a known back-log of 61 deceased patients stored in an off-site morgue according to the GSD Laboratory Morgue Policy and Procedure. These failures resulted in a delay in completion of death certificates, in notification to families of patient deaths, and in handling the patients' bodies after death. These failures had the potential to prolong distress and grief for families. Findings: 1. During a review of a log kept by the RMO of patient remains in an off-site morgue, the log indicated: a. Patient 2 died on 10/3/2022, family had not been found as of 9/5/2024 per the Public Administrator (PA), the death certificate had not been completed, and Patient 2's remains continued to be stored at the off-site morgue; b. Patient 3 died on 10/21/2022, on 5/23/2024 the PA spoke with Patient 3's family member who requested disposal of remains under county indigent (suffering from extreme poverty) plan,	A 083	To ensure the deficient practice does not recur, the RMO service will be held accountable for the following metrics and will be reported to the Community Board of Directors monthly: • Timeliness of Death Certificate Completion (not to exceed 8 days per State law) • Timelines of body being transferred to preferred mortuary within 8 days of death • Timeliness of Next of Kin Notification (not to exceed 8 days) • Number of bodies at RMO >90 days (goal less that 25%) An annual evaluation of RMO services will be presented to the Community Board of Directors for evaluation of the quality of service. **Responsible Person:** Reported to the Director of Quality by RMO Director of Laboratory As part of the new next of kin notification process, HIPAA compliant scripting for voicemails has been created. This scripting includes the caller leaving a local number for the next of kin to call back. A log will track the date of death, date and time message left, name of the deceased patient and the name of the person who was attempted to be reached. The Administrative Nurse Manager (ANS) can then reference this tracker when/if the next of kin calls back and ensure the correct information on the final disposition and location of the decedent is communicated. This does not change RMO's process of next of kin notification. **Responsible Person:** VP/Chief Nursing Executive	Tracking beginning 11/6/2024 Process started 11/14/2024 Education to be completed 11/22/24 and implemented 11/25/24

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A 083	Continued From page 3 the death certificate had not been completed, and Patient 3's remains continue to be stored at the off-site morgue; and c. Patient 4 died on 12/28/2022, a note indicated Spanish interpreter needed to proceed, the death certificate had not been completed, and Patient 4's remains continue to be stored at the off-site morgue. During an interview on 10/1/2024 at 1:15 p.m. with the Sacramento Market Leader of Laboratory Services: Lab, Cardiopulmonary, & Rehabilitation (SMLLSLCR), SMLLSLCR stated the RMO was responsible for making three attempts to contact family once patient remains left the local hospital. SMLLSLCR stated there was no expected time frame for the contact attempts. SMLLSLCR stated, until recently there was no log to track the attempts. SMLLSLCR stated, if the process fails to yield results, the case should be forwarded to the County Public Administrator, who would attempt to find family, and if none could be found after a diligent search, contact the coroner to pick up the body. SMLLSLCR stated, the Office of the Coroner would attempt to contact family if known family could not be reached. SMLLSLCR stated, records of referrals to the PA and the Coroner's Office had not been kept until recently. SMLLSLCR could not provide documented evidence of referrals to the PA or Coroner. During an interview on 10/2/2024 at 10:20 a.m. with Chairman of the Community Board (CCB) responsible for both the Community Board and the Quality Committee of the Community Board (QCCB), CCB stated the Community Board was comprised of the Chiefs of Staff and Presidents of the hospitals in the GSD, which included four	A 083	In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, compliance with timeliness of next of kin notifications, timeliness of completed death certificates and the length of stay of each body in the offsite morgue will be monitored on a monthly basis until 95% compliance for each metric is achieved for 4 consecutive months and annually thereafter. • Timeliness of Death Certificate: Numerator equals the number of hospital deceased patients overseen by RMO for at least 8 day whose death certificate was completed within 8 days of death / Denominator equals the number of hospital deceased patients transferred from hospital to RMO that remain at RMO for at least 8 days. • Timeliness of Next of Kin notification: Numerator equals number of hospital deceased patients, with known next of kin, overseen by RMO, whose next of kin are notified within 8 days / Denominator equals the number of hospital deceased patients, with known next of kin, overseen by RMO • Number of bodies at RMO >90 days (goal less than 25%): Numerator equals number of bodies remaining at RMO >90 days over a rolling 3 months / Denominator equals number of bodies sent to RMO over the same rolling 3 month period. The report will also detail out the length of stay for each body remaining at PML >90 days. **Responsible Person:** Reported to the Director of Quality by RMO Director of Laboratory	Tracking to begin 11/06/2024 Tracking to begin 11/06/2024 Tracking to begin 11/18/2024 Beginning 11/14/2024

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A 083	Continued From page 4 hospitals. The Community Board reviewed reports from the QCCB Committee. CCB stated they were not aware of prior hospital regulatory violations for failure to process patient remains. During review of the Community Board Meeting minutes for the period of January 2024 to August 2024 meetings, the minutes did not reference any concerns regarding processing patient remains. There was no information regarding untimely completion of death certificates or lack of notification of next of kin of the death of a patient. 2. During an interview on 10/2/2024 at 1:05 p.m. with Supervisor of Lab Support Services (SLSS), SLSS stated she was aware the RMO was failing to timely process patient remains and complete death certificate worksheets beginning in April 2023. SLSS stated, initially she tried to help more with the process in addition to her clinical laboratory duties. SLSS stated the backlog continued; she reported it to the Regional Laboratory Director and Hospital President (HP) in September 2023. SLSS stated "It went nowhere." SLSS stated no log or documents were kept for the Morgue processes until April 2024. During an interview on 10/3/2024 at 3 p.m. with the Regional Director of Laboratory Services (RDLS), RDLS stated he had been aware of the RMO backlog shortly after starting his role three months ago. During an interview on 10/3/2024 at 3:35 p.m. with the Chief Operating Officer (COO), the COO stated he started in his role three and half months ago and the lab reports to him. He was not aware of the back-log of processing human remains within RMO until it was a news story, in August	A 083	To immediately correct QAPI CFR(5): 482.21 and ensure the deficient practice does not recur the Quality Department created a tracker of all State self reported events, as well as regulatory and complaint surveys, that when surveyed, did not meet the statute and were substantiated and regulatory violations were cited dating back to 2021. This tracker includes a summary title of the event,CA number for reference, party responsible for the monitoring of the PoC metrics, details of the accepted PoC monitoring metrics, indication if compliance has been met, then if not yet met, the monitoring start date and metric tracking will be completed. The tracker will be reported on a per meeting (defined as monthly unless canceled or deferred staying within Bylaw requirements) basis to the Quality Management Committee (QMC), Quality Community Board meeting, and Community Board of Directors meeting. This reporting structure will ensure timely communication to the Community Board of Directors for effective oversight of the hospital. The practice since April 2024 has been to track and monitor completion of all survey action items within the Quality department. Moving forward for all new State self reported events and regulatory and complaint surveys, the tracker will list each corrective action and their completion dates. The current practice of reporting all State self reported events, as well as regulatory and complaint survey activity per meeting to Quality Management Committee (QMC), Quality Community Board meeting, and Community Board of Directors meeting, will remain the same. Current practice is to provide a written summary that includes all reported events and regulatory activity since the last meeting occurred. **Responsible Person:** Director of Quality	ongoing 11/14/2024

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A 083	Continued From page 5 2024. COO stated resolving the issues became a priority then. During an interview on 10/3/2024 at 4:15 p.m. with the Hospital President (HP), the HP stated he was legally responsible for all hospital services. HP stated he reports to a GSD Hospital President, but the Healthcare Organization Governing Body had delegated the responsibility of hospital services to him. HP stated he was aware of the failures of the RMO to timely process patient remains and complete the death certificate worksheets in September 2023. HP referred the issues to the GSD President in September 2023. HP stated the GSD President and legal department were working to resolve the issue. HP stated he had not received, nor asked for any updates on solutions. When asked to explain this lack of oversight, HP stated the problem would be addressed at the divisional level; HP stated, "It is not my scope." HP stated he was not aware of the failure to notify families. HP stated, "We assumed the remains being stored did not have families." HP explained the patient populations at the hospital included high numbers of homeless persons. HP stated he never reported the backlog of patient remains processing or family notifications to the Community Board. HP stated that National Board is only notified of regional issues from the Community Board. HP stated "I'm legally and morally responsible for those in the morgue". HP stated he was not aware of previous facility regulatory violations and plans of correction for failure to notify families of patient deaths. HP stated the previous QD notified him that all plans of corrections were completed. HP stated the previous plans of corrections did not have ongoing monitoring. HP stated QD does not have	A 083	In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually checked thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date. **Responsible Person:** Director of Quality To immediately correct Quality Improvement Activities CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3), and ensure the deficient practice does not recur the Quality Department created a tracker of all State self reported events, as well as regulatory and complaint surveys, that did not meet the statute and were substantiated and regulatory violations were cited dating back to 2021. This tracker includes a summary title of the event, CA number for reference, party responsible for the monitoring of the PoC metrics, details of the accepted PoC monitoring metrics, indication if compliance has been met, then if not yet met, the monitoring start date and metric tracking will be completed. Those events without evidence of noted compliance will be audited to validate the current state. If compliance is not met, metrics will be reinstated. The tracker will be maintained on an ongoing basis with all active and new events, and reported on a per meeting basis to the Quality Management Committee (QMC), Quality Community Board meeting, and Community Board of Directors meeting. The focus of the report is to provide a summary of current compliance and action taken if not meeting compliance. This reporting structure will ensure timely communication to the Community Board of Directors for effective oversight of the hospital.	Beginning 11/11/2024

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A 083	Continued From page 6 a direct line of reporting to him. In a concurrent interview and document review of the GSD Laboratory Morgue Policy and Procedure, approved 3/1/2022, with the SLSS on 10/3/2024 at 1 p.m., the document indicated processes for handling abandoned bodies and bodies with no next of kin. The document indicated the RMO should contact the public administrator and coroner when family could not be reached, or found, or the next of kin did not have resources to cremate or bury the body. The SLSS stated there was no documented evidence these agencies were contacted for assistance. In a document review of the Patient Safety Program Annual Summary and Evaluation for Fiscal Year 2023, which details categories of adverse events reported during the year, any regulatory findings, and active and completed plans of correction, submitted September 2023 to the Community Board, the document did not include documentation of the gaps in patient notification, death certificate processing according to legal requirements, or delay in handling patient remains. In a concurrent interview and record review of the newly created log of patient remains in off-site morgue storage, last updated 10/3/2024, with the QD on 10/3/2024 at 4:45 p.m., the QD confirmed the log indicated 11 bodies have been in storage since 2022, 15 bodies have been in storage since 2023, and 19 bodies have remained in storage from 1/1/2024 to 6/30/2024. The log indicated there were 61 patient remains in the off-site morgue on 10/3/2024.	A 083	In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually checked thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date. **Responsible Person:** Director of Quality Additionally, to correct and ensure the deficient practice related to the focus on removal of central venous catheters, the Critical Care team will be reeducating critical care nurses on the importance of necessity evaluation for central lines. Education will be assigned to all ICU registered nurses (RN) via Pathways. Effective 11/11/2024, prior to transferring out of the ICUs, each patient with a central line (excluding cardiac surgery patients) will have the "Review of Central Line Necessity Prior to transfer to med/surg/tele floor" completed. If a necessity indicator is not met, the RN will discuss removal with the provider. These forms will be submitted to the Manager for review, tracking and trending for potential PI work. **Responsible Person:** Senior Director of Critical Care In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, ICUs will monitor the number of patients transferring out of the ICUs to a med/surg/tele unit with a central line (excluding cardiac surgery patients). The goal is 95% of the patients transferring out of the ICUs to a med/surg/tele unit with a central line (excluding PICCs) will have an approved indication for use. The data will be monitored on a monthly basis until compliance is achieved and sustained for four (4) consecutive months. **Responsible Person:** VP Chief Nursing Officer	
A 263	QAPI	A 263		

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A 263	Continued From page 7 CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program that reflected the complexity of the hospital's organization and services for a census of 367 patients in a hospital bed capacity of 384, as evidenced by: A. The hospital QAPI program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations related in part to family notification of patient death and processing of the bodies of deceased patients, and the implementation of a process change for central venous catheter (a thin flexible tube that is	A 263		

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A 263	Continued From page 8 inserted into a vein and guided into a large vein above the right side of the heart) removal. Refer to A0283. These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement andf ongoing failures. The cumulative effect of these systemic problems resulted in the inability of the Hospital to comply with the statutorily mandated Condition of Participation for QAPI.	A 263		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

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A 283	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation, interviews, and record reviews, the hospital Quality Assessment and Performance Improvement (QAPI) Program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained when there was no documented evidence of implementation and completion for: 1. The Plan of Correction (POC, an action plan submitted by a hospital to a State Agency to correct a cited regulatory violation) for intake CA00511685, dated April 2022, indicated plans to educate staff regarding accuracy of family contact information in chart, timely notification of death to next of kin by physician and physician's timely completion of deceased patient's charts including the summary of hospital course and discharge summary. Additionally, the Quality Program Manager (QPM) was responsible for verification through chart audits and providing semiannual reporting of audit for integration into the QAPI process. The timeframe indicated on the POC stated "reporting will continue until four consecutive audit results are 100% excluding months with no cases". 2. The POC for intake CA00747251, dated July 2023, indicated the development of an education module for the Pathology (study of disease) Laboratory and Administrative Nursing Supervisor staff covering the steps to take after the death of a patient to ensure dignity and respect, following federal and state regulatory requirements and including responsible staff tasks. This POC would be verified by Quality and Patient Safety Program	A 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 283	Continued From page 10 Manager (QPSPM) with chart audits meeting measurable goals until "three consecutive months of goal performance was achieved". 3. A performance improvement project, dated 6/8/2023, identified by the Quality Management Committee (QMC) as a targeted area for improvement, focused on the removal of central venous catheters (CVC, a thin flexible tube that is inserted into a vein and guided into a large vein above the right side of the heart) prior to transfer to lower level of care (intensive care unit to medical or surgical units) to reduce the risk of CVC related patient adverse events. These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement. Findings: 1. During a review of the POC for intake CA00511685, dated April 2022, the POC included the following corrective actions, in part: a. Education provided to medical staff on contacting and documenting family notification of death. b. Department managers provided education to hospital staff about the importance of accuracy of information in the medical record, including contact numbers. c. Developed an auditing and reporting process to evaluate the accuracy of telephone numbers listed as contacts in the medical record. d. Scheduled semiannual reporting and of audit results to the QMC of the medical staff for integration into the established QAPI process. 2. During a review of the POC for intake	A 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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A 283	Continued From page 11 CA00747251, dated July 2023, the POC included the following corrective actions, in part: a. Development of an education module for Pathology Laboratory and Administrative Nursing Supervisors to include at time of death the patient will be cared for with dignity and respect, in accordance with federal and state regulatory requirements, the location of Notifications of Death Form, the documentation of deceased patient in morgue logbook and identify who is provided access to the morgue. b. Retrospective chart audits performed by QPSM to verified that patients were deposited in the morgue with the appropriate documentation. This audit was to continue until 3 consecutive months of goal performance of 100% compliance was achieved. During a review of the hospital QAPI plans, dated fiscal year 2023 and fiscal year 2024, the QAPI plans did not include any documented evidence of implementation of corrective actions identified in the POCs or evidence of tracking of performance improvement. During a concurrent interview and record review on 10/1/24, at 11:05 a.m., with the Quality Director (QD), the QD was provided a copy of the POCs for intakes CA00511685 and CA00747251. After reviewing the POCs, the QD stated, "I am not familiar with these POCs ...will research ...these were before I started and there was no handoff to me [from previous staff]". During an interview on 10/3/24, at 1:20 p.m., with the QD, the QD stated, "I have not been able to locate data for either POC". The QD stated, "No one was working on these [POCs], there is no data to provide implementation and tracking." The	A 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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A 283	Continued From page 12 QD confirmed there was no documented evidence the interventions in the POCs, that were dated April 2022 and July 2023 respectively, were monitored for success and sustained compliance per hospital QAPI plan and regulatory requirements. 3. During an interview on 10/3/24, at 11:45 a.m., with Critical Care Nurse Educator (CCNE), the CCNE stated, they are working on a performance improvement project (PIP) to remove CVC before the patient is transferred to the medical or surgical floor. The CCNE stated, starting in February of 2023, the QMC started to investigate CVC line removal before transfer to a lower level of care as a quality indicator. The CCNE stated the nursing staff had been educated via Pathways (an online learning module the hospital utilizes to educate nurses) to a new vascular (vein) access policy, which included a skills module for vascular access care and removal. This module was assigned on 3/9/23 with a due date of 4/30/23. When asked about how many patients were being sent to the medical/surgical floor with CVC for this PIP the CCNE stated, "We are not tracking the data." During a review of QMC minutes, dated June 2023, the QMC indicated the need to remove CVCs prior to transfer to a lower level of care. During a concurrent observation and interview of the 5C Trauma medical surgical and telemetry (continuous monitoring of heart activity) unit, on 10/3/24, at 10:20 a.m., with the QD, the QD stated the unit was focused on monthly report cards (an infographic that is posted on a bulletin board for all staff to see). The only PIP that was observed posted in the unit was for patient falls.	A 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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A 283	Continued From page 13 The QD stated that she did not see evidence of a PIP for CVC removal.	A 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050516	A. BUILDING _____ B. WING _____	R-C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY SAN JUAN MEDICAL CENTER	6501 COYLE AVE CARMICHAEL, CA 95608

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{A 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a federal complaint validation revisit survey for complaint number CA00912399. The sample size was 21. The facility was found to be in substantial compliance with 42 CFR, Part 482.23 Nursing Services Condition of Participation for Hospitals, effective October 4, 2024.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EXHIBIT 4

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY OF SACRAMENTO
DEPARTMENT OF HEALTH SERVICES

3052023297425 — STATE FILE NUMBER

CERTIFICATE OF DEATH
STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 3/06)

3202334014035 — LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

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

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months	Days	IF UNDER 24 HOURS Hours	Minutes	6. SEX
08/15/1991	31					F

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP* (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
UNK	UNK	☐ YES ☐ NO ☒ UNK	UNKNOWN	04/08/2023	1627

13. EDUCATION – Highest Level/Degree (see worksheet on back)	14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
UNKNOWN	☐ YES UNKNOWN ☐ NO	UNKNOWN

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

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location): UNK

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
UNK	UNK	UNK	UNK	UNK

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
PHIL MANNING, FUNERAL DIRECTOR	35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP*–FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
UNKNOWN	UNKNOWN	UNKNOWN	
31. NAME OF FATHER/PARENT–FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
UNKNOWN	UNKNOWN	UNKNOWN	UNK
35. NAME OF MOTHER/PARENT–FIRST	36. MIDDLE	37. LAST (BIRTH NAME)	38. BIRTH STATE
UNKNOWN	UNKNOWN	UNKNOWN	UNK

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION
04/05/2024	CREMATIONS ONLY 35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

41. TYPE OF DISPOSITION(S)	42. SIGNATURE OF EMBALMER	43. LICENSE NUMBER
TEMPORARY ENVAULTMENT	▸ NOT EMBALMED	-

44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER	46. SIGNATURE OF LOCAL REGISTRAR	47. DATE mm/dd/ccyy
CREMATIONS ONLY	FD2208	▸ OLIVIA KASIRYE MD	04/05/2024

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
MERCY SAN JUAN MEDICAL CENTER	☒ IP ☐ ER/OP ☐ DOA	☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SACRAMENTO	6501 COYLE AVENUE	CARMICHAEL

CAUSE OF DEATH

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

		Time Interval Between Onset and Death	108. DEATH REPORTED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(A) CARDIOPULMONARY ARREST	(AT) MINS	☒ YES ☐ NO REFERRAL NUMBER 24-01669
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B) METABOLIC VS TOXIC ENCEPHALOPATHY	(BT) DAYS	109. BIOPSY PERFORMED? ☐ YES ☒ NO
	(C) DIABETIC KETOACIDOSIS	(CT) DAYS	110. AUTOPSY PERFORMED? ☐ YES ☒ NO
	(D) INSULIN-DEPENDENT DIABETES	(DT) YEARS	111. USED IN DETERMINING CAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107:
CARDIOMYOPATHY WITH LAST KNOWN EJECTION FRACTION OF 45 PERCENT LIKELY SECONDARY TO METHAMPHETAMINE SUBSTANCE ABUSE, PROTEIN CALORIE MALNUTRITION

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.): NO

113A. DECEDENT PREGNANT IN LAST YEAR? ☐ YES ☒ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.

(A) Decedent Attended Since mm/dd/ccyy	(B) Decedent Last Seen Alive mm/dd/ccyy
04/06/2023	04/08/2023

115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
▸ NADEEM MUKHTAR, DO	20A17283	04/04/2024

118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE: NADEEM MUKHTAR, DO
6501 COYLE AVE, CARMICHAEL, CA 95608

CORONER'S USE ONLY

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

120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
☐ YES ☐ NO ☐ UNK		

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

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

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

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸		

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

AMENDED 1 OF 3

CERTIFIED COPY OF VITAL RECORDS
STATE OF CALIFORNIA, COUNTY OF SACRAMENTO

This is a true and exact reproduction of the document officially registered and placed on file with Sacramento County Department of Health Services.

002216535

DATE ISSUED May 21, 2024

Olivia Kasirye MD

OLIVIA KASIRYE, MD
LOCAL REGISTRAR

This copy is not valid unless prepared on an engraved border, displaying the date, seal and signature of the Registrar.

PBNCD (REV) 09/18

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT 5

BARRY VOGEL, STATE BAR NO. 108640
Bvogel@ljdfa.com
SCOTT W. FOLEY, STATE BAR NO. 278357
SFoley@ljdfa.com
LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES
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Sacramento, California 95825-6746
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Attorneys for Defendants
COMMONSPIRIT HEALTH and DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER; A DIVISION OF COMMON SPIRIT

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

GINGER CONGI, ANGIE RUBINO, CHANDRA PETERSON-CHASTAIN AND JESSIE PETERSON, via her estate, individually, Plaintiffs, vs. DIGNITY HEALTH, d/b/a MERCY SAN JUAN MEDICAL CENTER; a division of COMMON SPIRIT and DOES 1-50, inclusive, Defendants.	CASE NO.: 24CV015815 **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S SPECIAL INTERROGATORIES, SET ONE** TRIAL DATE: None Set ACTION FILED: 08/07/2024

PROPOUNDING PARTY: Plaintiff, GINGER CONGI

RESPONDING PARTY: Defendant, DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER

SET NUMBER: ONE

Defendant, DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER (hereinafter, "Defendant"), hereby answers, objects, or otherwise responds to Plaintiff, GINGER CONGI'S (hereinafter, "Plaintiff") Special Interrogatories, Set One, served on November 18, 2024, pursuant to Code of Civil Procedure section 2030.030, as follows:

/ / /

PRELIMINARY STATEMENT

These responses are made solely for the purpose of this action. Each answer is subject to all objections as to competence, relevance, materiality, propriety and admissibility, and any and all other objections and grounds which would require the exclusion of any statement herein if the Interrogatories were asked of, or any statements contained herein were made by, a witness present and testifying in Court, all of which objections and grounds are reserved and may be interposed at the time of trial.

Defendant has not completed its investigation of the facts relating to this case and has not completed its preparation for trial. The following responses are based upon information presently available to Defendant and are made without prejudice to Plaintiff of the right to utilize subsequently discovered facts.

Except for explicit facts admitted herein, no incidental or implied admissions are intended hereby. The fact that Defendant has answered any interrogatories should not be taken as an admission that Defendant accepts or admits the existence of any facts set forth or assumed by such interrogatory, or that such response constitutes admissible evidence. The fact that Defendant has answered part or all of any interrogatory is not intended and shall not be construed to be a waiver by Defendant of all or any part of any objection to any interrogatory made by Plaintiff.

Defendant objects to the Interrogatories to the extent they call for the disclosure of any information which is protected from discovery by the attorney-client privilege and/or the attorney work product doctrine.

The Preliminary Statement is incorporated into each of the responses set forth below.

RESPONSES TO SPECIAL INTERROGATORIES

SPECIAL INTERROGATORY NO. 1:

Describe the relationship between YOU and Mercy San Juan Medical Center.

(For this and all subsequent interrogatories, the terms "YOU" and "YOUR" refer to defendant Dignity Health doing business as Mercy San Juan Medical Center.)

/ / /

RESPONSE TO SPECIAL INTERROGATORY NO. 1:

Mercy San Juan Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

SPECIAL INTERROGATORY NO. 2:

Describe the relationship between YOU and COMMON SPIRIT.

(For this and all subsequent interrogatories, the term "COMMON SPIRIT" refers to defendant Common Spirit.)

RESPONSE TO SPECIAL INTERROGATORY NO. 2:

In February 2019, Dignity Health and Catholic Health Initiatives merged as CommonSpirit Health and created a new, nonprofit health system.

SPECIAL INTERROGATORY NO. 3:

Identify the person that removed Jessie Peterson's center line on April 8, 2023.

RESPONSE TO SPECIAL INTERROGATORY NO. 3:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

On April 8, 2023, Jessie Peterson attempted to remove her central line on her own and Nurse Nicole McCarver completed the process of removing the central line.

SPECIAL INTERROGATORY NO. 4:

Identify each person that attempted to contact Ginger Congi after Jessie Peterson's death on April 8, 2023.

RESPONSE TO SPECIAL INTERROGATORY NO. 4:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond. See Exhibit 2 attached to defendant's answer to the complaint, which is a copy of a Call Detail Records Search report, for documentation of the phone calls made by defendant's employees to Ginger Congi after Jessie Peterson's death.

SPECIAL INTERROGATORY NO. 5:

State the date YOU first became aware of the contact information of Jessie Peterson's next of kin.

RESPONSE TO SPECIAL INTERROGATORY NO. 5:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Jessie Peterson provided defendant with emergency contact information at least as early as 2021. However, the person Ms. Peterson identified as her emergency contact changed multiple times between 2021 and the time of her death in April 2023. Ms. Peterson identified her mother as her emergency contact during multiple visits to Mercy San Juan in 2021 and 2022, but changed her emergency contact to her sister on December 2, 2022, a friend on December 28, 2022, and back to her mother in early January 2023. Ms. Peterson's mother was listed as her emergency contact at the time of her death.

SPECIAL INTERROGATORY NO. 6:

Identify the person or persons responsible for the preparation of Certificates of Death at Mercy San Juan Medical Center.

RESPONSE TO SPECIAL INTERROGATORY NO. 6:

"A funeral director, or person acting in lieu thereof, shall prepare the [death] certificate and register it with the local registrar." (Health & Safety Code, § 102780.) If a decedent's next of kin does not respond to phone calls, defendant's employees with Decedent Affairs assist with preparation of the death certificate. Laura Lukin is the supervisor of defendant's Decedent Affairs.

SPECIAL INTERROGATORY NO. 7:

Describe Jessie Peterson's condition upon being admitted to Mercy San Juan Medical Center on April 6, 2023.

RESPONSE TO SPECIAL INTERROGATORY NO. 7:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

On April 6, 2023, Jessie Peterson was taken by ambulance to Mercy San Juan Medical Center's emergency department. Dr. Elliott Penna assessed Ms. Peterson in the emergency department and documented "hyperglycemia" as the chief complaint. He documented the following under the heading "Subjective Nursing Assessment": "pt. BIBA reporting hyperglycemia kussmaul respirations noted bgl 477." He documented the following under "History of Present Illness": "This is a 31-year-old female with history of DKA, polysubstance abuse, type 1 diabetes and homelessness presenting today with altered mentation. Bystanders called 911 as patient was found outside of 911 minimally responsive. Blood glucose 477 for EMS. Patient does not reliably answer questions." Dr. Penna's note includes documentation of Ms. Peterson's vital signs at 1959, which were blood pressure 135/110, heart rate 105, respiratory rate 17, oxygen saturations 100% on room air, and temperature 36.0° Celsius. Under the heading "Physical Exam," Dr. Penna documented the following: "Const: Patient curled in a ball on the stretcher, she is awake but confused and not readily answering questions [¶] Eyes: Able to track appropriately. Pupils appear 3-4mm [¶] HENT: NCAT, patient moving neck actively with no appeared [*sic*] pain or stiffness [¶] CV: Tachycardic. Warm, well-perfused extremities [¶] RESP: Unlabored respiratory effort [¶] GI: no distention or pain with movement [¶] MSK: Diffuse muscle wasting. Large joint range of motion intact with no obvious acute deformity [¶] Skin: Cool extremities [¶] Neuro: Alert, oriented x1. Moving all 4 extremities without obvious acute focal deficits however patient is severely confused, GCS 13 [¶] Psych: Withdrawn"

SPECIAL INTERROGATORY NO. 8:

Describe the financial arrangement between Mercy San Juan and Cremations Only for the storage of human bodies.

RESPONSE TO SPECIAL INTERROGATORY NO. 8:

Mortuary Support Services of Northern California LLC owns and operates Cremations Only, which is a licensed funeral establishment in Sacramento, and Sacramento Mortuary Transport ("SMT"), which is a mortuary transport and storage company. SMT operates a facility in which human bodies can be stored pending disposition. Defendant does not have a financial arrangement with Cremations Only.

SPECIAL INTERROGATORY NO. 9:

Identify the number of human bodies that Mercy San Juan current has in storage at Cremations Only.

RESPONSE TO SPECIAL INTERROGATORY NO. 9:

Mortuary Support Services of Northern California LLC owns and operates Cremations Only, which is a licensed funeral establishment in Sacramento, and Sacramento Mortuary Transport ("SMT"), which is a mortuary transport and storage company. SMT operates a facility in which human bodies can be stored pending disposition. Defendant does not have any human bodies stored at Cremations Only. As of January 30, 2025, there were 73 decedent bodies being stored at SMT for defendant.

SPECIAL INTERROGATORY NO. 10:

With respect to the response to Interrogatory No. 9, identify the name of each person held in storage at Cremations Only.

RESPONSE TO SPECIAL INTERROGATORY NO. 10:

Objection. This interrogatory seeks information that is protected by HIPAA and third parties' rights to privacy.

SPECIAL INTERROGATORY NO. 11:

With respect to the response to Interrogatory No. 9, identify how long each human body has been in storage at Cremations Only.

RESPONSE TO SPECIAL INTERROGATORY NO. 11:

Objection. This interrogatory seeks information that is protected by HIPAA and third parties' rights to privacy.

SPECIAL INTERROGATORY NO. 12:

Describe in complete detail the circumstances surrounding Jessie Peterson's death, including everything that caused her death.

RESPONSE TO SPECIAL INTERROGATORY NO. 12:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. In addition, it calls for expert opinion. Without waiving these

objections, defendant responds as follows:

Jessie Peterson began using drugs when she was 17 years old. She continued to struggle with illicit drug use—methamphetamines, heroin, fentanyl, and others—until her death 14 years later. In addition, she was unhoused for at least the last 11 years of her life and had trouble managing her insulin-dependent, type 1 diabetes. Due to the combination of being unhoused, insulin-dependent, and addicted to recreational drugs, Ms. Peterson found herself delivered to Mercy San Juan's emergency department on several occasions in 2021, 2022, and 2023, often with severe diabetic ketoacidosis. However, she typically left the hospital against medical advice ("AMA") once she started feeling better.

On March 30, 2023, bystanders observed Ms. Peterson on the side of the road confused and with an altered mental status, so they called 911. An ambulance transported Ms. Peterson to the Mercy San Juan emergency department where she was intubated due to respiratory failure. She was found to be in diabetic ketoacidosis with elevated blood sugar levels in the 700s with severe subcutaneous fat wasting in the orbital region and triceps as well as severe muscle wasting of the calves, thighs, temples, clavicle, and acromion bone region. On March 31, 2023, a case manager called Ms. Congi on the phone using the same number that was listed as Ms. Peterson's emergency contact at the time of her death. Ms. Congi confirmed Ms. Peterson was unhoused, but she said she did not know much about her daughter because she had not had any contact with her for a few months. On April 1, 2023, after extubation, Ms. Peterson left the hospital AMA after telling a physician she felt fine and had her diabetic supplies at home.

On April 6, 2023, bystanders observed Ms. Peterson was minimally responsive and called 911. The ambulance took Ms. Peterson to the Mercy San Juan emergency department with altered mentation, a blood glucose level of 477, and diffuse muscle wasting. The emergency department physician placed a central venous catheter for fluids and drug administration. Blood work revealed metabolic acidosis and severely elevated blood sugar levels consistent with diabetic ketoacidosis. Ms. Peterson was started on diabetic ketoacidosis protocol, including an insulin drip, and was started on vancomycin due to wounds on her feet. She was put in soft restraints to prevent her from pulling on any lines or tubes.

On April 7, 2023, Ms. Peterson was still very disoriented and could not hold a conversation. A nurse called Ms. Congi on the phone but there was no answer.

On April 8, 2023, at 1243, Ms. Peterson was alert and oriented when she spoke to a social worker, reported continuing to be unhoused, and said she had nowhere to go at discharge but was open to going to a shelter if a bed was available. She confirmed that her mother was her emergency contact. Later that day, a nurse noted that Ms. Peterson asked for a snack and became upset when the nurse told her she would have to wait an hour to eat because her blood sugar level was too high. Ms. Peterson screamed that she was going to leave AMA and said she wanted her lines out. Ms. Peterson attempted to pull her central venous catheter out and succeeded in removing about one-fourth of it before the nurse could get to her and safely remove it intact. Ms. Peterson became obtunded less than five minutes later. The nurse called a code blue and CPR was initiated, but Ms. Peterson did not survive and was pronounced dead at 1627.

Defendant does not know what caused Ms. Peterson's death. However, the cause of death listed on her death certificate is "cardiopulmonary arrest[,]" "metabolic vs toxic encephalopathy[,]" "diabetic ketoacidosis[,]" and "insulin-dependent diabetes[.]" Other significant conditions contributing to her death that were listed on her death certificate are "cardiomyopathy with last known ejection fraction of 45 percent likely secondary to methamphetamine substance abuse, protein calorie malnutrition[.]"

SPECIAL INTERROGATORY NO. 13:

Describe in complete detail the circumstances surrounding the transfer of Jessie Peterson's body to an offsite storage facility following her death.

RESPONSE TO SPECIAL INTERROGATORY NO. 13:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Jessie Peterson passed away on April 8, 2023, at 1627 while a patient at Mercy San Juan Medical Center. Her body was taken to the hospital morgue at approximately 2000 and stored there for a day. On April 9, 2023, Mercy San Juan released Ms. Peterson's body to Sacramento Mortuary Transport ("SMT") for storage at SMT's facility.

SPECIAL INTERROGATORY NO. 14:

IDENTIFY all offsite storage facilities where YOU stored Jessie Peterson's body after her death. (For this interrogatory the term "IDENTIFY" means to state the name, address, and telephone number of the storage facility.)

RESPONSE TO SPECIAL INTERROGATORY NO. 14:

Sacramento Mortuary Transport.

SPECIAL INTERROGATORY NO. 15:

IDENTIFY all persons employed by or associated with each offsite storage facility identified in response to Special Interrogatory No. 13 with whom YOU communicated between April 8, 2023, to present.

(For this and all subsequent interrogatories, the terms "IDENTIFY" and "IDENTITY" when used in connection with natural persons, means to state the name, address, phone number, and job title of that person.)

RESPONSE TO SPECIAL INTERROGATORY NO. 15:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond.

SPECIAL INTERROGATORY NO. 16:

Describe all COMMUNICATIONS between YOU and each person identified in response to Special Interrogatory No. 14 related to Jessie Peterson.

(For this and all subsequent interrogatories, the terms "COMMUNICATION," "COMMUNICATIONS" and "COMMUNICATED" means any oral, written or electronic transmission of information, including but not limited to meetings, discussions, conversations, telephone calls, telegrams, memoranda, letters, telecopies, telexes, conferences, messages, notes, or seminars.)

RESPONSE TO SPECIAL INTERROGATORY NO. 16:

The only communication defendant had with Sacramento Mortuary Transport was to contact them (most likely by phone) to let them know that defendant had need of their services to transport and store a decedent.

SPECIAL INTERROGATORY NO. 17:

Describe YOUR policies and procedures related to the transfer of dead bodies to offsite storage facilities in effect between January 1, 2019, to the present.

RESPONSE TO SPECIAL INTERROGATORY NO. 17:

See the policy attached to defendant's response to plaintiffs' request for production of documents, set one, as Exhibit 5, which is titled "Greater Sacramento Division Laboratories Morge Policy and Procedure."

SPECIAL INTERROGATORY NO. 18:

Identify the person that reported the death of Jessie Peterson to the Coroner.

RESPONSE TO SPECIAL INTERROGATORY NO. 18:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Nurse Nicole McCarver.

SPECIAL INTERROGATORY NO. 19:

Describe in detail all attempts YOU made to contact Jessie Peterson's next of kin to inform them of Jessie Peterson's death on or after April 8, 2023, including the IDENTITY of the person who attempted the contact, the date of the attempted contact, and the method of the attempted contact.

RESPONSE TO SPECIAL INTERROGATORY NO. 19:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

On April 8, 2023, a Mercy San Juan Medical Center nurse called a code blue because Jessie Peterson became obtunded. CPR was initiated, but Ms. Peterson did not survive and was pronounced dead at 1627. During the code blue at approximately 1545 and 1546, a chaplain named Perry Mayforth attempted to contact Ms. Peterson's mother, Ginger Congi, via phone by calling the phone number listed as Ms. Peterson's emergency contact and which had been used successfully to speak with Ms. Congi just eight days earlier. Nurse Brenda Jensen and possibly other unknown hospital employees attempted to contact Ms. Congi via phone on April 8, 2023,

at 1726, 1727, 1731, 1740, 2245, and 2246 and on April 9, 2023, at 0026, 0027, 0031, and 0040 by calling the same phone number that was used by Mr. Mayforth.

SPECIAL INTERROGATORY NO. 20:

IDENTIFY the person who was responsible for ensuring that Jessie Peterson's next of kin was notified of her death.

RESPONSE TO SPECIAL INTERROGATORY NO. 20:

A Mercy San Juan Medical Center employee—a nurse, a chaplain, or a social worker—or the attending physician at the time of death or his or her representative.

SPECIAL INTERROGATORY NO. 21:

Describe in detail YOUR policies and procedures as of April 8, 2023, for informing the next of kin of a patient's death.

RESPONSE TO SPECIAL INTERROGATORY NO. 21:

See the applicable policies attached to defendant's response to plaintiffs' request for production of documents, set one, as Exhibit 5. The policies are titled "Post-Mortem Care," "Greater Sacramento Division Laboratories Morge Policy and Procedure," "Death Pronouncement," and "Morgue Policy and Procedure." See also "Mercy San Juan Medical Center Medical Staff Rules and Regulations" at page 14, section VII.D.

SPECIAL INTERROGATORY NO. 22:

IDENTIFY the physician who was responsible for issuing a Certificate of Death for Jessie Peterson in accordance with Health & Safety Code section 102800.

RESPONSE TO SPECIAL INTERROGATORY NO. 22:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

The physician attending to Jessie Peterson at the time of her death, which was Dr. Nadeen Mukhtar. Or, if the attending physician was unable to pronounce Ms. Peterson's death, the emergency department physician on shift at the time of Ms. Peterson's death.

SPECIAL INTERROGATORY NO. 23:

Describe in complete detail YOUR policies and procedures as of April 8, 2023, for issuing

a Certificate of Death following the death of a patient.

RESPONSE TO SPECIAL INTERROGATORY NO. 23:

See the applicable policies attached to defendant's response to plaintiffs' request for production of documents, set one, as Exhibit 5. The policies are titled "Post-Mortem Care" and "Greater Sacramento Division Laboratories Morge Policy and Procedure." See also "Mercy San Juan Medical Center Medical Staff Rules and Regulations" at page 15, section VII.F.

SPECIAL INTERROGATORY NO. 24:

Describe in complete detail YOUR policies and procedures as of April 8, 2023, for reporting a patient's death in an Electronic Death Registration System.

RESPONSE TO SPECIAL INTERROGATORY NO. 24:

See the applicable policy attached to defendant's response to plaintiffs' request for production of documents, set one, as Exhibit 5. The policy is titled "Greater Sacramento Division Laboratories Morgue Policy and Procedure."

SPECIAL INTERROGATORY NO. 25:

State whether YOU reported Jessie Peterson's death in an Electronic Death Registration System.

RESPONSE TO SPECIAL INTERROGATORY NO. 25:

Yes.

SPECIAL INTERROGATORY NO. 26:

If your response to Special Interrogatory No. 24 is in the affirmative, describe all circumstances surrounding YOUR report of Jessie Peterson's death in the Electronic Death Registration System, including but not limited to the date the report was made and the IDENTITY of the person who made the report.

RESPONSE TO SPECIAL INTERROGATORY NO. 26:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond. However, defendant believes the report would have been done by Trish Hunt with defendant's Decedent Affairs or a Sacramento Mortuary Transport employee.

SPECIAL INTERROGATORY NO. 27:

IDENTIFY the person that GINGER CONGI spoke to on April 11, 2023, as described in paragraph 22 of the COMPLAINT.

(For this and all subsequent interrogatories, the term "GINGER CONGI" means plaintiff Ginger Congi.)

RESPONSE TO SPECIAL INTERROGATORY NO. 27:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond.

SPECIAL INTERROGATORY NO. 28:

State YOUR policies and procedures for recording or tracking incoming calls to Mercy San Juan Medical Center between April 8, 2023, and April 18, 2024.

RESPONSE TO SPECIAL INTERROGATORY NO. 28:

See the applicable policy attached to defendant's response to plaintiffs' request for production of documents, set one, as Exhibit 7. The policy is titled "Record Retention."

SPECIAL INTERROGATORY NO. 29:

Explain in detail why a Certificate of Death was not issued for Jessie Peterson until April 4, 2024.

RESPONSE TO SPECIAL INTERROGATORY NO. 29:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

While investigation of this matter by counsel for the defendant is not complete, there are several reasons why the defendant failed to reach its goal of timely disposition of the remains of decedent, not the least of which is the fact that it appears at this stage of litigation, prior to the depositions of decedent's next of kin, that decedent's mother may have intentionally not responded to 12 calls over the course of two days from the hospital to her phone, which had been a working number for her as little as 8 days earlier, and that she did this because her relationship with the decedent had deteriorated to the point that she wanted no involvement with the decedent, apparently because the decedent had developed a substance abuse problem which made a normal

mother daughter relationship unachievable. If she had answered the phone, there would not have been the delays that ensued. As described already in response to Special Interrogatory No. 12 and described more fully in response to Special Interrogatory No. 30, decedent's mother had picked up the phone several times when called on the same number in the context of treatment for decedent on January 8, 2021, November 1, 2021, November 20, 2022, January 13, 2023, and March 31, 2023. Also, per the records, decedent informed a social worker in November 2022 and/or December 2022 that she and her mother were estranged and on March 31, 2023, a case manager documented that the mother said she did not know much about decedent because they had not had any contact for a few months. Regardless of whether investigation and discovery in this matter reveals that decedent's mother did intentionally not answer the many calls made from the hospital to her phone seeking to notify her of the death of her daughter, it appears that a severe backlog in processing remains which began with the unprecedented surge in U.S. deaths from COVID-19, combined with coinciding staffing challenges within the defendant's organization, constitutes the rest of the explanation for the delay, but as already stated, fact investigation in the context of this lawsuit is continuing.

SPECIAL INTERROGATORY NO. 30:

Describe all COMMUNICATIONS between YOU and GINGER CONGI.

RESPONSE TO SPECIAL INTERROGATORY NO. 30:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

On January 8, 2021, Nurse Joreen Yabut documented a phone conversation with Ginger Congi related to consent for surgery on behalf of Jessie Peterson.

On November 1, 2021, Nurse Maricel Sison documented that she had spoken to Ms. Congi on the phone and Ms. Congi said she would visit Ms. Peterson in the hospital the following day.

On November 20, 2022, a social worker named Leslie Pearson documented a phone conversation with Ms. Congi wherein Ms. Congi "reported pt has a significant history of substance abuse. She said she spoke to pt about a week ago as pt told her she needed glasses. She said she speaks to pt when she is in the hospital. Mother reported that pt has been to treatment

several times but starts feeling better and uses again. She does not think pt will want to go to treatment. Mother said they have no control over pt and she is aware that due to pt's lifestyle and diabetes she is at risk of dying. She said she is not aware of pt being diagnosed with a mental health illness, however said she feels she most likely does have a mental health illness. She said about two years ago pt made a comment that she wanted to run into traffic. She said pt has not had any suicide attempts and tells her she does not want to die. Mother said pt will most likely start feeling better and leave AMA."

On January 13, 2023, Ms. Pearson documented the following with respect to a phone conversation with Ms. Congi: "SW spoke to pt's mother who was aware pt was at the hospital. She said pt is addicted to drugs and she is hopeful pt will get help, but said she is non-compliant. Mother to come visit pt tomorrow at the hospital."

On January 14, 2023, Nurse Ron Rodriguez documented that when he discussed the plan of care and treatment with Ms. Peterson, Ms. Congi was present at the bedside.

On March 31, 2023, a case manager named Donna Cowin documented that she had spoken to Ms. Congi on the phone and documented the following: "she [Ms. Congi] has not had contact w/ pt for a few months" and Ms. Congi "states that she does not know much about her daughter and has not had contact with her for a few months."

SPECIAL INTERROGATORY NO. 31:

IDENTIFY each person employed by or in any way affiliated with Mercy San Juan Medical Center with whom GINGER CONGI COMMUNICATED between April 8, 2023, to present.

RESPONSE TO SPECIAL INTERROGATORY NO. 31:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond. Defendant does not have any documentation of any such communications.

SPECIAL INTERROGATORY NO. 32:

For each person identified in response to Special Interrogatory No. 30, describe in detail each COMMUNICATION between that person and GINGER CONGI from April 8, 2023, to

present, including but not limited to the date and substance of each COMMUNICATION.

RESPONSE TO SPECIAL INTERROGATORY NO. 32:

After making a reasonable and good faith effort to obtain the requested information, defendant does not have personal knowledge sufficient to respond. Defendant does not have any documentation of any such communications.

SPECIAL INTERROGATORY NO. 33:

Describe the relationship between YOU and East Lawn Mortuary.

RESPONSE TO SPECIAL INTERROGATORY NO. 33:

There is no relationship between defendant and East Lawn Mortuary.

SPECIAL INTERROGATORY NO. 34:

Describe all COMMUNICATIONS between YOU and East Lawn Mortuary related to Jessie Peterson.

RESPONSE TO SPECIAL INTERROGATORY NO. 34:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Jessie Peterson's family selected East Lawn Mortuary for release of her body. Any communication between defendant and East Lawn would have been related to the logistics of releasing decedent to East Lawn.

SPECIAL INTERROGATORY NO. 35:

Describe in detail all complaints received by YOU from January 1, 2019, to the present related to the failure to timely notify the next of kin of a decedent.

RESPONSE TO SPECIAL INTERROGATORY NO. 35:

Defendant did not find any such complaints in its complaints and grievances log.

SPECIAL INTERROGATORY NO. 36:

IDENTIFY all patients who died at Mercy San Juan Medical Center between January 1, 2019, to present for whom YOU failed to issue a Certificate of Death within 8 days following the patient's death.

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RESPONSE TO SPECIAL INTERROGATORY NO. 36:

Objection. This interrogatory seeks information that is protected by HIPAA and f rights to privacy.

SPECIAL INTERROGATORY NO. 37:

IDENTIFY every person with whom YOU communicated about the INCIDENT.

RESPONSE TO SPECIAL INTERROGATORY NO. 37:

Objection. This interrogatory seeks information that is protected by the attorney-client privilege, the attorney work product doctrine, and/or the patient safety work product doctrine.

SPECIAL INTERROGATORY NO. 38:

Describe the substance of all COMMUNICATIONS between YOU and each person identified in response to Special Interrogatory No. 36 related to the INCIDENT.

RESPONSE TO SPECIAL INTERROGATORY NO. 38:

Objection. This interrogatory seeks information that is protected by the attorney-client privilege, the attorney work product doctrine, and/or the patient safety work product doctrine.

SPECIAL INTERROGATORY NO. 39:

Describe all COMMUNICATIONS between YOU and members of law enforcement about Jessie Peterson.

RESPONSE TO SPECIAL INTERROGATORY NO. 39:

On April 8, 2023, Nurse Nicole McCarver documented that she sent a message to Dr. Nadeem Mukhtar at 1736 to inform her that she (Nurse McCarver) had called the Sacramento County Coroner's Office and "they stated 'this is not a coroners [*sic*] case'".

SPECIAL INTERROGATORY NO. 40:

IDENTIFY the social worker identified as "Teresa" in paragraph 12 in the COMPLAINT who called GINGER CONGI on December 1, 2022.

RESPONSE TO SPECIAL INTERROGATORY NO. 40:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Teresa Vandenboom.

SPECIAL INTERROGATORY NO. 41:

IDENTIFY the case manager identified as "Gail" in paragraph 12 of the COMPLAINT who called GINGER CONGI on December 1, 2022.

RESPONSE TO SPECIAL INTERROGATORY NO. 41:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

Gail Zanoli.

SPECIAL INTERROGATORY NO. 42:

Describe how it came about in April 2024 that YOU discovered that a Certificate of Death had not been issued for Jesse Peterson.

RESPONSE TO SPECIAL INTERROGATORY NO. 42:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

While investigation of this matter by counsel for the defendant is not complete, there are several reasons why the defendant failed to reach its goal of timely disposition of the remains of decedent, not the least of which is the fact that it appears at this stage of litigation, prior to the depositions of decedent's next of kin, that decedent's mother may have intentionally not responded to 12 calls over the course of two days from the hospital to her phone, which had been a working number for her as little as 8 days earlier, and that she did this because her relationship with the decedent had deteriorated to the point that she wanted no involvement with the decedent, apparently because the decedent had developed a substance abuse problem which made a normal mother daughter relationship unachievable. If she had answered the phone, there would not have been the delays that ensued. As described already in response to Special Interrogatory No. 12 and described more fully in response to Special Interrogatory No. 30, decedent's mother had picked up the phone several times when called on the same number in the context of treatment for decedent on January 8, 2021, November 1, 2021, November 20, 2022, January 13, 2023, and March 31, 2023. Also, per the records, decedent informed a social worker in November 2022 and/or December 2022 that she and her mother were estranged and on March 31, 2023, a case

manager documented that the mother said she did not know much about decedent because they had not had any contact for a few months. Regardless of whether investigation and discovery in this matter reveals that decedent's mother did intentionally not answer the many calls made from the hospital to her phone seeking to notify her of the death of her daughter, it appears that a severe backlog in processing remains which began with the unprecedented surge in U.S. deaths from COVID-19, combined with coinciding staffing challenges within the defendant's organization, constitutes the rest of the explanation for the delay, but as already stated, fact investigation in the context of this lawsuit is continuing.

SPECIAL INTERROGATORY NO. 43:

IDENTIFY who was the person that discovered in April 2024, that YOU had not issued a Certificate of Death for Jesse Peterson.

RESPONSE TO SPECIAL INTERROGATORY NO. 43:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. Without waiving these objections, defendant responds as follows:

While investigation of this matter by counsel for the defendant is not complete, there are several reasons why the defendant failed to reach its goal of timely disposition of the remains of decedent, not the least of which is the fact that it appears at this stage of litigation, prior to the depositions of decedent's next of kin, that decedent's mother may have intentionally not responded to 12 calls over the course of two days from the hospital to her phone, which had been a working number for her as little as 8 days earlier, and that she did this because her relationship with the decedent had deteriorated to the point that she wanted no involvement with the decedent, apparently because the decedent had developed a substance abuse problem which made a normal mother daughter relationship unachievable. If she had answered the phone, there would not have been the delays that ensued. As described already in response to Special Interrogatory No. 12 and described more fully in response to Special Interrogatory No. 30, decedent's mother had picked up the phone several times when called on the same number in the context of treatment for decedent on January 8, 2021, November 1, 2021, November 20, 2022, January 13, 2023, and March 31, 2023. Also, per the records, decedent informed a social worker in November 2022

and/or December 2022 that she and her mother were estranged and on March 31, 2023, a case manager documented that the mother said she did not know much about decedent because they had not had any contact for a few months. Regardless of whether investigation and discovery in this matter reveals that decedent's mother did intentionally not answer the many calls made from the hospital to her phone seeking to notify her of the death of her daughter, it appears that a severe backlog in processing remains which began with the unprecedented surge in U.S. deaths from COVID-19, combined with coinciding staffing challenges within the defendant's organization, constitutes the rest of the explanation for the delay, but as already stated, fact investigation in the context of this lawsuit is continuing.

SPECIAL INTERROGATORY NO. 44:

On page 27 of 29 of the attached Medical Records it is stated that that "Chaplaincy" attempted to call Jessie Peterson's family, IDENTIFY the person or persons that placed those phone calls.

RESPONSE TO SPECIAL INTERROGATORY NO. 44:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. In addition, it calls for speculation. Without waiving these objections, defendant responds as follows:

The medical record was authored by Dr. Haritheertham Nagaraj, and that physician would be the person to ask this question. However, other medical records indicate that a chaplain named Perry Mayforth attempted to contact Ms. Peterson's mother, Ginger Congi, on April 6, 2023, at 1545 and 1546 via phone by calling the phone number listed as Ms. Peterson's emergency contact and which had been used successfully to speak with Ms. Congi just eight days earlier.

SPECIAL INTERROGATORY NO. 45:

On page 27 of 29 of the attached Medical Records it is stated that that "other services" attempted to call Jessie Peterson's family, IDENTIFY the person or persons that placed those phone calls.

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RESPONSE TO SPECIAL INTERROGATORY NO. 45:

Objection. This interrogatory seeks information that is protected by HIPAA and Jessie Peterson's right to privacy. In addition, it calls for speculation. Without waiving these objections, defendant responds as follows:

The medical record was authored by Dr. Haritheertham Nagaraj, and that physician would be the person to ask this question. However, other medical records indicate that a chaplain named Perry Mayforth attempted to contact Ms. Peterson's mother, Ginger Congi, on April 6, 2023, at 1545 and 1546 via phone by calling the phone number listed as Ms. Peterson's emergency contact and which had been used successfully to speak with Ms. Congi just eight days earlier. Nurse Brenda Jensen and possibly other unknown hospital employees attempted to contact Ms. Congi via phone on April 8, 2023, at 1726, 1727, 1731, 1740, 2245, and 2246 and on April 9, 2023, at 0026, 0027, 0031, and 0040 by calling the same phone number that was used by Mr. Mayforth.

SPECIAL INTERROGATORY NO. 46:

Provide the contact information for all of the doctors identified in the attached Medical Records.

RESPONSE TO SPECIAL INTERROGATORY NO. 46:

That information is equally available to plaintiffs by accessing the California Medical Board's website.

SPECIAL INTERROGATORY NO. 47:

Provide the contact information for all of the medical staff identified in the attached Medical Records, for example, the person identified as the "bedside RN" on page 2 of 29 of the attached Medical Records.

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RESPONSE TO SPECIAL INTERROGATORY NO. 47:

Objection. This interrogatory is vague as to "medical staff," overly broad, burdensome, and harassing. In addition, it calls for speculation. If plaintiffs point out every reference to "medical staff" in the records attached to their special interrogatories, set one, by page number, subheading, and quoted material, defendant may be able to identify and provide contact information for who is being referred to.

Respectfully Submitted,

Dated: March 24, 2025

LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES

/s/ Scott Foley

By: _____

SCOTT FOLEY
Attorneys for Defendants
COMMONSPIRIT HEALTH and DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER; A DIVISION OF COMMON SPIRIT

Re: Peterson v. Dignity Health, et al.

VERIFICATION

I, the undersigned say:

I have read the foregoing **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S SPECIAL INTERROGATORIES, SET ONE**

[] I am a party to this action. The matters stated in it are true to my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe them to be true.

[X] I am the Interim Manager of Patient Safety for Mercy San Juan Medical Center and an authorized agent of Defendant Dignity Health dba Mercy San Juan Medical Center in this action and make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in it are true.

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

Executed this 24th day of March, 2025, at Sacramento, California.

CHASTITY REUSCHLE
Interim Manager of Patient Safety

PROOF OF SERVICE - 1013a, 2015.5 C.C.P.

STATE OF CALIFORNIA]
]
COUNTY OF SACRAMENTO]

I am employed in the County of Sacramento, State of California. I am over the age of 18 and not a party to the within action; my business address is LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES, 655 University Avenue, Suite 119, Sacramento, California 95825-6746; my business email address is bcrocker@ljdfa.com.

On March 24, 2025, I served the foregoing document described as **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S SPECIAL INTERROGATORIES, SET ONE** on the interested parties in Re Peterson, et al. vs. Dignity Health dba Mercy San Juan Medical Center, Court Case No. 24CV015815, by placing a true copy thereof enclosed in a sealed envelope addressed as follows:

SEE ATTACHED MAILING LIST

X **BY ELECTRONIC SERVICE:** [Code of Civ. Proc. §1010.6] by electronically mailing the document(s) listed above to the e-mail address(es) set forth above, or as stated on the attached service list per agreement in accordance with Code of Civil Procedure Section 1010.6.

____ **BY OVERNIGHT DELIVERY:** I deposited such envelope in a facility regularly maintained by GENERAL LOGISTICS SYSTEMS with delivery fees fully provided for or delivered the envelope to a courier or driver of GENERAL LOGISTICS SYSTEMS authorized to receive documents at LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES, 655 University Avenue, Suite 119, Sacramento, California 95825-6746.

____ **BY MAIL:** I caused such envelope with postage thereon fully prepaid to be placed in the United States mail at Sacramento, California. I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Sacramento, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

____ **BY FACSIMILE:** I sent via facsimile, a copy of said document(s) to the following addressee(s) at the following facsimile number(s) in accordance with the written confirmation of counsel in this action.

____ **BY PERSONAL SERVICE:** I caused such envelope to be delivered by hand to the offices of the addressee(s).

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on March 24, 2025, at Sacramento, California.

/s/ *Bonnie Crocker*
BONNIE CROCKER

Peterson, et al. vs. Dignity Health dba Mercy San Juan Medical Center
Court Case No.: 24CV015815

Marc R. Greenberg
Anna-Sophie Tirre
Tucker Ellis LLP
515 South Flower Street, Forty-Second Floor
Los Angeles, CA 90071

Phone: 213-430-3400
Fax: 213-430-3409
Email: marc.greenberg@tuckerellis.com
anna-sophie.tirre@tuckerellis.com

Attorney for Plaintiffs, Ginger Congi, Angie Rubino, Chandra Peterson-Chastain and Jessie Peterson via her estate, individually

EXHIBIT 6

AMA PolicyFinder

Informed

Search

Code of Medical Ethics

2.3.3 Informing Families of a Patient's Death

Topic: Code of Medical Ethics
Policy Subtopic: Opinions on Consent, Communication & Decision Making (2.3 Communication with Patients)
Meeting Type: NA
Year Last Modified: 2017
Action: NA
Type: Code of Medical Ethics
Council & Committees: NA

Informing a patient's family that the patient has died is a duty that is fundamental to the patient-physician relationship. When communicating this event, physicians should give foremost attention to the family's emotional needs and the integrity of the patient-physician relationship.

The following guidelines apply to communicating news of a patient's death:

(a) Any physician informing a patient's family about the patient's death has a responsibility to:

(i) communicate this information compassionately;

(ii) disclose the death in a timely manner.

(b) Ordinarily, the treating physician should take responsibility for informing the family. However, it may be appropriate to delegate the task of informing the family to another physician if the other physician has a previous close personal relationship with the patient or family and the appropriate skill.

(c) Medical students should not be asked to inform family members of a patient's death. Medical students should be trained in communication skills relating to death and dying, and should be encouraged to accompany attending physicians when news of a patient's death is conveyed to family members.

AMA Principles of Medical Ethics: I,IV

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Policy Timeline

Issued: 2016

EXHIBIT 7

BARRY VOGEL, STATE BAR NO. 108640
Bvogel@ljdfa.com
SCOTT W. FOLEY, STATE BAR NO. 278357
SFoley@ljdfa.com
LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES
655 University Avenue, Suite 119
Sacramento, California 95825-6746
Telephone (916) 563-3100 • Facsimile (916) 565-3704

Attorneys for Defendants
COMMONSPIRIT HEALTH and DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER; A DIVISION OF COMMON SPIRIT

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

GINGER CONGI, ANGIE RUBINO, CHANDRA PETERSON-CHASTAIN AND JESSIE PETERSON, via her estate, individually, Plaintiffs, vs. DIGNITY HEALTH, d/b/a MERCY SAN JUAN MEDICAL CENTER; a division of COMMON SPIRIT and DOES 1-50, inclusive, Defendants.	CASE NO.: 24CV015815 **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S REQUEST FOR ADMISSIONS, SET ONE** TRIAL DATE: None Set ACTION FILED: 08/07/2024

PROPOUNDING PARTY: Plaintiff, GINGER CONGI

RESPONDING PARTY: Defendant, DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER

SET NUMBER: ONE

Defendant, DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER (hereinafter, "Defendant"), hereby answers, objects, or otherwise responds to Plaintiff, GINGER CONGI'S (hereinafter, "Plaintiff") Request for Admissions, Set One, served on November 18, 2024, pursuant to Code of Civil Procedure section 2033, as follows:

/ / /

DEFINITIONS

As used herein, the word "DOCUMENT" shall mean originals and all copies, unless identical, regardless of origin or location, or written, recorded and graphic matter, however produced or reproduced, formal or informal, whether for internal or external use, including, but not limited to: correspondence, letters, memoranda, notes, reports, contracts, agreements, directives, instructions, court papers, lists of persons or things, blueprints, sketches, graphic representations, maps, books, pamphlets, canceled checks, mechanical and electrical sound recordings, charts, catalogs, tapes, indices, data sheets, statistical tables and diagrams, memoranda or records of telephone or personal conversations or conferences, inter-office communications, electronic data processing inputs and memories of all kinds, including tapes and discs, computer reports and printouts and electronic mail messages.

The words "YOU" and "YOUR" means and refers to Defendant, DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER.

"INSPECTION PROCEDURES" means any method of visual inspection for the purposes of observing the condition, defects and/or foreign objects presenting hazards to users.

"IDENTIFY" means and includes the name, business and residence address, and telephone number of each person, if requested; as to a writing, the term "IDENTIFY" means and includes the name and address of the present custodian, the date prepared, and the title and author of each writing.

The term, “PLAINTIFF” refers to GINGER CONGI.

The term, “DEFENDANT” refers to DIGNITY HEALTH dba MERCY SAN JUAN MEDIAL CENTER and its agents, employees, servants, attorneys, representatives and anyone else acting on its behalf or at its request.

The terms, “PERTAINING TO,” “PERTAIN(S) TO,” “RELATING TO,” “RELATE(S) TO,” “REFERRING TO,” or “REFER TO” as used in this document include, without limitation, relating to, mentioning, referring to, describing, summarizing, evidencing, constituting, demonstrating or explaining.

/ / /

The term "SUBJECT INCIDENT" refers to the incident that occurred on _____, which is the subject of this litigation.

As used herein, the singular shall include the plural, as may be appropriate, the conjunctive includes the disjunctive and the disjunctive includes the conjunctive, and all includes each and every.

RESPONSES TO REQUEST FOR ADMISSIONS

REQUEST FOR ADMISSION NO. 1:

Admit that YOU called GINGER CONGI on December 1, 2022.

(For this and all subsequent requests, the terms "YOU" and "YOUR" refer to defendant Dignity Health; the term "GINGER CONGI" means plaintiff Ginger Congi.)

RESPONSE TO REQUEST FOR ADMISSION NO. 1:

Admit.

REQUEST FOR ADMISSION NO. 2:

Admit that YOU were in possession of GINGER CONGI's telephone number prior to April 8, 2023.

RESPONSE TO REQUEST FOR ADMISSION NO. 2:

Admit.

REQUEST FOR ADMISSION NO. 3:

Admit that YOU had a duty to notify Jessie Peterson's next of kin of her death.

RESPONSE TO REQUEST FOR ADMISSION NO. 3:

Admit.

REQUEST FOR ADMISSION NO. 4:

Admit that YOU did not inform Jessie Peterson' next of kin of her death.

RESPONSE TO REQUEST FOR ADMISSION NO. 4:

Defendant admits that it attempted to notify Jessie Peterson's next of kin—Ginger Congi—of Jessie Peterson's death via multiple telephone calls both on the day of her death and the following day, but Ms. Congi did not answer the phone. Defendant did not leave a voicemail message for Ms. Congi due to HIPAA concerns and due to concerns about the appropriateness

generally of relaying such information via voicemail.

REQUEST FOR ADMISSION NO. 5:

Admit that YOU had a duty to report Jessie Peterson's death in an Electronic Death Registration System.

RESPONSE TO REQUEST FOR ADMISSION NO. 5:

Admit.

REQUEST FOR ADMISSION NO. 6:

Admit that YOU did not report Jessie Peterson's death in an Electronic Death Registration System.

RESPONSE TO REQUEST FOR ADMISSION NO. 6:

Admit.

REQUEST FOR ADMISSION NO. 7:

Admit that the attending physician did not complete Jessie Peterson's Certificate of Death within 15 hours after her death as required by Health & Safety Code section 102800.

RESPONSE TO REQUEST FOR ADMISSION NO. 7:

Admit.

REQUEST FOR ADMISSION NO. 8:

Admit that YOU transferred Jessie Peterson's body to an offsite storage facility on April 9, 2023.

RESPONSE TO REQUEST FOR ADMISSION NO. 8:

Admit.

REQUEST FOR ADMISSION NO. 9:

Admit that YOU told GINGER CONGI on April 11, 2023, that Jessie Peterson had been discharged from Mercy San Juan Medical Center.

RESPONSE TO REQUEST FOR ADMISSION NO. 9:

After making a reasonable inquiry concerning the matter, the information known or readily obtainable is insufficient to enable defendant to admit the matter.

/ / /

REQUEST FOR ADMISSION NO. 10:

Admit that by prior to April 2023, YOU knew that Mercy San Juan Medical Center had a problem with timing filing Certificates of Death, based on the lawsuit brought by Valarie Gray, Case No. 34-2022-00315771.

RESPONSE TO REQUEST FOR ADMISSION NO. 10:

Defendant admits that prior to April 2023, it was aware that there were decedent bodies for which certificates of death had not been completed and was working toward getting those certificates completed and filed.

REQUEST FOR ADMISSION NO. 11:

Admit that Dignity Health's Mercy General Hospital didn't prepare a Certificate of Death for Tonya Walker, until April 15, 2024, after her death on or about November 2, 2023.

RESPONSE TO REQUEST FOR ADMISSION NO. 11:

Objection. This request seeks information that is protected by HIPAA and Tonya Walker's right to privacy.

REQUEST FOR ADMISSION NO. 12:

Admit that Dignity Health's Mercy Hospital of Folsom didn't prepare a Certificate of Death for Phillip Coss, until December 29, 2023, after her death on or about May 27, 2023.

RESPONSE TO REQUEST FOR ADMISSION NO. 12:

Objection. This request seeks information that is protected by HIPAA and Phillip Coss' right to privacy.

REQUEST FOR ADMISSION NO. 13:

Admit that by prior to April 2023, YOU knew that Mercy San Juan Medical Center was not filing timely Certificates of Death, based on the lawsuit brought by Valarie Gray, Case No. 34-2022-00315771.

RESPONSE TO REQUEST FOR ADMISSION NO. 13:

Defendant admits that prior to April 2023, it was aware that there were decedent bodies for which certificates of death had not been completed and was working toward getting those certificates completed and filed.

REQUEST FOR ADMISSION NO. 14:

Admit that by prior to April 2023, YOU knew that various Dignity Health facilities were not filing timely Certificates of Death.

RESPONSE TO REQUEST FOR ADMISSION NO. 14:

Defendant admits that prior to April 2023, it was aware that there were decedent bodies for which certificates of death within the Dignity Health system had not been completed and was working toward getting those certificates completed and filed.

REQUEST FOR ADMISSION NO. 15:

Admit that by prior to April 2023, YOU knew that Mercy San Juan Medical Center was not filing timely Certificates of Death, based on the lawsuit brought by Valarie Gray, Case No. 34-2022-00315771.

RESPONSE TO REQUEST FOR ADMISSION NO. 15:

Defendant admits that prior to April 2023, it was aware that there were decedent bodies for which certificates of death had not been completed and was working toward getting those certificates completed and filed.

REQUEST FOR ADMISSION NO. 16:

Admit that by prior to April 2023, YOU did nothing to correct Dignity Health's issues with respect to timely filing Certificates of Death.

RESPONSE TO REQUEST FOR ADMISSION NO. 16:

Deny.

Respectfully Submitted,

Dated: February 13, 2025

LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES

By: /s/ Scott Foley
SCOTT FOLEY
Attorneys for Defendants
COMMONSPIRIT HEALTH and DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER; A DIVISION OF COMMON SPIRIT

Re: Peterson v. Dignity Health, et al.

VERIFICATION

I, the undersigned say:

I have read the foregoing **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S REQUEST FOR ADMISSIONS, SET ONE**

[] I am a party to this action. The matters stated in it are true to my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe them to be true.

[X] I am the Interim Manager of Patient Safety for Mercy San Juan Medical Center and an authorized agent of Defendant Dignity Health dba Mercy San Juan Medical Center in this action and make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in it are true.

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

Executed this 11th day of February, 2025, at Sacramento, California.

CHASTITY REUSCHLE
Interim Manager of Patient Safety

PROOF OF SERVICE - 1013a, 2015.5 C.C.P.

STATE OF CALIFORNIA]
]
COUNTY OF SACRAMENTO]

I am employed in the County of Sacramento, State of California. I am over the age of 18 and not a party to the within action; my business address is LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES, 655 University Avenue, Suite 119, Sacramento, California 95825-6746; my business email address is bcrocker@ljdfa.com.

On February 13, 2025, I served the foregoing document described as **DEFENDANT DIGNITY HEALTH dba MERCY SAN JUAN MEDICAL CENTER'S RESPONSES TO PLAINTIFF'S REQUEST FOR ADMISSIONS, SET ONE** on the interested parties in Re Peterson, et al. vs. Dignity Health dba Mercy San Juan Medical Center, Court Case No. 24CV015815, by placing a true copy thereof enclosed in a sealed envelope addressed as follows:

SEE ATTACHED MAILING LIST

X BY ELECTRONIC SERVICE: [Code of Civ. Proc. §1010.6] by electronically mailing the document(s) listed above to the e-mail address(es) set forth above, or as stated on the attached service list per agreement in accordance with Code of Civil Procedure Section 1010.6.

____ BY OVERNIGHT DELIVERY: I deposited such envelope in a facility regularly maintained by GENERAL LOGISTICS SYSTEMS with delivery fees fully provided for or delivered the envelope to a courier or driver of GENERAL LOGISTICS SYSTEMS authorized to receive documents at LA FOLLETTE, JOHNSON, DeHAAS, FESLER & AMES, 655 University Avenue, Suite 119, Sacramento, California 95825-6746.

____ BY MAIL: I caused such envelope with postage thereon fully prepaid to be placed in the United States mail at Sacramento, California. I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Sacramento, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

____ BY FACSIMILE: I sent via facsimile, a copy of said document(s) to the following addressee(s) at the following facsimile number(s) in accordance with the written confirmation of counsel in this action.

____ BY PERSONAL SERVICE: I caused such envelope to be delivered by hand to the offices of the addressee(s).

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on February 13, 2025, at Sacramento, California.

/s/ Bonnie Crocker
BONNIE CROCKER

Peterson, et al. vs. Dignity Health dba Mercy San Juan Medical Center
Court Case No.: 24CV015815

Marc R. Greenberg
Anna-Sophie Tirre
Tucker Ellis LLP
515 South Flower Street, Forty-Second Floor
Los Angeles, CA 90071

Phone: 213-430-3400
Fax: 213-430-3409
Email: marc.greenberg@tuckerellis.com
anna-sophie.tirre@tuckerellis.com

Attorney for Plaintiffs, Ginger Congi, Angie Rubino, Chandra Peterson-Chastain and Jessie Peterson via her estate, individually

EXHIBIT 8

MISSING PERSON

Jessie Marie Peterson

MISSING SINCE:	04/07/2023	SEX:	Female
DOB:	08/15/1991	RACE:	White
HEIGHT:	5' 7"	EYES:	Hazel
WEIGHT:	100 lbs.	HAIR:	Brown
DENTAL X-RAYS AVAILABLE:	No		

Jessie Marie Peterson's date of last contact was on April 7, 2023.

Contact

AGENCY:	Sacramento County Sheriff's Office
PHONE NUMBER:	(916) 874-5467
CASE NUMBER:	23-234756

EXHIBIT 9

TITAN
Legal Services
Where Knowledge and Service Matter

CLIENT: Tucker Ellis LLP
515 S. Flower Street, 42nd Floor
Los Angeles, CA 90071

ATTENTION: Sofia Escalante

FILE NUMBER: 019848-000001

CASE NAME: Ginger Congi, et al.
vs
Dignity Health, d/b/a Mercy San Juan Medical Center, et al.

PRODUCTION DATE: January 15, 2025

RECORDS SUBJECT NAME: Jesse Peterson (See Attachment 3)

FACILITY NAME: Cremations Only
35 Quinta Court, Suite C
Sacramento, CA 95823

☑ THE ENCLOSED RECORDS COMPLETE YOUR REQUEST FROM THIS CUSTODIAN

☐ THIS REQUEST IS INCOMPLETE FOR THE FOLLOWING REASON:

- ☐ Billing records were not available at the time of copying and will be fowarded to your office when they become available.
- ☐ X-Rays were not available at the time of copying and will be forwarded when available.

☐ THERE ARE NO RECORDS AT THE ABOVE LOCATION

☐ OTHER: _____

_____

Titan Legal Reference No.: SU419551-03

2050 W 190th Street, Suite 200
Torrance, CA 90504

Order: SU419551-03/CPROOF21

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:
Marc R. Greenberg SBN 123115 Anna-Sophie Tirre SBN 336835
Tucker Ellis LLP
515 South Flower Street, Forty-Second Floor
Los Angeles, CA 90071
TELEPHONE NO.: 213.430.3400 FAX NO.: 213.430.3409
E-MAIL ADDRESS: marc.greenberg@tuckerellis.com; anna-sophie.tirre@tuckerellis.com
ATTORNEY FOR *(Name)*: Plaintiffs

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO
STREET ADDRESS: 720 9th Street
MAILING ADDRESS:
CITY AND ZIP CODE: Sacramento 95814
BRANCH NAME: Gordon D. Schaber Sacramento County Courthouse

PLAINTIFF/PETITIONER: Ginger Congi, et al.

DEFENDANT/RESPONDENT: Dignity Health, d/b/a Mercy San Juan Medical Center, et al.

DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

CASE NUMBER: 24CV015815

THE PEOPLE OF THE STATE OF CALIFORNIA, TO *(name, address, and telephone number of deponent, if known):*
Cremations Only, 35 Quinta Ct., Sacramento, CA 95823

1. **YOU ARE ORDERED TO PRODUCE THE BUSINESS RECORDS described in item 3, as follows:**

To *(name of deposition officer)*: Titan Legal Service
On *(date)*: January 15, 2025 At *(time)*: 10:00 a.m.
Location *(address)*: 2050 W. 190th Street, Suite 200, Torrance, CA 90504

Do not release the requested records to the deposition officer prior to the date and time stated above.

a. ☒ by delivering a true, legible, and durable **copy** of the business records described in item 3, enclosed in a sealed inner wrapper with the title and number of the action, name of witness, and date of subpoena clearly written on it. The inner wrapper shall then be enclosed in an outer envelope or wrapper, sealed, and mailed to the deposition officer at the address in item 1.

b. ☐ by delivering a true, legible, and durable **copy** of the business records described in item 3 to the deposition officer at the witness's address, on receipt of payment in cash or by check of the reasonable costs of preparing the copy, as determined under Evidence Code section 1563(b).

c. ☐ by making the **original** business records described in item 3 available for inspection at your business address by the attorney's representative and permitting **copying** at your business address under reasonable conditions during normal business hours.

2. *The records are to be produced by the date and time shown in item 1 (but not sooner than 20 days after the issuance of the deposition subpoena, or 15 days after service, whichever date is later). Reasonable costs of locating records, making them available or copying them, and postage, if any, are recoverable as set forth in Evidence Code section 1563(b). The records shall be accompanied by an affidavit of the custodian or other qualified witness pursuant to Evidence Code section 1561.*

3. The records to be produced are described as follows *(if electronically stored information is demanded, the form or forms in which each type of information is to be produced may be specified):*

☒ Continued on Attachment 3.

4. **IF YOU HAVE BEEN SERVED WITH THIS SUBPOENA AS A CUSTODIAN OF CONSUMER OR EMPLOYEE RECORDS UNDER CODE OF CIVIL PROCEDURE SECTION 1985.3 OR 1985.6 AND A MOTION TO QUASH OR AN OBJECTION HAS BEEN SERVED ON YOU, A COURT ORDER OR AGREEMENT OF THE PARTIES, WITNESSES, *AND* CONSUMER OR EMPLOYEE AFFECTED MUST BE OBTAINED BEFORE YOU ARE REQUIRED TO PRODUCE CONSUMER OR EMPLOYEE RECORDS.**

DISOBEDIENCE OF THIS SUBPOENA MAY BE PUNISHED AS CONTEMPT BY THIS COURT. YOU WILL ALSO BE LIABLE FOR THE SUM OF FIVE HUNDRED DOLLARS AND ALL DAMAGES RESULTING FROM YOUR FAILURE TO OBEY.

Date issued: December 20, 2024

Marc R. Greenberg
(TYPE OR PRINT NAME)

▶ Marc R. Greenberg
(SIGNATURE OF PERSON ISSUING SUBPOENA)

Attorney for Plaintiffs
(TITLE)

(Proof of service on reverse)

Form Adopted for Mandatory Use
Judicial Council of California
SUBP-010 [Rev. January 1, 2012]

Code of Civil Procedure, §§ 2020.410–2020.440;
Government Code, § 68097.1
www.courts.ca.gov

PLAINTIFF/PETITIONER: **Ginger Congi, et al.**	CASE NUMBER:
DEFENDANT/RESPONDENT: **Dignity Health, d/b/a Mercy San Juan Medical Center, et al.**	**24CV015815**

PROOF OF SERVICE OF DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

1. I served this *Deposition Subpoena for Production of Business Records* by personally delivering a copy to the person served as follows:
   a. Person served *(name)*: Chelle "H"
   b. Address where served: 35 Quinta Court Ste. C Sacramento, CA 95823
   c. Date of delivery: 12/27/2024
   d. Time of delivery: 12:20
   e. (1) ☒ Witness fees were paid. Amount: . . . . . $ 15.00
      (2) ☐ Copying fees were paid. Amount: . . . . . $ _____
   f. Fee for service: . . . . . $ _____
2. I received this subpoena for service on *(date)*: 12/26/2024
3. Person serving: William Ross
   a. ☐ Not a registered California process server.
   b. ☐ California sheriff or marshall.
   c. ☐ Registered California process server.
   d. ☐ Employee or independent contractor of a registered California process server.
   e. ☐ Exempt from registration under Bus. & Prof. Code section 22350(b).
   f. ☑ Registered professional photocopier.
   g. ☐ Exempt from registration under Bus. & Prof. Code section 22451.
   h. Name, address, and telephone number and, if applicable, county of registration and number:

Titan Legal Services, Inc.
2050 W. 190th Street, Suite 200
Torrance, CA 90504
(310) 464-8655
Los Angeles Co. Reg No.: 2014051805
Expiration Date: April 10, 2025

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 12/27/2024

▶ _____
(SIGNATURE)

(For California sheriff or marshall use only)
I certify that the foregoing is true and correct.

Date:

▶ _____
(SIGNATURE)

SHORT TITLE:	CASE NUMBER:
Ginger Congi, et al. v. Dignity Health, d/b/a Mercy San Juan Medical Center, et al.	24CV015815

ATTACHMENT *(Number):* 3

(This Attachment may be used with any Judicial Council form.)

a. All documents relating to the storage of Jesse Peterson from approximately April 2023 to April 2024.
b. All documents relating to the storage of Tonya Walker from approximately November 2023 to April 2024.
c. All documents relating to invoices to Mercy San Juan for the storage of Jesse Peterson.
d. All documents related to efforts by Cremations Only to contact the family of Jesse Peterson.
e. All invoices issued to Mercy San Juan Hospital / Dignity Health for storage of human remains from January 2022 to present.
f. All records showing the number of bodies currently held in storage at Cremations Only that lack a Certificate of Death.
g. All communications with Mercy San Juan Hospital regarding Jesse Peterson or this lawsuit.
h. All communications with Mercy San Juan Hospital that discuss storage of human remains past 30 days.
i. All contracts between Cremations Only and Mercy San Juan Hospital/Dignity Health from January 2022 to present.
j. All documents related to the State of California Cemetery And Funeral Bureau investigation and citation, citation number IC 2019 419, relating to Cremations Only.

(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)

Proof of Service

I, Trixie Estanislao, and any employee retained by Titan Legal Services, Inc., am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action, my business address is **2050 W. 190th Street, Suite 200, Torrance, CA 90504.**

On **December 20, 2024** I served the foregoing documents described as:

DEPOSITION SUBPOENA FOR THE PRODUCTION OF BUSINESS RECORDS (with Attachment 3);

[XX] to interested parties on this action by sending the true copies thereof addressed as follows:

La Follette, Johnson, De Haas, Fesler & Ames
Barry Vogel / Scott W. Foley
655 University Avenue, Suite 119
Sacramento, CA 95825

[XX] VIA U.S. MAIL
As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. Postal Service on the same day with postage thereon fully paid at Torrance, California, in the ordinary course of business.

Executed on December 20, 2024, at Torrance, CA.

[XX] (State) I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Signed: _____
Trixie Estanislao

DECLARATION OF CUSTODIAN OF RECORDS

Records pertain to: **Jesse Peterson (See Attachment 3)**

Description of Records: **See Attachment 3**

I, the undersigned, am duly authorized custodian of records for **Cremations Only, whose business address is 35 Quinta Court, Suite C, Sacramento, CA, 95823,** and have authority to certify records. I am qualified to testify as to the preparation and maintenance of the records sought by the subpoena or authorization attached hereto and, if called as a witness, could testify competently thereto. Further, I hereby certify to the following (check appropriate boxes):

☑ **CERTIFICATION OF RECORDS COPIED**

1. The accompanying copies are true copies of all records in my custody or control described in the subpoena or authorization.

   [ ] If applicable, When Only Partial Records are Produced The following records described in the subpoena or authorization are not in my custody for the following reasons.

2. (a) the record was made at or near the time by or from information transmitted by someone with knowledge; (b) the record was kept in the course of a regularly conducted activity of a business, organization, occupation, or calling, whether or not for profit; (c) making the record was a regular practice of that activity;

3. The accompanying records were prepared in the following manner. **(check all applicable boxes)** [ ] from microfilm/microfiche; ☑ from computer stored data; [ ] by photocopying the original paper record; [ ] by electronic duplication process; [ ] by photographic duplication process; [ ] other (describe):

[ ] CERTIFICATION OF NO RECORDS
[ ] CERTIFICATION OF NO XRAYS/MRI'S/ RADIOLOGICAL FILMS [ ] CERTIFICATION OF NO BILLING RECORDS
[ ] CERTIFICATION OF NO COLORED PHOTOS

1. A thorough search has been made for the documents, records and things called for in the subpoena or authorization and, based upon the information provided, no such items were found.
2. No copies or records are transmitted because we do not have said records.
3. If Items 1. and 2. above do not apply please Explain the reason why you have NO RECORDS:

I DECLARE under penalty of perjury under the laws of California that the foregoing is true and correct.

Executed on January 30, 2025 at Sacramento, California

Print Name Jennifer Richards Signed [signature]

Phone 916-564-0400

****** DO NOT WRITE BELOW THIS LINE, FOR TITAN USE ONLY ******

DECLARATION OF PROFESSIONAL PHOTOCOPIER

(California Evidence Codes 1400, 1560; Code of Civil Procedure 1985.3, 2020(e) and Business and Professions Code 22462)

As a representative of "Titan Legal Services, Inc.", I hereby declare that the attached are true and complete copies of all records which were provided to me on this date.

Said records will be delivered only to the party or entity issuing this request.

Executed on 2/17/2025 at Torrance, California

Print Name [illegible] Signed [signature]

Titan ref#: SU419551-03/Cproof7

FD-2208

Cremations Only

On 30 May 2024, we received a phone call from Mercy General saying a family was told by a deputy that they needed to identify a loved one that passed away and the loved one was at our location for a hospital hold. I informed her that they would need to coordinate that with the deputy because that is their jurisdiction since SMT is just the holding facility for the hospital. About 30 minutes later I got a call from a lady named Dalee saying she had a missing persons report filed for her sister and the deputy called them saying they located her at Mercy General but she was at SMT for a hospital hold. Dalee asked if she could see her sister, I told her I would take a look at her condition and call back. I viewed Ms. Walker then informed Dalee that it was my personal and professional opinion that they remember her the way she was and not view her.

31 May 2024, Tiffy sent a message in slack that Judy called about a viewing, I called her back and spoke with Dalee. They expressed how Judy was in the middle of chemotherapy yesterday when she was informed that Ms. Walker had been found and she really needed to see her. Dalee explained that they really needed to see her for closure. I told her I would talk with my supervisor and call her back, 5 minutes later they showed up to the office. I met with the mother Judy Ortiz, her sister from the moms side Dalee Marez and a sister from the dads side Kalia Zachary. I explained to the three of them that she was unidentifiable, I expressed how they should remember her as is and I completely do not think they should see their loved one in that condition. Dalee mentioned how people told them she was beaten to death and left in a ditch so they searched in ditches, they found her personal belongings in different areas, her car abandoned somewhere else, one person told them she was dismembered and never to be found so no matter what they have to see her and make sure it is really her. Especially since they already thought the worst could have happened and it could not be any worse than they already thought, visualized and

FD-2208

Cremations Only

imagined. I told them I personally viewed Ms. Tonya and she is not able to be recognized and I really think it is not a good idea to see her that way. Judy said she was not leaving our facility without seeing that it was really her baby and getting closure. We agreed that is was completed against our personal and professional opinions, thoughts and feelings and they would sign a hold harmless agreement and pay the private ID viewing fee, Dalee said she could tell by the look in my eyes and on my face that I truly did not want them to see Ms. Tonya in that condition. I asked her if there was anything I could say to get her to not want to see her and she said no matter what I said, they needed closure and had to see her.

Ms. Tonya Walker was placed on the prep table, I removed some of the plastic from around her, placed a sheet over her and angled her so the pulled blood and fluids would drain out. I left her arm band accessible so they could see the hospital identification tag if necessary. I had the three of them sign the form, gave them a copy and told them one last time please reconsider not viewing her in that condition but they said no lets proceed. I took Judy, Dalee and Kalia into the prep room and closed the door for privacy. As Judy was being held up by Dalee and Kalia all on the right side and I on the left, Judy asked if there was a tattoo on her left arm, I said "it looks like writing but I cannot make out details" Dalee came on the left side and said "it is her mom I recognize this side of her face structure and that is the DJ tattoo from when she was in her teens." They said thank you, we all left the prep room and went into the arrangement room, Kalia stepped outside for fresh air and I gave Judy and Dalee the next steps on the waiver of rights, death certificate and cremation. Kalia came back in and asked about her smell, I apologized and said unfortunately that was another reason I did not want them seeing her and experiencing that. I kept saying "I am so sorry" and they would reply "it is

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Cremations Only

okay" or "no thank you for that" or just being very appreciative, I escorted them out and said again I am so deeply sorry and my condolences.

3 June 2024 Kalia called to ask if there was a way she could see her sister again so she could take photos of her.. They said they want to take the picture because they feel like the hospital is responsible for her death. Since she's been sitting here for 6 months they will be contacting a lawyer. Nyjaih told them we would call Kalia back 916-868-1099. I spoke with Kalia about a second viewing and I reminded her that the first viewing was not recommended let alone a second one, I explained that due to the condition of Ms. Tonya Walker, that we would have to go through the steps to prepare her a second time and there is an additional cost for viewings. Kalia said the cost did not matter; she was adamant on wanting to see her again and obtain a photo of her tattoo. Kalia came in for a second viewing and we discussed not seeing her at all, she mentioned the other sister was more emotionally scared and she was the strongest one to see her. I explained to her that seeing Ms. Tonya Walker was not a good idea and she said it was a must to view her. Kalia asked about taking photos; I told her it was not recommended, she said she understands but she is still going to take one. Kalia placed a face mask on for the smell and she and I went into the prep room for a second time, I again removed the sheet and plastic for Kalia to view her sister. She spent less than 3 minutes in the prep room, said thank you and left. I apologized again and offered my condolences, she accepted, said thank you again and left.

Respectfully,

Chelle Haney

Cremations Only FD-2208
35 Quinta Court, Ste C
Sacramento, CA 95823
916-564-0400

Gmail Jennifer Richards <jennifer@cremationsandburial.com>

One Year Since DOD Approaching

4 messages

Jennifer Richards <jennifer@cremationsandburial.com> Wed, Apr 3, 2024 at 11:36 AM
To: Laura Lurkin <laura.lukin@commonspirit.org>
Cc: James Lofton <james@cremationsandburial.com>

Good morning Laura

I did a spot check on the hospital holds that are approaching one year from death that we do not have a record of filing on your behalf; patients still in our care.

I thought it would be helpful for you and your team - please let me know if you have any questions.

Methodist:
[redacted] DOD [redacted]

Mercy General
[redacted] DOD [redacted]

Mercy San Juan
Jessie Peterson DOD 4/8/2023
[redacted] DOD
[redacted] DOD [redacted]

Thank you,

--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
jennifer@cremationsandburial.com

Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org> Wed, Apr 3, 2024 at 5:44 PM
To: Jennifer Richards <jennifer@cremationsandburial.com>, James Lofton <jamescremationsonly@gmail.com>

Hi Jennifer and James. Thank you so much for looking at the dates for those that are coming up on 1 year. I really appreciate that. Here is the info if you would please do the death certificates for them.

MSJ Jessie Peterson dob 8/15/91 dod 4/8/23 tod is 1627 Dr. is Nadeem Mukhtar - hospitalist- would you be able to do this ASAP as it will be 1 year in 5 days****
MGH [redacted] dob [redacted] dod [redacted] tod [redacted] Dr. is Enkee Turshintogs-Hospitalist
MET [redacted] dob [redacted] dod [redacted] tod [redacted] Dr Paterra Yang- Hospitalist
MSJ [redacted] dob [redacted] dod [redacted] tod [redacted] Dkine Billow - Hospitalist
MSJ [redacted] dob [redacted] dod [redacted] tod [redacted] Dr. Debby Sentana- hospitalist

Thank you so much

Laura Lukin
Regional Laboratory Support Supervisor
Clinical Laboratory and Pathology Services

Dignity Health

Sacramento System Office

4400 Duckhorn Drive, Suite 200

Sacramento, CA 95834

916-515-4010 office 831-706-8087

laura.lukin@commonspirit.org

On Wed, Apr 3, 2024 at 9:37 AM Jennifer Richards <jennifer@cremationsandburial.com> wrote:
USE CAUTION - EXTERNAL EMAIL

[Quoted te t hidden]

Jennifer Richards <jennifer@cremationsandburial.com> Wed, Apr 3, 2024 at 6:16 PM
To: Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org>
Cc: James Lofton <jamescremationsonly@gmail.com>

You're welcome! We will get started on these right away!
[Quoted te t hidden]

Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org> Wed, Apr 3, 2024 at 7:21 PM
To: Jennifer Richards <jennifer@cremationsandburial.com>

Thank you x 100!

Laura Lukin
Regional Laboratory Support Supervisor
Clinical Laboratory and Pathology Services

Dignity Health

Sacramento System Office

4400 Duckhorn Drive, Suite 200

Sacramento, CA 95834

916-515-4010 office 831-706-8087

laura.lukin@commonspirit.org

[Quoted te t hidden]

Gmail

Jennifer Richards <jennifer@crematlonsandburial.com>

PETERSON, Jessie - MSJ

2 messages

Jennifer Richards <jennifer@crematlonsandburial.com> Fri, Apr 5, 2024 at 5:10 PM
To: Laura Lurkin <laura.lukin@commonspirit.org>, Alannah Jordan CA-SACRAMENTO <alannah.jordan@commonspirit.org>

Peterson is done!! See attached

--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
jennifer@crematlonsandburial.com

PETERSON, Jessie MSJ.pdf
305K

Alannah Jordan CA-SACRAMENTO <alannah.jordan@commonspirit.org> Fri, Apr 5, 2024 at 5:24 PM
To: Jennifer Richards <jennifer@crematlonsandburial.com>
Cc: Laura Lurkin <laura.lukin@commonspirit.org>

Thank you!

Alannah Jordan
Pathological Lab Services
Office Assistant II
(916)515-4045

On Fri, Apr 5, 2024 at 3:13 PM Jennifer Richards <jennifer@crematlonsandburial.com> wrote:

USE CAUTION - EXTERNAL EMAIL

Peterson is done!! See attached

--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
jennifer@crematlonsandburial.com

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 3/05)

STATE FILE NUMBER

LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

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

AKA, ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months	IF UNDER ONE YEAR Days	IF UNDER 24 HOURS Hours	IF UNDER 24 HOURS Minutes	6. SEX
08/15/1991	31					F

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP* (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
UNK	UNK	☐ YES ☐ NO ☒ UNK	UNKNOWN	04/08/2023	1627

13. EDUCATION – Highest Level/Degree (see worksheet on back)	14/15. WAS DECEDENT HISPANIC/LATINO/A/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
UNKNOWN	☐ YES UNKNOWN ☐ NO	UNKNOWN

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

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)
UNK

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
UNK	UNK	UNK	UNK	UNK

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
PHIL MANNING, FUNERAL DIRECTOR	35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP–FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
UNKNOWN	UNKNOWN	UNKNOWN	
31. NAME OF FATHER/PARENT–FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
UNKNOWN	UNKNOWN	UNKNOWN	UNK
35. NAME OF MOTHER/PARENT–FIRST	36. MIDDLE	37. LAST (BIRTH NAME)	38. BIRTH STATE
UNKNOWN	UNKNOWN	UNKNOWN	UNK

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION	
04/05/2024	CREMATIONS ONLY 35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823	
41. TYPE OF DISPOSITION(S)	42. SIGNATURE OF EMBALMER	43. LICENSE NUMBER
TEMPORARY ENVAULTMENT	▸ NOT EMBALMED	-
44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER / 46. SIGNATURE OF LOCAL REGISTRAR	47. DATE mm/dd/ccyy
CREMATIONS ONLY	FD2208 / ▸ OLIVIA KASIRYE MD	04/05/2024

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
MERCY SAN JUAN MEDICAL CENTER	☒ IP ☐ ER/OP ☐ DOA	☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SACRAMENTO	6501 COYLE AVENUE	CARMICHAEL

CAUSE OF DEATH

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

		Time Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(A) CARDIOPULMONARY ARREST	(AT) MINS
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B) METABOLIC VS TOXIC ENCEPHALOPATHY	(BT) DAYS
	(C) DIABETIC KETOACIDOSIS	(CT) DAYS
	(D) INSULIN-DEPENDENT DIABETES	(DT) YEARS

108. DEATH REPORTED TO CORONER?	109. BIOPSY PERFORMED?	110. AUTOPSY PERFORMED?	111. USED IN DETERMINING CAUSE?
☒ YES ☐ NO	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☐ NO
REFERRAL NUMBER 24-01669			

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
CARDIOMYOPATHY WITH LAST KNOWN EJECTION FRACTION OF 45 PERCENT LIKELY SECONDARY TO METHAMPHETAMINE SUBSTANCE ABUSE, PROTEIN CALORIE MALNUTRITION

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113A. DECEDENT PREGNANT IN LAST YEAR?
NO	☐ YES ☒ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
	▸ NADEEM MUKHTAR, DO	20A17283	04/04/2024

Decedent Attended Since (A) mm/dd/ccyy	Decedent Last Seen Alive (B) mm/dd/ccyy	118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE
04/06/2023	04/08/2023	NADEEM MUKHTAR, DO 6501 COYLE AVE, CARMICHAEL, CA 95608

CORONER'S USE ONLY

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

120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
☐ YES ☐ NO ☐ UNK		

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

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

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

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸		

STATE REGISTRAR	A	B	C	D	E		FAX AUTH.#	CENSUS TRACT
						PRINTED ON: 04/05/2024 02:29 PM BY LOFTON, JAMES (JLOFTON)		

APPLICATION AND PERMIT FOR DISPOSITION OF HUMAN REMAINS

USE BLACK INK ONLY — MAKE NO ERASURES, WHITEOUTS, PHOTOCOPIES, OR OTHER ALTERATIONS

1A. NAME OF DECEDENT—FIRST	1B. MIDDLE	1C. LAST
JESSIE	-	PETERSON

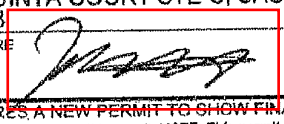
2. SEX	3. DATE OF BIRTH (MONTH, DAY, YEAR)	4. DATE OF DEATH (MONTH, DAY, YEAR)	5. (FETAL DEATH ONLY) DATE OF EVENT (MONTH, DAY, YEAR)
F	08/15/1991	04/08/2023	

6A. CITY OF DEATH	6B. COUNTY OF DEATH—IF OUTSIDE OF CALIFORNIA, ENTER STATE
CARMICHAEL	SACRAMENTO

7A. NAME OF INFORMANT	7B. RELATIONSHIP TO DECEDENT	8A. TYPED NAME AND ADDRESS OF CALIFORNIA-LICENSED FUNERAL DIRECTOR OR PERSON ACTING AS SUCH—STREET NUMBER AND NAME, CITY, STATE, ZIP CODE	8B. CALIFORNIA LICENSE NUMBER—IF APPLICABLE
PHIL MANNING	FUNERAL DIRECTOR	CREMATIONS ONLY 35 QUINTA COURT STE C, SACRAMENTO, CA 95823	FD2208

7C. INFORMANT'S FULL MAILING ADDRESS—STREET NUMBER AND NAME, CITY, STATE, ZIP CODE
35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

ACKNOWLEDGEMENT OF APPLICANT—I hereby acknowledge as applicant that I have the right to control disposition pursuant to Health & Safety Code Section 7100, and that the disposition stated herein is one of the dispositions authorized by Health & Safety Code Section 103055.

9A. APPLICANT SIGNATURE ▶ 

9B. DATE SIGNED 4/5/24

PERMIT AND AUTHORIZATION OF LOCAL REGISTRAR—ANY CHANGE IN DISPOSITION REQUIRES A NEW PERMIT TO SHOW FINAL DISPOSITION
This permit is issued in accordance with provisions of the California Health and Safety Code and is the authority for the disposition specified in this permit. **NOTE: This permit gives no right of disposal outside of California.**

10A. AMOUNT OF FEE PAID	10B. DATE PERMIT ISSUED	10C. SIGNATURE OF LOCAL REGISTRAR ISSUING PERMIT
$ 12.00	04/05/2024	▶ OLIVIA KASIRYE MD

10D. ADDRESS OF REGISTRAR OF DISTRICT OF DEATH—IF DEATH OCCURRED IN CALIFORNIA	10E. ADDRESS OF REGISTRAR OF DISTRICT OF DISPOSITION—IF DIFFERENT FROM 10D
SACRAMENTO PUBLIC HEALTH 7001 EAST PARKWAY, SUITE 600, SACRAMENTO, CA 95823	

11. AUTHORIZED DISPOSITION(S)	FOR CORONER'S USE ONLY
TEMPORARY ENVAULTMENT	

BURIAL OR SCATTERING IN A CEMETERY (INCLUDES ENTOMBMENT)	12A. NAME AND ADDRESS OF CALIFORNIA CEMETERY	12B. DATE BURIED	12C. INTERMENT NUMBER—IF APPLICABLE
		12D. SIGNATURE OF PERSON IN CHARGE OF BURIAL OR SCATTERING ▶	
CREMATION	13A. NAME AND ADDRESS OF CALIFORNIA CREMATORY	13B. DATE CREMATED	13C. CREMATION NUMBER—IF APPLICABLE
		13D. SIGNATURE OF PERSON IN CHARGE OF CREMATION ▶	
SCIENTIFIC USE	14A. NAME AND ADDRESS OF CALIFORNIA FACILITY RECEIVING REMAINS	14B. DATE RECEIVED	
		14C. SIGNATURE OF PERSON IN CHARGE OF FACILITY ▶	
TRANSIT	15A. NAME AND ADDRESS IN RECEIVING STATE OR COUNTRY WHERE REMAINS OR CREMATED REMAINS ARE TO BE SHIPPED	15B. NAME AND ADDRESS OF PERSON IN CHARGE OF PLACING WITH THE CARRIER	
		15C. SIGNATURE OF PERSON IN CHARGE OF PLACING WITH THE CARRIER ▶	15D. DATE SHIPPED
SCATTERING/ BURIAL AT SEA OR DISPOSITION OTHER THAN IN A CEMETERY	16A. ADDRESS, NEAREST POINT ON SHORELINE, OR OTHER DESCRIPTION SUFFICIENT TO IDENTIFY FINAL PLACE AND CALIFORNIA DISTRICT OF DISPOSITION; IF BURIAL AT SEA, ONLY ENTER LATITUDE AND LONGITUDE TEMP ENVAULTMENT AT CREMATIONS ONLY 35 QUINTA COURT SUITE C SACRAMENTO, CA 95823	16B. DATE OF DISPOSITION	16C. LICENSE NUMBER OF CREMATED REMAINS DISPOSER—IF APPLICABLE
		16D. SIGNATURE OF PERSON IN CHARGE OF SCATTERING OR BURIAL ▶	

UPON AUTHORIZATION OF PERMIT, DISTRIBUTE COPIES AS FOLLOWS:

COPY 1 – ACCOMPANIES REMAINS TO THE STATED PLACE OF DISPOSITION. PERSON IN CHARGE OF DISPOSITION IS RESPONSIBLE FOR COMPLETING AND FORWARDING THE PERMIT WITHIN 10 DAYS OF DISPOSITION TO THE REGISTRAR OF THE DISTRICT IN WHICH DISPOSITION OCCURRED OR THE DISTRICT NEAREST THE POINT WHERE THE CREMATED REMAINS WERE SCATTERED AT SEA.*
COPY 2 – RETAINED BY PERSON IN CHARGE OF THE CEMETERY, CREMATORY, FACILITY FOR SCIENTIFIC USE, OR BY THE PERSON IN CHARGE OF DISPOSING OF THE CREMATED REMAINS.
COPY 3 – RETURN TO COUNTY OF DEATH WHEN THE REMAINS ARE DISPOSED OF IN ANOTHER DISTRICT. IF NOT APPLICABLE, COPY 3 MAY BE DISCARDED.*
COPY 4 – RETAINED BY REGISTRAR ISSUING THE PERMIT.*

* THE LOCAL REGISTRAR MAY DESTROY ANY ORIGINAL OR DUPLICATE PERMIT AFTER ONE YEAR FROM ISSUE DATE.

STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF VITAL RECORDS VS 9B Rev. 01/01/2008

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
CEMETERY AND FUNERAL BUREAU
1625 North Market Blvd., Suite S-208, Sacramento, CA 95834
P (916) 574-7870 | F (916) 928-7988 | www.cfb.ca.gov

NOTICE OF CITATION AND ASSESSMENT OF FINE

February 3, 2020

SENT VIA CERTIFIED
AND REGULAR MAIL

Cremations Only (FD 2208)
1321 Howe Ave., Suite 201
Sacramento, CA 95825

RE: License No: FD 2208
Case No: I 2019 419
Citation No: IC 2019 419

The Department of Consumer Affairs, Cemetery and Funeral Bureau (Bureau), issues this citation pursuant to Business and Professions Code (BPC) section 125.9 and California Code of Regulations (CCR), Title 16, Division 12, Article 5.5 (commencing with section 1240).

VIOLATION

BPC section 7707 states:

> *Gross negligence, gross incompetence or unprofessional conduct in the practice of funeral directing or embalming constitutes a ground for disciplinary action.*

Scott Lang, a Field Representative for the Bureau, investigated a complaint filed against Cremations Only (FD 2208), previously known as All Seasons Burial & Cremation. The Bureau's investigation revealed a violation of BPC section 7707 when the establishment failed to timely scatter the cremated remains of multiple decedents, and neglected to oversee the cremated remains in storage to assure scattering was taking place in a timely manner.

Violation of BPC section 7707 constitutes an administrative fine for which ranges from $100.00 to $5,000.00. You are not being assessed an administrative fine for violation of BPC section 7707. Abatement will be considered satisfactory resolution of the violation cited.

The total fine assessment is $0.

Payment of the administrative fine, if any, and abatement will be considered satisfactory resolution of the violation(s) cited.

Notwithstanding the above assessment of fines, in accordance with BPC section 125.9(b)(3), the total fine(s) assessed for the violations contained in this citation shall not exceed

$5,000.00.

This citation shall become a final order of the Bureau 30 days after the date of issuance.

Payment of any administrative fine shall be due within 30 days of the date of issuance of the citation. Payment shall be made by cashier's check or money order only, payable to the Cemetery and Funeral Bureau. A personal or business check will not be accepted. Please indicate the citation number on the cashier's check or money order and mail it to the Bureau at 1625 North Market Blvd., Suite S208, Sacramento, CA 95834.

If you wish to contest all or part of this citation, you may request a formal appeal hearing by filing with the Bureau a written request for a hearing within 30 days of the date of issuance of this citation. For further information regarding a formal appeal, please refer to CCR section 1244 (enclosed).

Without waiving your right to request a formal hearing, you may also request an informal office conference by filing with the Bureau a written request within 10 days of service of the citation, pursuant to CCR section 1245 (enclosed). You may, but need not, be represented by counsel.

If this citation is not contested, either informally or formally, payment of any administrative fine shall not constitute an admission of the violations charged.

Failure to pay any fine within 30 days of the issuance or affirmation of the citation shall constitute a violation and may result in further disciplinary action. If the citation is not contested and the fine is not paid, the full amount of the administrative fine shall be added to the fee for renewal of your license and your license shall not be renewed without payment of the renewal fee and administrative fine.

ORDER OF ABATEMENT

The Bureau hereby directs that you immediately take such action as may be necessary to achieve full compliance with all provisions of the Cemetery and Funeral Act, Health and Safety Code and regulations adopted by the Bureau.

If you have any questions, please contact the Cemetery and Funeral Bureau at (916) 574-7870.

Sincerely,

Gina Sanchez, Bureau Chief
Cemetery and Funeral Bureau

Enclosure

cc: Scott Lang, Field Representative

EXHIBIT 10

BMD-003A

ATTORNEY OR PARTY WITHOUT ATTORNEY: STATE BAR NUMBER: 221261 NAME: Jamie A. Pearson, Esq. FIRM NAME: UBALDI & MCPHERSON LLP STREET ADDRESS: 555 University Ave., Suite 140 CITY SACRAMENTO STATE: CA ZIP CODE: 95825 TELEPHONE NO.: (916) 265-4555 FAX NO.: (916) 265-4568 E-MAIL ADDRESS: lsmith@umllp.com ATTORNEY FOR (*name*) Petitioner Dignity Health dba Mercy San Juan Medical Center	FOR COURT USE ONLY **ELECTRONICALLY FILED** Superior Court of California County of Sacramento 06/24/2024 By: Glenn Juanengo Deputy
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO STREET ADDRESS: 3341 Power Inn Road MAILING ADDRESS: 3341 Power Inn Road CITY AND ZIP CODE: Sacramento, 95826 BRANCH NAME: William R. Ridgeway Family Relations Courthouse	
IN THE MATTER OF (*name*): RENEE B[redacted]	CASE NUMBER: 24PR001815
DECLARATION IN SUPPORT OF PETITION TO ESTABLISH FACT, TIME, AND PLACE OF DEATH	HEARING DATE AND TIME: DEPT.:

(*Name of declarant*): Laura Lukin declares as follows:

1. I make the statements in this declaration based on my personal knowledge or on the contents of the documents identified in item 5. (*"Personal knowledge" of a fact is knowledge that is **not** gained from another person's statements to you about that fact.)*
2. a. I am at least 18 years of age.
   b. I reside at (*street address and city*): Work Address: 4400 Duckhorn Drive, Suite 200, Sacramento, CA 94834

   County: Sacramento State: California
3. (*Name of deceased person*): RENEE B[redacted] died at
   approximately (*time*): 5:34 [X] a.m. [ ] p.m. on (*date*): 11/05/2022 at the following place:
   a. City, town, township, or other (*identify "other" if known*): Mercy San Juan Medical Center, 6501 Coyle Ave., Carmichael
   b. [X] County: Sacramento State (U.S.): California
   c. [ ] State or province: Country:
4. Facts showing when and where the person named in item 3 died and explaining how I have personal knowledge of those facts
   [X] are stated in the space below [X] are stated in Attachment 4 to this declaration.
   (If you are relying solely on the contents of the documents identified in item 5, please advise in the space below.)

   I am relying solely on the contents of documents identified in item 5. Ms. B[redacted] died on November 5, 2022 at Mercy San Juan Medical Center. She has remained in the custody and control of Petitioner since the time of her death. Her sister would like Ms. B[redacted] remains sent to a funeral home, but the remains cannot be released without a death certificate.

IN THE MATTER OF *(name)*: RENEE E[redacted]	CASE NUMBER:

5. [X] Attached are true and correct copies of the following documents *(check each box that applies)*:

   a. [ ] Police report dated *(date of each)*:

   b. [ ] Coroner's report dated *(date)*:

   c. [ ] Private physician's report dated *(date of each)*:

   d. [X] Other documents dated *(describe and give the date of each document; "Other documents" could include school or college records, vaccination certificates and other medical records, employment records, documents showing sources of support other than employment, family correspondence, diaries, photographs, and other similar family records)*:

   Custodian of records declaration for Mercy San Juan Medical Center records plus Mercy San Juan Medical Center records

   [ ] Continued on Attachment 5d.

6. The death of the person named in Item 3, or the date, time, or place of death [X] is not [ ] is Important to a court case or proceeding that is now pending and described below. *(If you selected "is," briefly describe the proceeding and provide the case name and number, the name and address of the court where the proceeding is pending, the names of all parties to the proceeding, and the names, addresses, and telephone numbers of their attorneys. **Note: A court order made on a petition under Health and Safety Code section 103450, et seq., may not be effective against claims of persons or organizations not given notice of the petition for the order.)***

   [ ] Continued on Attachment 6.

7. Number of pages attached: 9

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: June 24, 2024

Laura Lukin, Regional Laboratory Support Supervisor
Pathology Services & Decedent Affairs on behalf of
Petitioner Dignity Health dba Mercy San Juan Medical Center

(TYPE OR PRINT NAME OF DECLARANT)

▶ Laura Lukin

(SIGNATURE OF DECLARANT)

DECLARATION IN SUPPORT OF PETITION TO ESTABLISH FACT, TIME, AND PLACE OF DEATH

SHORT TITLE: IN THE MATTER OF RENEE B[redacted]	CASE NUMBER

ATTACHMENT *(Number)*: 1b(3)

(This Attachment may be used with any Judicial Council form.)

I, LAURA LUKIN, declare as follows:

1. I am employed by CommonSpirit Health as Regional Laboratory Support Supervisor for Pathology Services and am Supervisor of Decedent Affairs. I have held these positions since March of 2022. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. Part of my duties include supervising the Regional Morgue for the Sacramento area CommonSpirit Health/Dignity Health hospitals. Mercy San Juan Medical Center is one of these hospitals. The morgue located within Mercy San Juan Medical Center is very small. Because of this, CommonSpirit Health/Dignity Health has contracted with Sacramento Mortuary Transport ("SMT") to transport deceased patients from Mercy San Juan Medical Center to SMT's facility in South Sacramento until such time as the deceased patients can be released for their final resting places. The deceased patients who have been moved to SMT's facility are still considered "patients" of CommonSpirit/Dignity Health and remain within the system's custody and control. A death certificate is necessary for any deceased patient to be released from CommonSpirit Health/Dignity Health's custody and control and SMT's facility.

3. I am responsible for obtaining death certificates for deceased CommonSpirit Health/Dignity Health patients who have been moved to SMT's facility. In order to accomplish this, it is necessary for me to access the medical records of the deceased patients. Therefore, I have access to Renee B[redacted] medical records from Mercy San Juan Medical Center. I have reviewed Ms. B[redacted] medical records, including those medical records that have been included as supporting evidence for this Petition. My personal knowledge of the date, time, and place of Ms. B[redacted] death are based on my review of the medical records attached to this Petition. The remains of Renee B[redacted] are currently located at SMT's facility, but remain within the custody and control of CommonSpirit Health/Dignity Health.

4. Renee B[redacted] died at Mercy San Juan Medical Center, located at 6501 Coyle Avenue, Carmichael, CA, 95608, on November 5, 2022. An ambulance brought Ms. B[redacted] to Mercy San Juan Medical Center after she suffered a cardiac arrest approximately 45 minutes prior to her arrival. She received continuous cardiopulmonary resuscitation first from the ambulance crew then from the Emergency Department staff. The emergency medicine physician attempted to call family members listed on the hospital face sheet, but was only able to leave voice mail messages. Ms. B[redacted] had a signed POLST form on file ("portable medical orders") that indicated her wishes to not be resuscitated or intubated. She was then extubated and placed on comfort care, shortly after which she became pulseless and apneic. She passed away at 0534 hours.

5. Her attending physician noted that the causes of death were cardiac arrest (minutes); acute hypoxic respiratory failure (minutes); end-stage renal disease on dialysis (months). The Medical Examiner was notified of her death.

6. Ms. B[redacted] has a son, [redacted] and a sister, [redacted] Voicemail messages have been left for [redacted], as recently as April 24, 2024, [redacted] was contacted on April 24, 2024, and said [redacted] has changed his telephone number multiple times. [redacted] also stated it was her intention to find a funeral home for Ms. B[redacted], but that a death certificate was required. [redacted] was informed that Petitioner would obtain the death certificate. Mercy San Juan Medical Center cannot release Ms. B[redacted] remains until a death certificate is obtained.

7. The COVID-19 pandemic impacted the process of obtaining death certificates for CommonSpirit Health/Dignity Health patients. The pandemic created a backlog of patients being held at SMT's facility. This backlog, and the associated staffing issues that arose in order to address the backlog, are the reasons why Ms. B[redacted] death certificate was not entered within a year of her death.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 24 day of June, 2024, at Sacramento, California.

Laura Lukin

LAURA LUKIN

(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)

CUSTODIAN OF RECORDS DECLARATION

I, STEPHANIE GONZALES, declare as follows:

1. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. I am an authorized custodian of records for the records maintained on patients treated at Mercy San Juan Medical Center. My title is Manager of Health Information Management.

3. A patient chart is maintained on each patient treated at Mercy San Juan Medical Center. This chart is maintained by the Health Information Management Department at Mercy San Juan Medical Center.

4. The documents and entries in documents pertaining to a patient are prepared at or near the time of their occurrence by persons with knowledge of the circumstances or events.

5. The Mercy San Juan Medical Center medical records attached to this declaration are true and correct copies of documents from the patient chart of Renee B[redacted], date of birth 08/24/1962 for care and treatment she received at Mercy San Juan Medical Center on November 5, 2022. These records are maintained in the regular course of business by Mercy San Juan Medical Center.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 20th day of June, 2024.

S Gonzales

STEPHANIE GONZALES

Notification of Death
11/05/22 05:39 PDT Performed by Morey, Colette RN
Entered on 11/05/22 05:42 PDT

Updated on
11/05/22 06:09 PDT by Morey, Colette RN
11/05/22 05:57 PDT by Morey, Colette RN
11/05/22 05:45 PDT by Morey, Colette RN

Notification
Notifications: Medical examiner, Admitting, Organ bank, Supervisor
Pronounced by: Penna
Date/Time of Death: 11/05/22 05:34
Potential Medical Examiner Case: Yes
Candidate to Donate per Organ Bank: Eyes, Tissue
Organ Donation Approval: Other: Organ bank would like to be notified when next of kin has been contacted
Date/Time Organ Bank Notified: 11/05/22 05:43
Organ Bank Member Notified: Marcy referral number 12935815
Release of Remains: Yes
Release of Decedent: Yes

Release of Remains
Family consent signature: 4/24/24: called son [redacted] at [redacted]
Family consent print: left VM.
Family consent date: called sister [redacted] at [redacted]
Witness signature: left a VM. [redacted] will call coroner's office
Witness consent print: for indigent cremation. She said [redacted]
Witness consent date: has changed his phone # multiple times so we don't have contact for him.

Release of Decedent
Mortuary rep sig:
Mortuary rep print: 4/24/24: Spoke with [redacted] again, Coroner
Mortuary rep date: called that DC isn't done. Medical Records would not give her the cause of death.
Release Witness sig: [redacted] wants to find a funeral home for
Release Witness print: Renee instead, check back in.
Release Witness date:

Medical Examiner
Name of ME Notified of Death: Griffin
Badge Number: 34
Date/Time ME Notified of Death: 11/05/22 06:02
Medical Examiner Released Case: Yes

EXHIBIT 11

A02

ORDER ESTABLISHING FACT OF DEATH

FILED / ENDORSED
JAN 16 2025
By , Deputy Clerk

In the Superior Court of the State of California

In and for the County of Sacramento

In the matter of the petition of

Dignity Health dba Mercy San Juan Medical Center

Number 25PR000061

Department 129

To establish the fact of death of

ALMEZA D[redacted]

The verified petition of Dignity Health dba Mercy San Juan Medical Center to establish the fact of the death of ALMEZA D[redacted] having been filed herein on the 9th day of January, A.D., 2025, and such petition having by an order of court been duly set for hearing on the 16th day of January, A.D., 2025, at the hour of 1:30 o'clock p.m. m. of said day; and now on said day said matter coming on regularly for hearing and it appearing to the satisfaction of this court from the evidence introduced that the said Dignity Health dba Mercy San Juan Medical Center, petitioner herein, is beneficially interested in establishing of record the fact of the death of said ALMEZA D[redacted], in that Mr. D[redacted] died at Mercy San Juan Medical Center on December 24, 2022, and has remained in Petitioner's custody, control, and possession since that date. The Sacramento County Public Administrator denied referral of the case because no family or financial assets could be found ; and it appearing that on the 24th day of December, A.D., 2022, the death of ALMEZA D[redacted] occurred at Mercy San Juan Medical Center, in the County of Sacramento, State of California; that said death has not been registered in conformity with the provisions of law in effect at the time of said death or such record has been lost or destroyed after having been filed; and no one appearing at said hearing to oppose the making of this order;

It is therefore ordered, adjudged, and decreed that on the 24th day of December, A.D., 2022, the death of ALMEZA D[redacted] occurred at Mercy San Juan Medical Center, County of Sacramento, State of California.

Done in court this 16th day of January, A.D., 2025

▶ _____
Judge of the Superior Court

HEATH LANGLE
COURT COMMISSIONER

Before filing the above order, insert in the certificate form below, as of the date of the death, the personal and statistical particulars required for the records of the State Registrar. A certified copy of the above order must be filed with the State Registrar before the order shall become effective. **USE BLACK INK ONLY.**

STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF VITAL RECORDS **FORM VS 109 (Rev. 04/20)**

VS109-S1 012008

COURT ORDER DELAYED REGISTRATION OF DEATH
STATE OF CALIFORNIA

NO ERASURES, WHITEOUTS, PHOTOCOPIES, OR ALTERATIONS

STATE FILE NUMBER _____ LOCAL REGISTRATION NUMBER _____

TYPE OR PRINT CLEARLY IN BLACK INK ONLY – THIS FORM BECOMES THE OFFICIAL DEATH RECORD

DECEDENT PERSONAL DATA

1A. NAME—FIRST	1B. MIDDLE	1C. LAST
ALMEZA		D[redacted]

2A. DATE OF DEATH—MM/DD/CCYY	2B. HOUR	3. DATE OF BIRTH—MM/DD/CCYY	4. AGE IN YEARS	IF UNDER ONE YEAR: MONTHS / DAYS	IF UNDER 24 HOURS: HOURS / MINUTES
12/24/2022	1146 [redacted]	[redacted]1951	71		

5. BIRTH STATE/FOREIGN COUNTRY	6. HISPANIC (IF YES, SPECIFY ORIGIN)	7. RACE—Up to 3 Races/Ethnicities May Be Listed	8. SEX
UNKNOWN	YES ☐ _____ NO ☒	UNKNOWN	Male

9. MILITARY SERVICE?	10. SOCIAL SECURITY NUMBER	11. EDUCATION—YEARS COMPLETED	12. MARITAL/STATE REGISTERED DOMESTIC PARTNERSHIP STATUS
YES ☐ NO ☐ UNK ☒	[redacted]	UNKNOWN	UNKNOWN

13A. USUAL OCCUPATION	13B. USUAL KIND OF BUSINESS/INDUSTRY	13C. USUAL EMPLOYER	13D. YEARS IN OCCUPATION
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

14A. NAME OF SURVIVING SPOUSE/STATE REGISTERED DOMESTIC PARTNER--FIRST	14B. MIDDLE	14C. LAST (BIRTH)
UNKNOWN	UNKNOWN	UNKNOWN

15A. NAME OF FATHER/PARENT--FIRST	15B. MIDDLE	15C. LAST (BIRTH)	16. STATE/FOREIGN COUNTRY OF BIRTH
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

17A. NAME OF MOTHER/PARENT—FIRST	17B. MIDDLE	17C. LAST (BIRTH)	18. STATE/FOREIGN COUNTRY OF BIRTH
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN

USUAL RESIDENCE

19A. RESIDENCE—STREET and NUMBER, OR LOCATION	19B. CITY	19C. STATE/FOREIGN COUNTRY	19D. ZIP CODE
[redacted]	Sacramento	California	95841

19E. COUNTY	19F. NUMBER OF YEARS IN THIS COUNTY
Sacramento	UNKNOWN

20. NAME, RELATIONSHIP, MAILING ADDRESS, AND ZIP CODE OF INFORMANT

Laura Lukin, Regional Laboratory Support Supervisor for Pathology Services & Decedent Affairs, 4400 Duckhorn Dr., #200, Sacramento, CA 94834, on behalf of Mercy San Juan Medical Center

PLACE OF DEATH

21A. PLACE OF DEATH	21B. COUNTY
Mercy San Juan Medical Center	Sacramento

21C. ADDRESS—STREET and NUMBER, OR LOCATION	21D. CITY
6501 Coyle Ave.	Carmichael

21E. IF HOSPITAL, SPECIFY: ☐ IP ☒ ER/OP ☐ DOA

21F. IF OTHER THAN HOSPITAL, SPECIFY: ☐ HOSPICE ☐ NURSING HOME/LTC ☐ HOME ☐ OTHER

CAUSE OF DEATH

22. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR A, B, AND C)

IMMEDIATE CAUSE (A) Cardiac arrest

DUE TO (B)

DUE TO (C)

TIME INTERVAL BETWEEN ONSET AND DEATH: Hours

23. DEATH REPORTED TO CORONER? ☐ YES _____ ☐ NO
REFERRAL NUMBER

24. BIOPSY PERFORMED? ☐ YES _____ ☒ NO

25A. AUTOPSY PERFORMED? ☐ YES _____ ☒ NO

25B. USED IN DETERMINING CAUSE? ☐ YES _____ ☒ NO

26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN ITEM 22.	27. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 22 OR 26? IF YES, LIST TYPE OF OPERATION AND DATE.	28. IF FEMALE, PREGNANT IN YEAR PRIOR TO DEATH? ☐ YES _____ ☐ NO

INJURY INFORMATION

29. LOCATION—STREET AND NUMBER, OR LOCATION, AND CITY

30. DESCRIBE HOW INJURY OCCURRED (EVENTS WHICH RESULTED IN INJURY)

FUNERAL DIRECTOR

31A. DISPOSITION(S)	31B. PLACE OF FINAL DISPOSITION (NAME AND FULL ADDRESS)	31C. DATE OF DISPOSITION—MM/DD/CCYY

32A. NAME OF FUNERAL ESTABLISHMENT (OR PERSON ACTING IN LIEU OF FUNERAL DIRECTOR)	32B. LICENSE NUMBER

STATE REGISTRAR USE ONLY

OFFERED FOR FILING PURSUANT TO ORDER NUMBER _____ OF THE SUPERIOR COURT OF THE STATE OF CALIFORNIA IN AND FOR THE COUNTY OF _____, MADE THE _____ DAY OF _____, A.D., 20____, ESTABLISHING OF RECORD THE FACT OF DEATH IN THE STATE OR COUNTRY OF _____. NO DEATH CERTIFICATE HAS BEEN FOUND ON FILE IN THE OFFICE OF VITAL RECORDS FOR THE ABOVE DECEDENT.

33. OFFICE OF VITAL RECORDS	34. DATE ACCEPTED FOR REGISTRATION

EXHIBIT 12

Gmail **Jennifer Richards <mssllc.jennifer@gmail.com>**

5/2/2023 Inventory Lists

1 message

Jennifer Richards <mssllc.jennifer@gmail.com> Tue, May 2, 2023 at 8:04 PM
To: Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org>, Letricia Hunt CA-SACRAMENTO <letricia.hunt@commonspirit.org>

Good evening,

Attached please find inventory lists as of 5/2/2023.

Thank you,

--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
MSSLLC.Jennifer@gmail.com

6 attachments

- **WOODLAND MEMORIAL 05022023.pdf** 44K
- **BRUCEVILLE TERRACE 05022023.pdf** 48K
- **MERCY FOLSOM 05022023.pdf** 47K
- **MERCY SAN JUAN 05022023.pdf** 59K
- **MERCY GENERAL 05022023.pdf** 53K
- **METHODIST 05022023.pdf** 54K

05/02/2023 5:58 PM

Bruceville Terrace

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	10/19/2022 21:33:11	Bruceville Terrace	[redacted]	
2	4/23/2023 9:36:58	Bruceville Terrace		
3	4/30/2023 6:27:17	Bruceville Terrace		

05/02/2023 5:59 PM

Mercy Hospital of Folsom

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	8/21/2022 14:06:08	Mercy Hospital of Folsom	[redacted]	
2	9/13/2022 3:07:27	Mercy Hospital of Folsom		

05/02/2023 5:59 PM

Mercy General Hospital

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	10/12/2021 11:28:11	Mercy General Hospital	[redacted]	
2	10/12/2021 11:28:11	Mercy General Hospital		
3	1/18/2022 11:09:28	Mercy General Hospital		
4	2/7/2022 10:55:52	Mercy General Hospital		
5	2/16/2022 14:23:22	Mercy General Hospital		
6	4/29/2022 14:29:25	Mercy General Hospital		
7	5/16/2022 12:19:19	Mercy General Hospital		
8	8/3/2022 16:16:47	Mercy General Hospital		
9	8/22/2022 14:07:23	Mercy General Hospital		
10	12/11/2022 17:08:43	Mercy General Hospital		
11	12/12/2022 16:52:25	Mercy General Hospital		
12	1/11/2023 14:08:32	Mercy General Hospital		
13	1/18/2023 12:43:47	Mercy General Hospital		
14	2/26/2023 12:33:29	Mercy General Hospital		
15	3/29/2023 11:32:33	Mercy General Hospital		
16	4/4/2023 13:03:04	Mercy General Hospital		
17	4/12/2023 12:33:26	Mercy General Hospital		
18	4/17/2023 18:00:42	Mercy General Hospital		
19	4/24/2023 14:58:16	Mercy General Hospital		
20	4/30/2023 13:35:52	Mercy General Hospital		
21	4/30/2023 13:52:38	Mercy General Hospital		
22	4/30/2023 13:57:09	Mercy General Hospital		
23	5/2/2023 15:28:48	Mercy General Hospital		

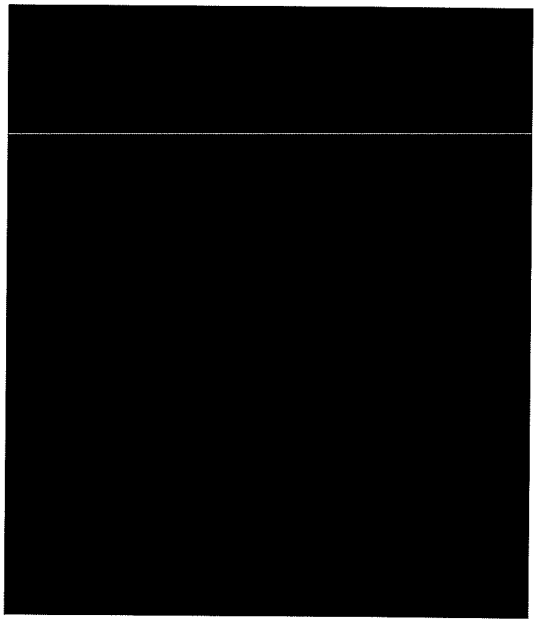
05/02/2023 6:00 PM

Mercy San Juan Medical Center

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	10/13/2021 16:28:20	Mercy San Juan Medical Center	[redacted]	
2	10/27/2021 15:20:52	Mercy San Juan Medical Center		
3	1/8/2022 19:24:04	Mercy San Juan Medical Center		
4	1/17/2022 16:07:06	Mercy San Juan Medical Center		
5	1/18/2022 16:52:07	Mercy San Juan Medical Center		
6	2/2/2022 13:45:03	Mercy San Juan Medical Center		
7	2/9/2022 3:30:43	Mercy San Juan Medical Center		
8	3/5/2022 15:28:09	Mercy San Juan Medical Center		
9	3/16/2022 13:01:39	Mercy San Juan Medical Center		
10	5/31/2022 14:55:22	Mercy San Juan Medical Center		
11	6/2/2022 19:12:25	Mercy San Juan Medical Center		
12	6/19/2022 14:39:17	Mercy San Juan Medical Center		
13	6/19/2022 14:40:16	Mercy San Juan Medical Center		
14	7/10/2022 1:42:52	Mercy San Juan Medical Center		
15	8/20/2022 20:36:02	Mercy San Juan Medical Center		
16	9/18/2022 1:02:36	Mercy San Juan Medical Center		
17	10/4/2022 12:12:52	Mercy San Juan Medical Center		
18	10/21/2022 18:12:00	Mercy San Juan Medical Center		
19	11/6/2022 23:14:35	Mercy San Juan Medical Center		
20	11/12/2022 11:59:39	Mercy San Juan Medical Center		
21	11/24/2022 11:51:38	Mercy San Juan Medical Center		
22	12/10/2022 9:02:49	Mercy San Juan Medical Center		
23	12/11/2022 17:35:27	Mercy San Juan Medical Center		
24	12/16/2022 11:07:15	Mercy San Juan Medical Center		
25	12/23/2022 15:21:20	Mercy San Juan Medical Center		
26	12/25/2022 6:02:14	Mercy San Juan Medical Center		
27	12/29/2022 19:36:06	Mercy San Juan Medical Center		
28	1/1/2023 18:20:38	Mercy San Juan Medical Center		
29	1/9/2023 0:10:45	Mercy San Juan Medical Center		
30	1/21/2023 15:25:06	Mercy San Juan Medical Center		
31	2/22/2023 12:52:27	Mercy San Juan Medical Center		
32	2/23/2023 13:38:16	Mercy San Juan Medical Center		
33	3/4/2023 20:09:27	Mercy San Juan Medical Center		
34	3/15/2023 11:43:25	Mercy San Juan Medical Center		
35	3/15/2023 12:47:28	Mercy San Juan Medical Center		
36	3/26/2023 13:16:16	Mercy San Juan Medical Center		
37	3/28/2023 12:50:12	Mercy San Juan Medical Center		
38	3/28/2023 12:53:17	Mercy San Juan Medical Center		
39	3/29/2023 12:21:29	Mercy San Juan Medical Center		
40	3/29/2023 15:43:47	Mercy San Juan Medical Center		

41	4/9/2023 17:39:57	Mercy San Juan Medical Center
42	4/14/2023 13:04:31	Mercy San Juan Medical Center
43	4/19/2023 12:13:09	Mercy San Juan Medical Center
44	4/24/2023 19:52:03	Mercy San Juan Medical Center
45	4/27/2023 12:34:17	Mercy San Juan Medical Center
46	4/28/2023 16:32:35	Mercy San Juan Medical Center
47	4/30/2023 1:11:38	Mercy San Juan Medical Center
48	4/30/2023 1:28:59	Mercy San Juan Medical Center
49	4/30/2023 14:07:19	Mercy San Juan Medical Center
50	4/30/2023 15:30:18	Mercy San Juan Medical Center
52	5/1/2023 14:35:48	Mercy San Juan Medical Center
53	5/1/2023 15:34:48	Mercy San Juan Medical Center
54	5/1/2023 23:37:56	Mercy San Juan Medical Center
55	5/2/2023 13:00:50	Mercy San Juan Medical Center
56	5/2/2023 13:03:01	Mercy San Juan Medical Center
57	5/2/2023 13:40:46	Mercy San Juan Medical Center
58	5/2/2023 13:42:22	Mercy San Juan Medical Center

JESSIE PETERSON



05/02/2023 6:00 PM

Methodist Hospital of Sacramento

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	10/12/2021 11:28:11	Methodist Hospital of Sacramento	[redacted]	
2	11/18/2021 10:59:56	Methodist Hospital of Sacramento		
3	6/7/2022 1:32:47	Methodist Hospital of Sacramento		
4	6/21/2022 5:09:43	Methodist Hospital of Sacramento		
5	7/15/2022 8:43:21	Methodist Hospital of Sacramento		
6	9/17/2022 20:28:10	Methodist Hospital of Sacramento		
7	10/12/2022 0:00:00	Methodist Hospital of Sacramento		
8	12/12/2022 10:11:57	Methodist Hospital of Sacramento		
9	12/14/2022 20:41:13	Methodist Hospital of Sacramento		
10	12/18/2022 5:39:44	Methodist Hospital of Sacramento		
11	2/9/2023 11:46:57	Methodist Hospital of Sacramento		
12	2/23/2023 10:45:55	Methodist Hospital of Sacramento		
13	4/2/2023 18:32:16	Methodist Hospital of Sacramento		
14	4/23/2023 5:03:47	methodist Hospital of Sacramento		
15	4/28/2023 10:24:01	Methodist Hospital of Sacramento		
16	5/1/2023 15:02:02	Methodist Hospital of Sacramento		

05/02/2023 6:01 PM

Woodland Memorial Hospital

	Timestamp	BillingParty	Decedent First Name	Decedent Last Name
1	4/13/2023 14:24:27	Woodland Memorial Hospital	[redacted]	

Gmail **Jennifer Richards <mssllc.jennifer@gmail.com>**

Hi Jennifer

2 messages

Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org> Thu, Jul 20, 2023 at 11:38 AM
To: Jennifer Richards <mssllc.jennifer@gmail.com>

Hello. I was hoping I would be released to work by now but the MD said no.

Would you mind sending me a list of the current inventory? How are things going?

Laura Lukin
Regional Laboratory Support Supervisor
Clinical Laboratory and Pathology Services

Dignity Health

Sacramento System Office

4400 Duckhorn Drive, Suite 200

Sacramento, CA 95834

831-706-8087 (cell)

laura.lukin@commonspirit.org

Jennifer Richards <mssllc.jennifer@gmail.com> Thu, Jul 20, 2023 at 1:01 PM
To: Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org>

Good morning, Laura,

Well, sometimes we just need to allow ourselves more time. I have a procedure coming up in September. The doctor says I will need 6 weeks; I say, Oh no, we can do 4. She laughed at me. So we will, but I do hope you are feeling well.

I have attached a current list for your reference. Things are going well; it hasn't been too busy on our end. I cannot speak for Dignity. The good news is that the coroner is starting to move cases out, and we have been able to assist with a few death certificate filings.

Let me know if we can be of further assistance.
[Quoted text hidden]
--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
MSSLLC.Jennifer@gmail.com

Dignity Inventory 07202023.xlsx
15K

Timestamp	Hospital Name	Decedent First Name	Decedent Last Name
8/21/2022 14:06	Mercy Hospital of Folsom	[redacted]	
9/13/2022 3:07	Mercy Hospital of Folsom		
5/27/2023 21:39	Mercy Hospital of Folsom		
7/9/2023 4:17	Mercy Hospital of Folsom		
7/16/2023 18:13	Mercy Hospital of Folsom		
10/19/2022 21:33	Bruceville Terrace		
4/23/2023 9:36	Bruceville Terrace		
4/30/2023 6:27	Bruceville Terrace		
6/4/2023 20:26	Bruceville Terrace		
6/27/2023 15:33	Bruceville Terrace		
7/9/2023 2:05	Bruceville Terrace		
10/12/2021 11:28	Mercy General Hospital		
10/12/2021 11:28	Mercy General Hospital		
1/18/2022 11:09	Mercy General Hospital		
2/7/2022 10:55	Mercy General Hospital		
2/16/2022 14:23	Mercy General Hospital		
4/29/2022 14:29	Mercy General Hospital		
5/16/2022 12:19	Mercy General Hospital		
8/22/2022 14:07	Mercy General Hospital		
12/11/2022 17:08	Mercy General Hospital		
1/11/2023 14:08	Mercy General Hospital		
1/18/2023 12:43	Mercy General Hospital		
2/26/2023 12:33	Mercy General Hospital		
3/29/2023 11:32	Mercy General Hospital		
5/16/2023 14:52	Mercy General Hospital		
5/17/2023 14:10	Mercy General Hospital		
5/25/2023 0:51	Mercy General Hospital		
6/2/2023 13:32	Mercy General Hospital		
6/8/2023 19:48	Mercy General Hospital		
6/12/2023 2:07	Mercy General Hospital		
6/15/2023 17:02	Mercy General Hospital		
7/14/2023 11:51	Mercy General Hospital		
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7/14/2023 17:13	Mercy General Hospital		
7/17/2023 13:53	Mercy General Hospital		
7/17/2023 13:55	Mercy General Hospital		
7/17/2023 15:18	Mercy General Hospital		
10/13/2021 16:28	Mercy San Juan Medical Center		
10/27/2021 15:20	Mercy San Juan Medical Center		
1/8/2022 19:24	Mercy San Juan Medical Center		
1/17/2022 16:07	Mercy San Juan Medical Center		
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2/9/2022 3:30	Mercy San Juan Medical Center		
3/5/2022 15:28	Mercy San Juan Medical Center		
3/16/2022 13:01	Mercy San Juan Medical Center		
5/31/2022 14:55	Mercy San Juan Medical Center		

6/2/2022 19:12 Mercy San Juan Medical Center
6/19/2022 14:39 Mercy San Juan Medical Center
6/19/2022 14:40 Mercy San Juan Medical Center
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10/21/2022 18:12 Mercy San Juan Medical Center
11/6/2022 23:14 Mercy San Juan Medical Center
11/12/2022 11:59 Mercy San Juan Medical Center
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12/11/2022 17:35 Mercy San Juan Medical Center
12/16/2022 11:07 Mercy San Juan Medical Center
12/23/2022 15:21 Mercy San Juan Medical Center
12/25/2022 6:02 Mercy San Juan Medical Center
12/29/2022 19:36 Mercy San Juan Medical Center
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1/9/2023 0:10 Mercy San Juan Medical Center
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7/17/2023 2:38 Mercy San Juan Medical Center
7/19/2023 17:38 Mercy San Juan Medical Center
10/12/2021 11:28 Methodist Hospital of Sacramento
11/18/2021 10:59 Methodist Hospital of Sacramento
6/7/2022 1:32 Methodist Hospital of Sacramento
6/21/2022 5:09 Methodist Hospital of Sacramento

[redacted]

JESSIE PETERSON

[redacted]

7/15/2022 8:43	Methodist Hospital of Sacramento
9/17/2022 20:28	Methodist Hospital of Sacramento
10/12/2022 0:00	Methodist Hospital of Sacramento
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12/14/2022 20:41	Methodist Hospital of Sacramento
12/18/2022 5:39	Methodist Hospital of Sacramento
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2/23/2023 10:45	Methodist Hospital of Sacramento
4/2/2023 18:32	Methodist Hospital of Sacramento
5/23/2023 20:22	Methodist Hospital of Sacramento
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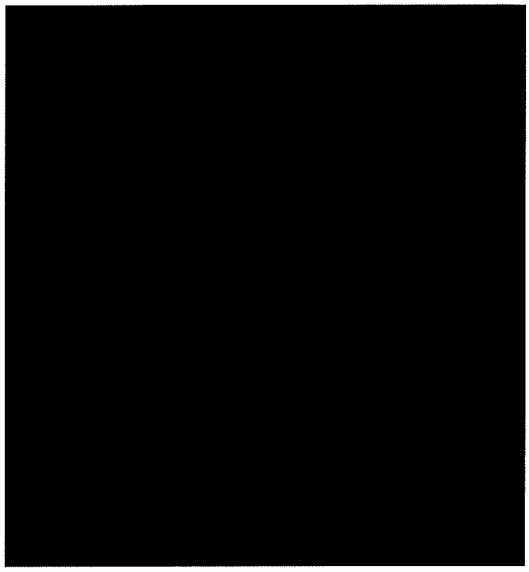
7/14/2023 1:37	Methodist Hospital of Sacramento
7/14/2023 1:39	Methodist Hospital of Sacramento
7/17/2023 1:08	Methodist Hospital of Sacramento
7/18/2023 5:34	Methodist Hospital of Sacramento
6/6/2023 22:25	Woodland Memorial Hospital



Gmail **Jennifer Richards <mssllc.jennifer@gmail.com>**

Inventory

1 message

Jennifer Richards <mssllc.jennifer@gmail.com> Tue, Sep 12, 2023 at 12:49 PM
To: Laura Lukin CA-Rancho Cordova <laura.lukin@commonspirit.org>

--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
MSSLLC.Jennifer@gmail.com

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138K

09122023 1013am

Methodist Hospital of Sacrament

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8	12/12/2022 10:11:57	Methodist Hospital of Sacramento		
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10	12/18/2022 5:39:44	Methodist Hospital of Sacramento		
11	2/9/2023 11:46:57	Methodist Hospital of Sacramento		
12	4/17/2023 3:00:02	Methodist Hospital of Sacramento		
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18	9/3/2023 4:17:36	Methodist Hospital of Sacramento		
19	9/12/2023 8:02:28	Methodist Hospital of Sacramento		
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09122023 1013am

Mercy General Hospital

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6	8/22/2022 14:07:23	Mercy General Hospital		
7	12/11/2022 17:08:43	Mercy General Hospital		
8	1/11/2023 14:08:32	Mercy General Hospital		
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15	7/31/2023 13:19:11	Mercy General Hospital		
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19	8/28/2023 16:33:51	Mercy General Hospital		
20	9/4/2023 12:17:57	Mercy General Hospital		
21	9/8/2023 13:53:13	Mercy General Hospital		
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09122023 1013am

Mercy Hospital of Folsom

	Timestamp		Decedent First Name	Decedent Last Name
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3	5/27/2023 21:39:51	Mercy Hospital of Folsom		
4	7/9/2023 4:17:35	Mercy Hospital of Folsom		
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09122023 1013am

Bruceville Terrace

	Timestamp		Decedent First Name	Decedent Last Name
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09122023 1028am

Mercy San Juan Medical Center

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5	2/2/2022 13:45:03	Mercy San Juan Medical Center		
6	2/9/2022 3:30:43	Mercy San Juan Medical Center		
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15	9/18/2022 1:02:36	Mercy San Juan Medical Center		
16	10/4/2022 12:12:52	Mercy San Juan Medical Center		
17	10/21/2022 18:12:00	Mercy San Juan Medical Center		
18	11/6/2022 23:14:35	Mercy San Juan Medical Center		
19	11/12/2022 11:59:39	Mercy San Juan Medical Center		
20	11/24/2022 11:51:38	Mercy San Juan Medical Center		
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25	12/25/2022 6:02:14	Mercy San Juan Medical Center		
26	12/29/2022 19:36:06	Mercy San Juan Medical Center		
27	1/1/2023 18:20:38	Mercy San Juan Medical Center		
28	1/9/2023 0:10:45	Mercy San Juan Medical Center		
29	1/21/2023 15:25:06	Mercy San Juan Medical Center		
30	2/23/2023 13:38:16	Mercy San Juan Medical Center		
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37	3/29/2023 12:21:29	Mercy San Juan Medical Center		
38	3/29/2023 15:43:47	Mercy San Juan Medical Center		
39	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
40	4/30/2023 15:30:18	Mercy San Juan Medical Center	[redacted]	

41	5/11/2023 13:48:54	Mercy San Juan Medical Center
42	5/12/2023 16:02:58	Mercy San Juan Medical Center
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44	7/28/2023 14:19:32	Mercy San Juan Medical Center
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62	9/11/2023 0:36:26	Mercy San Juan Medical Center
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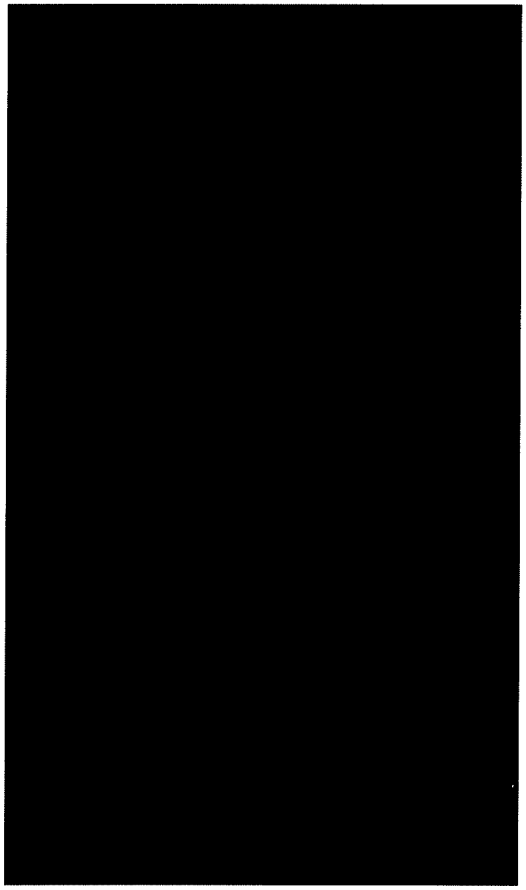


Gmail

Jennifer Richards <jennifer@cremationsandburial.com>

PETERSON Jessie

2 messages

Jennifer Richards <jennifer@cremationsandburial.com>
To: Laura Lurkin <laura.lukin@commonspirit.org>

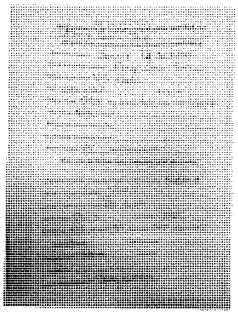
Wed, Oct 2, 2024 at 11:19 AM

Hello Laura

I have attached an image of the run slip - please let me know if you need anything more!
--

Jennifer Richards
Chief Operations Officer, Mortuary Support Services

dba Sacramento Mortuary Transport dba Cremations Only dba All Seasons FS
35 Quinta Ct Ste C/D Sacramento CA 95823
Phone: (888) 974-3923 | Fax: (888) 792-5485
jennifer@cremationsandburial.com

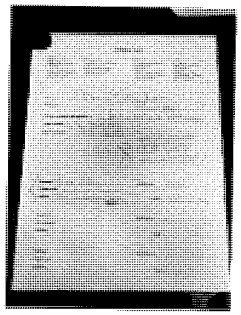


PETERSON, Jessie MSJ.jpg
1224K

Jennifer Richards <jennifer@cremationsandburial.com>
To: Laura Lurkin <laura.lukin@commonspirit.org>

Wed, Oct 2, 2024 at 11:40 AM

Here is the release too - just in case
[Quoted text hidden]



PETERSON Jessie Release MSJ.jpg
1160K

07/14/2023 12:10 PM

Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
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3	1/8/2022 19:24:04	Mercy San Juan Medical Center	[redacted]	[redacted]
4	1/17/2022 16:07:06	Mercy San Juan Medical Center	[redacted]	[redacted]
5	2/2/2022 13:45:03	Mercy San Juan Medical Center	[redacted]	[redacted]
6	2/9/2022 3:30:43	Mercy San Juan Medical Center	[redacted]	[redacted]
7	3/5/2022 15:28:09	Mercy San Juan Medical Center	[redacted]	[redacted]
8	3/16/2022 13:01:39	Mercy San Juan Medical Center	[redacted]	[redacted]
9	5/31/2022 14:55:22	Mercy San Juan Medical Center	[redacted]	[redacted]
10	6/2/2022 19:12:25	Mercy San Juan Medical Center	[redacted]	[redacted]
11	6/19/2022 14:39:17	Mercy San Juan Medical Center	[redacted]	[redacted]
12	6/19/2022 14:40:16	Mercy San Juan Medical Center	[redacted]	[redacted]
13	7/10/2022 1:42:52	Mercy San Juan Medical Center	[redacted]	[redacted]
14	8/20/2022 20:36:02	Mercy San Juan Medical Center	[redacted]	[redacted]
15	9/18/2022 1:02:36	Mercy San Juan Medical Center	[redacted]	[redacted]
16	10/4/2022 12:12:52	Mercy San Juan Medical Center	[redacted]	[redacted]
17	10/21/2022 18:12:00	Mercy San Juan Medical Center	[redacted]	[redacted]
18	11/6/2022 23:14:35	Mercy San Juan Medical Center	[redacted]	[redacted]
19	11/12/2022 11:59:39	Mercy San Juan Medical Center	[redacted]	[redacted]
20	11/24/2022 11:51:38	Mercy San Juan Medical Center	[redacted]	[redacted]
21	12/10/2022 9:02:49	Mercy San Juan Medical Center	[redacted]	[redacted]
22	12/11/2022 17:35:27	Mercy San Juan Medical Center	[redacted]	[redacted]
23	12/16/2022 11:07:15	Mercy San Juan Medical Center	[redacted]	[redacted]
24	12/23/2022 15:21:20	Mercy San Juan Medical Center	[redacted]	[redacted]
25	12/25/2022 6:02:14	Mercy San Juan Medical Center	[redacted]	[redacted]
26	12/29/2022 19:36:06	Mercy San Juan Medical Center	[redacted]	[redacted]
27	1/1/2023 18:20:38	Mercy San Juan Medical Center	[redacted]	[redacted]
28	1/9/2023 0:10:45	Mercy San Juan Medical Center	[redacted]	[redacted]
29	1/21/2023 15:25:06	Mercy San Juan Medical Center	[redacted]	[redacted]
30	2/23/2023 13:38:16	Mercy San Juan Medical Center	[redacted]	[redacted]
31	3/4/2023 20:09:27	Mercy San Juan Medical Center	[redacted]	[redacted]
32	3/15/2023 11:43:25	Mercy San Juan Medical Center	[redacted]	[redacted]
33	3/15/2023 12:47:28	Mercy San Juan Medical Center	[redacted]	[redacted]
34	3/26/2023 13:16:16	Mercy San Juan Medical Center	[redacted]	[redacted]
35	3/28/2023 12:50:12	Mercy San Juan Medical Center	[redacted]	[redacted]
36	3/28/2023 12:53:17	Mercy San Juan Medical Center	[redacted]	[redacted]
37	3/29/2023 12:21:29	Mercy San Juan Medical Center	[redacted]	[redacted]
38	3/29/2023 15:43:47	Mercy San Juan Medical Center	[redacted]	[redacted]
39	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
40	4/19/2023 12:13:09	Mercy San Juan Medical Center	[redacted]	[redacted]

41	4/30/2023 15:30:18	Mercy San Juan Medical Center	[redacted]	[redacted]
42	5/11/2023 13:48:54	Mercy San Juan Medical Center	[redacted]	[redacted]
43	5/12/2023 16:02:58	Mercy San Juan Medical Center	[redacted]	[redacted]
44	6/4/2023 16:51:34	Mercy San Juan Medical Center	[redacted]	[redacted]
45	6/11/2023 15:42:14	Mercy San Juan Medical Center	[redacted]	[redacted]
46	7/6/2023 14:24:47	Mercy San Juan Medical Center	[redacted]	[redacted]
47	7/7/2023 13:13:15	Mercy San Juan Medical Center	[redacted]	[redacted]
48	7/9/2023 19:05:49	Mercy San Juan Medical Center	[redacted]	[redacted]
49	7/14/2023 14:31:08	Mercy San Juan Medical Center	[redacted]	[redacted]
50	7/14/2023 14:32:50	Mercy San Juan Medical Center	[redacted]	[redacted]
52	7/14/2023 15:11:51	Mercy San Juan Medical Center	[redacted]	[redacted]
53	7/15/2023 18:00:18	Mercy San Juan Medical Center	[redacted]	[redacted]
54	7/16/2023 19:35:56	Mercy San Juan Medical Center	[redacted]	[redacted]
55	7/16/2023 19:37:48	Mercy San Juan Medical Center	[redacted]	[redacted]
56	7/16/2023 20:41:56	Mercy San Juan Medical Center	[redacted]	[redacted]
57	7/16/2023 20:44:10	Mercy San Juan Medical Center	[redacted]	[redacted]
58	7/17/2023 2:38:03	Mercy San Juan Medical Center	[redacted]	[redacted]

06/12/2023 11:39 AM

Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
1	10/13/2021 16:28:20	Mercy San Juan Medical Center	[redacted]	[redacted]
2	10/27/2021 15:20:52	Mercy San Juan Medical Center	[redacted]	[redacted]
3	1/8/2022 19:24:04	Mercy San Juan Medical Center	[redacted]	[redacted]
4	1/17/2022 16:07:06	Mercy San Juan Medical Center	[redacted]	[redacted]
5	1/18/2022 16:52:07	Mercy San Juan Medical Center	[redacted]	[redacted]
6	2/2/2022 13:45:03	Mercy San Juan Medical Center	[redacted]	[redacted]
7	2/9/2022 3:30:43	Mercy San Juan Medical Center	[redacted]	[redacted]
8	3/5/2022 15:28:09	Mercy San Juan Medical Center	[redacted]	[redacted]
9	3/16/2022 13:01:39	Mercy San Juan Medical Center	[redacted]	[redacted]
10	5/31/2022 14:55:22	Mercy San Juan Medical Center	[redacted]	[redacted]
11	6/2/2022 19:12:25	Mercy San Juan Medical Center	[redacted]	[redacted]
12	6/19/2022 14:39:17	Mercy San Juan Medical Center	[redacted]	[redacted]
13	6/19/2022 14:40:16	Mercy San Juan Medical Center	[redacted]	[redacted]
14	7/10/2022 1:42:52	Mercy San Juan Medical Center	[redacted]	[redacted]
15	8/20/2022 20:36:02	Mercy San Juan Medical Center	[redacted]	[redacted]
16	9/18/2022 1:02:36	Mercy San Juan Medical Center	[redacted]	[redacted]
17	10/4/2022 12:12:52	Mercy San Juan Medical Center	[redacted]	[redacted]
18	10/21/2022 18:12:00	Mercy San Juan Medical Center	[redacted]	[redacted]
19	11/6/2022 23:14:35	Mercy San Juan Medical Center	[redacted]	[redacted]
20	11/12/2022 11:59:39	Mercy San Juan Medical Center	[redacted]	[redacted]
21	11/24/2022 11:51:38	Mercy San Juan Medical Center	[redacted]	[redacted]
22	12/10/2022 9:02:49	Mercy San Juan Medical Center	[redacted]	[redacted]
23	12/11/2022 17:35:27	Mercy San Juan Medical Center	[redacted]	[redacted]
24	12/16/2022 11:07:15	Mercy San Juan Medical Center	[redacted]	[redacted]
25	12/23/2022 15:21:20	Mercy San Juan Medical Center	[redacted]	[redacted]
26	12/25/2022 6:02:14	Mercy San Juan Medical Center	[redacted]	[redacted]
27	12/29/2022 19:36:06	Mercy San Juan Medical Center	[redacted]	[redacted]
28	1/1/2023 18:20:38	Mercy San Juan Medical Center	[redacted]	[redacted]
29	1/9/2023 0:10:45	Mercy San Juan Medical Center	[redacted]	[redacted]
30	1/21/2023 15:25:06	Mercy San Juan Medical Center	[redacted]	[redacted]
31	2/22/2023 12:52:27	Mercy San Juan Medical Center	[redacted]	[redacted]
32	2/23/2023 13:38:16	Mercy San Juan Medical Center	[redacted]	[redacted]
33	3/4/2023 20:09:27	Mercy San Juan Medical Center	[redacted]	[redacted]
34	3/15/2023 11:43:25	Mercy San Juan Medical Center	[redacted]	[redacted]
35	3/15/2023 12:47:28	Mercy San Juan Medical Center	[redacted]	[redacted]
36	3/26/2023 13:16:16	Mercy San Juan Medical Center	[redacted]	[redacted]
37	3/28/2023 12:50:12	Mercy San Juan Medical Center	[redacted]	[redacted]
38	3/28/2023 12:53:17	Mercy San Juan Medical Center	[redacted]	[redacted]
39	3/29/2023 12:21:29	Mercy San Juan Medical Center	[redacted]	[redacted]
40	3/29/2023 15:43:47	Mercy San Juan Medical Center	[redacted]	[redacted]

41	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
42	4/19/2023 12:13:09	Mercy San Juan Medical Center	[redacted]	[redacted]
43	4/27/2023 12:34:17	Mercy San Juan Medical Center	[redacted]	[redacted]
44	4/30/2023 15:30:18	Mercy San Juan Medical Center	[redacted]	[redacted]
45	5/11/2023 13:48:54	Mercy San Juan Medical Center	[redacted]	[redacted]
46	5/12/2023 16:02:58	Mercy San Juan Medical Center	[redacted]	[redacted]
47	6/4/2023 16:51:34	Mercy San Juan Medical Center	[redacted]	[redacted]
48	6/7/2023 14:57:58	Mercy San Juan Medical Center	[redacted]	[redacted]
49	6/10/2023 6:37:55	Mercy San Juan Medical Center	[redacted]	[redacted]
50	6/10/2023 6:38:56	Mercy San Juan Medical Center	[redacted]	[redacted]
52	6/10/2023 7:48:22	Mercy San Juan Medical Center	[redacted]	[redacted]
53	6/10/2023 7:49:59	Mercy San Juan Medical Center	[redacted]	[redacted]
54	6/11/2023 15:42:14	Mercy San Juan Medical Center	[redacted]	[redacted]
55	6/11/2023 15:43:31	Mercy San Juan Medical Center	[redacted]	[redacted]
56	6/11/2023 16:03:17	Mercy San Juan Medical Center	[redacted]	[redacted]

06/19/2023 11:07 AM

Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
1	10/13/2021 16:28:20	Mercy San Juan Medical Center	[redacted]	[redacted]
2	10/27/2021 15:20:52	Mercy San Juan Medical Center	[redacted]	[redacted]
3	1/8/2022 19:24:04	Mercy San Juan Medical Center	[redacted]	[redacted]
4	1/17/2022 16:07:06	Mercy San Juan Medical Center	[redacted]	[redacted]
5	2/2/2022 13:45:03	Mercy San Juan Medical Center	[redacted]	[redacted]
6	2/9/2022 3:30:43	Mercy San Juan Medical Center	[redacted]	[redacted]
7	3/5/2022 15:28:09	Mercy San Juan Medical Center	[redacted]	[redacted]
8	3/16/2022 13:01:39	Mercy San Juan Medical Center	[redacted]	[redacted]
9	5/31/2022 14:55:22	Mercy San Juan Medical Center	[redacted]	[redacted]
10	6/2/2022 19:12:25	Mercy San Juan Medical Center	[redacted]	[redacted]
11	6/19/2022 14:39:17	Mercy San Juan Medical Center	[redacted]	[redacted]
12	6/19/2022 14:40:16	Mercy San Juan Medical Center	[redacted]	[redacted]
13	7/10/2022 1:42:52	Mercy San Juan Medical Center	[redacted]	[redacted]
14	8/20/2022 20:36:02	Mercy San Juan Medical Center	[redacted]	[redacted]
15	9/18/2022 1:02:36	Mercy San Juan Medical Center	[redacted]	[redacted]
16	10/4/2022 12:12:52	Mercy San Juan Medical Center	[redacted]	[redacted]
17	10/21/2022 18:12:00	Mercy San Juan Medical Center	[redacted]	[redacted]
18	11/6/2022 23:14:35	Mercy San Juan Medical Center	[redacted]	[redacted]
19	11/12/2022 11:59:39	Mercy San Juan Medical Center	[redacted]	[redacted]
20	11/24/2022 11:51:38	Mercy San Juan Medical Center	[redacted]	[redacted]
21	12/10/2022 9:02:49	Mercy San Juan Medical Center	[redacted]	[redacted]
22	12/11/2022 17:35:27	Mercy San Juan Medical Center	[redacted]	[redacted]
23	12/16/2022 11:07:15	Mercy San Juan Medical Center	[redacted]	[redacted]
24	12/23/2022 15:21:20	Mercy San Juan Medical Center	[redacted]	[redacted]
25	12/25/2022 6:02:14	Mercy San Juan Medical Center	[redacted]	[redacted]
26	12/29/2022 19:36:06	Mercy San Juan Medical Center	[redacted]	[redacted]
27	1/1/2023 18:20:38	Mercy San Juan Medical Center	[redacted]	[redacted]
28	1/9/2023 0:10:45	Mercy San Juan Medical Center	[redacted]	[redacted]
29	1/21/2023 15:25:06	Mercy San Juan Medical Center	[redacted]	[redacted]
30	2/22/2023 12:52:27	Mercy San Juan Medical Center	[redacted]	[redacted]
31	2/23/2023 13:38:16	Mercy San Juan Medical Center	[redacted]	[redacted]
32	3/4/2023 20:09:27	Mercy San Juan Medical Center	[redacted]	[redacted]
33	3/15/2023 11:43:25	Mercy San Juan Medical Center	[redacted]	[redacted]
34	3/15/2023 12:47:28	Mercy San Juan Medical Center	[redacted]	[redacted]
35	3/26/2023 13:16:16	Mercy San Juan Medical Center	[redacted]	[redacted]
36	3/28/2023 12:50:12	Mercy San Juan Medical Center	[redacted]	[redacted]
37	3/28/2023 12:53:17	Mercy San Juan Medical Center	[redacted]	[redacted]
38	3/29/2023 12:21:29	Mercy San Juan Medical Center	[redacted]	[redacted]
39	3/29/2023 15:43:47	Mercy San Juan Medical Center	[redacted]	[redacted]
40	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON

Faxed 6.19.23

41	4/19/2023 12:13:09	Mercy San Juan Medical Center	[redacted]	[redacted]
42	4/27/2023 12:34:17	Mercy San Juan Medical Center	[redacted]	[redacted]
43	4/30/2023 15:30:18	Mercy San Juan Medical Center	[redacted]	[redacted]
44	5/11/2023 13:48:54	Mercy San Juan Medical Center	[redacted]	[redacted]
45	5/12/2023 16:02:58	Mercy San Juan Medical Center	[redacted]	[redacted]
46	6/4/2023 16:51:34	Mercy San Juan Medical Center	[redacted]	[redacted]
47	6/11/2023 15:42:14	Mercy San Juan Medical Center	[redacted]	[redacted]
48	6/14/2023 12:36:03	Mercy San Juan Medical Center	[redacted]	[redacted]
49	6/14/2023 16:21:52	Mercy San Juan Medical Center	[redacted]	[redacted]
50	6/15/2023 18:28:01	Mercy San Juan Medical Center	[redacted]	[redacted]
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55	6/18/2023 13:59:06	Mercy San Juan Medical Center	[redacted]	[redacted]
56	6/18/2023 14:12:24	Mercy San Juan Medical Center	[redacted]	[redacted]
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06/30/2023 10:31 AM

Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
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3	1/8/2022 19:24:04	Mercy San Juan Medical Center	[redacted]	[redacted]
4	1/17/2022 16:07:06	Mercy San Juan Medical Center	[redacted]	[redacted]
5	2/2/2022 13:45:03	Mercy San Juan Medical Center	[redacted]	[redacted]
6	2/9/2022 3:30:43	Mercy San Juan Medical Center	[redacted]	[redacted]
7	3/5/2022 15:28:09	Mercy San Juan Medical Center	[redacted]	[redacted]
8	3/16/2022 13:01:39	Mercy San Juan Medical Center	[redacted]	[redacted]
9	5/31/2022 14:55:22	Mercy San Juan Medical Center	[redacted]	[redacted]
10	6/2/2022 19:12:25	Mercy San Juan Medical Center	[redacted]	[redacted]
11	6/19/2022 14:39:17	Mercy San Juan Medical Center	[redacted]	[redacted]
12	6/19/2022 14:40:16	Mercy San Juan Medical Center	[redacted]	[redacted]
13	7/10/2022 1:42:52	Mercy San Juan Medical Center	[redacted]	[redacted]
14	8/20/2022 20:36:02	Mercy San Juan Medical Center	[redacted]	[redacted]
15	9/18/2022 1:02:36	Mercy San Juan Medical Center	[redacted]	[redacted]
16	10/4/2022 12:12:52	Mercy San Juan Medical Center	[redacted]	[redacted]
17	10/21/2022 18:12:00	Mercy San Juan Medical Center	[redacted]	[redacted]
18	11/6/2022 23:14:35	Mercy San Juan Medical Center	[redacted]	[redacted]
19	11/12/2022 11:59:39	Mercy San Juan Medical Center	[redacted]	[redacted]
20	11/24/2022 11:51:38	Mercy San Juan Medical Center	[redacted]	[redacted]
21	12/10/2022 9:02:49	Mercy San Juan Medical Center	[redacted]	[redacted]
22	12/11/2022 17:35:27	Mercy San Juan Medical Center	[redacted]	[redacted]
23	12/16/2022 11:07:15	Mercy San Juan Medical Center	[redacted]	[redacted]
24	12/23/2022 15:21:20	Mercy San Juan Medical Center	[redacted]	[redacted]
25	12/25/2022 6:02:14	Mercy San Juan Medical Center	[redacted]	[redacted]
26	12/29/2022 19:36:06	Mercy San Juan Medical Center	[redacted]	[redacted]
27	1/1/2023 18:20:38	Mercy San Juan Medical Center	[redacted]	[redacted]
28	1/9/2023 0:10:45	Mercy San Juan Medical Center	[redacted]	[redacted]
29	1/21/2023 15:25:06	Mercy San Juan Medical Center	[redacted]	[redacted]
30	2/23/2023 13:38:16	Mercy San Juan Medical Center	[redacted]	[redacted]
31	3/4/2023 20:09:27	Mercy San Juan Medical Center	[redacted]	[redacted]
32	3/15/2023 11:43:25	Mercy San Juan Medical Center	[redacted]	[redacted]
33	3/15/2023 12:47:28	Mercy San Juan Medical Center	[redacted]	[redacted]
34	3/26/2023 13:16:16	Mercy San Juan Medical Center	[redacted]	[redacted]
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36	3/28/2023 12:53:17	Mercy San Juan Medical Center	[redacted]	[redacted]
37	3/29/2023 12:21:29	Mercy San Juan Medical Center	[redacted]	[redacted]
38	3/29/2023 15:43:47	Mercy San Juan Medical Center	[redacted]	[redacted]
39	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
40	4/19/2023 12:13:09	Mercy San Juan Medical Center	[redacted]	[redacted]

07/03/2023 12:17 PM

Mercy San Juan Medical Center

	Timestamp		Decedent First Name	Decedent Last Name
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2	10/27/2021 15:20:52	Mercy San Juan Medical Center	[redacted]	[redacted]
3	1/8/2022 19:24:04	Mercy San Juan Medical Center	[redacted]	[redacted]
4	1/17/2022 16:07:06	Mercy San Juan Medical Center	[redacted]	[redacted]
5	2/2/2022 13:45:03	Mercy San Juan Medical Center	[redacted]	[redacted]
6	2/9/2022 3:30:43	Mercy San Juan Medical Center	[redacted]	[redacted]
7	3/5/2022 15:28:09	Mercy San Juan Medical Center	[redacted]	[redacted]
8	3/16/2022 13:01:39	Mercy San Juan Medical Center	[redacted]	[redacted]
9	5/31/2022 14:55:22	Mercy San Juan Medical Center	[redacted]	[redacted]
10	6/2/2022 19:12:25	Mercy San Juan Medical Center	[redacted]	[redacted]
11	6/19/2022 14:39:17	Mercy San Juan Medical Center	[redacted]	[redacted]
12	6/19/2022 14:40:16	Mercy San Juan Medical Center	[redacted]	[redacted]
13	7/10/2022 1:42:52	Mercy San Juan Medical Center	[redacted]	[redacted]
14	8/20/2022 20:36:02	Mercy San Juan Medical Center	[redacted]	[redacted]
15	9/18/2022 1:02:36	Mercy San Juan Medical Center	[redacted]	[redacted]
16	10/4/2022 12:12:52	Mercy San Juan Medical Center	[redacted]	[redacted]
17	10/21/2022 18:12:00	Mercy San Juan Medical Center	[redacted]	[redacted]
18	11/6/2022 23:14:35	Mercy San Juan Medical Center	[redacted]	[redacted]
19	11/12/2022 11:59:39	Mercy San Juan Medical Center	[redacted]	[redacted]
20	11/24/2022 11:51:38	Mercy San Juan Medical Center	[redacted]	[redacted]
21	12/10/2022 9:02:49	Mercy San Juan Medical Center	[redacted]	[redacted]
22	12/11/2022 17:35:27	Mercy San Juan Medical Center	[redacted]	[redacted]
23	12/16/2022 11:07:15	Mercy San Juan Medical Center	[redacted]	[redacted]
24	12/23/2022 15:21:20	Mercy San Juan Medical Center	[redacted]	[redacted]
25	12/25/2022 6:02:14	Mercy San Juan Medical Center	[redacted]	[redacted]
26	12/29/2022 19:36:06	Mercy San Juan Medical Center	[redacted]	[redacted]
27	1/1/2023 18:20:38	Mercy San Juan Medical Center	[redacted]	[redacted]
28	1/9/2023 0:10:45	Mercy San Juan Medical Center	[redacted]	[redacted]
29	1/21/2023 15:25:06	Mercy San Juan Medical Center	[redacted]	[redacted]
30	2/23/2023 13:38:16	Mercy San Juan Medical Center	[redacted]	[redacted]
31	3/4/2023 20:09:27	Mercy San Juan Medical Center	[redacted]	[redacted]
32	3/15/2023 11:43:25	Mercy San Juan Medical Center	[redacted]	[redacted]
33	3/15/2023 12:47:28	Mercy San Juan Medical Center	[redacted]	[redacted]
34	3/26/2023 13:16:16	Mercy San Juan Medical Center	[redacted]	[redacted]
35	3/28/2023 12:50:12	Mercy San Juan Medical Center	[redacted]	[redacted]
36	3/28/2023 12:53:17	Mercy San Juan Medical Center	[redacted]	[redacted]
37	3/29/2023 12:21:29	Mercy San Juan Medical Center	[redacted]	[redacted]
38	3/29/2023 15:43:47	Mercy San Juan Medical Center	[redacted]	[redacted]
39	4/9/2023 17:39:57	Mercy San Juan Medical Center	JESSIE	PETERSON
40	4/19/2023 12:13:09	Mercy San Juan Medical Center	[redacted]	[redacted]

1/2/2025 10:40:45

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
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3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
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33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	[redacted]	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
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54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
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56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]	[redacted]
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61	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]	[redacted]
62	12/26/2024 11:47:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	12/26/2024 11:52:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	12/30/2024 0:49:54	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	12/30/2024 10:54:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
67	12/30/2024 10:55:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
68	12/30/2024 13:40:15	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	12/31/2024 11:41:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
70	12/31/2024 12:31:05	Mercy San Juan Medical Cen	[redacted]	[redacted]
71	1/1/2025 21:57:11	Mercy San Juan Medical Cen	[redacted]	[redacted]
72	1/1/2025 22:01:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
73	1/1/2025 23:19:43	Mercy San Juan Medical Cen	[redacted]	[redacted]

1/3/2025 14:39:54

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
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2	6/2/2022 19:12:25	Mercy San Juan Medical Cen	[redacted]	[redacted]
3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	[redacted]	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	[redacted]	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]	[redacted]
59	12/23/2024 10:53:59	Mercy San Juan Medical Cen	[redacted]	[redacted]
60	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]	[redacted]
61	12/26/2024 11:52:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
62	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	12/30/2024 0:49:54	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	12/30/2024 10:55:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	12/30/2024 13:40:15	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	12/31/2024 12:31:05	Mercy San Juan Medical Cen	[redacted]	[redacted]
67	1/1/2025 23:19:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
68	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	1/3/2025 11:02:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
70	1/3/2025 11:05:09	Mercy San Juan Medical Cen	[redacted]	[redacted]

1/10/2025 14:11:02

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
1	5/31/2022 14:55:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
2	6/2/2022 19:12:25	Mercy San Juan Medical Cen	[redacted]	[redacted]
3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	[redacted]	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	[redacted]	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]	[redacted]
59	12/23/2024 10:53:59	Mercy San Juan Medical Cen	[redacted]	[redacted]
60	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]	[redacted]
61	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
62	12/30/2024 0:49:54	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	12/31/2024 12:31:05	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	1/1/2025 23:19:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	1/5/2025 2:15:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
67	1/6/2025 10:53:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
68	1/7/2025 12:39:11	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	1/8/2025 16:28:32	Mercy San Juan Medical Cen	[redacted]	[redacted]
70	1/9/2025 16:26:07	Mercy San Juan Medical Cen	[redacted]	[redacted]
71	1/10/2025 13:27:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
72	1/10/2025 13:29:41	Mercy San Juan Medical Cen	[redacted]	[redacted]

1/14/2025 16:01:10

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
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3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	[redacted]	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	[redacted]	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]
59	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]
60	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]
61	12/30/2024 0:49:54	Mercy San Juan Medical Cen	[redacted]
62	1/1/2025 23:19:43	Mercy San Juan Medical Cen	[redacted]
63	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]
64	1/5/2025 2:15:06	Mercy San Juan Medical Cen	[redacted]
65	1/6/2025 10:53:10	Mercy San Juan Medical Cen	[redacted]
66	1/12/2025 4:15:53	Mercy San Juan Medical Cen	[redacted]
67	1/13/2025 2:52:23	Mercy San Juan Medical Cen	[redacted]
68	1/13/2025 13:32:16	Mercy San Juan Medical Cen	[redacted]
69	1/13/2025 13:34:08	Mercy San Juan Medical Cen	[redacted]
70	1/13/2025 16:43:19	Mercy San Juan Medical Cen	[redacted]

1/17/2025 14:17:02

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
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2	6/2/2022 19:12:25	Mercy San Juan Medical Cen	[redacted]	[redacted]
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4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	[redacted]	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
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37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]	[redacted]
59	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]	[redacted]
60	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
61	12/30/2024 0:49:54	Mercy San Juan Medical Cen	[redacted]	[redacted]
62	1/1/2025 23:19:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	1/5/2025 2:15:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	1/6/2025 10:53:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	1/15/2025 10:53:21	Mercy San Juan Medical Cen	[redacted]	[redacted]
67	1/15/2025 13:14:01	Mercy San Juan Medical Cen	[redacted]	[redacted]
68	1/17/2025 13:16:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	1/17/2025 13:17:34	Mercy San Juan Medical Cen	[redacted]	[redacted]

1/22/2025 16:03:44

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
1	5/31/2022 14:55:22	Mercy San Juan Medical Cen	James	[redacted]
2	6/2/2022 19:12:25	Mercy San Juan Medical Cen	Charles	[redacted]
3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	Michael	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	Herman	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	Janette	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	Stephen	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	Renee	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	Almeza	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	William	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	Rudy	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	Dianna	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	Anthony	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	Michael	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	Marc	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	Brenda	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	Eula	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	David	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	Marilyn	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	Camella	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	Boris	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	Terry	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	Beverly	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	Janis	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	David	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	Micheal	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	Martin	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	James	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	Hilary	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	Darlene	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	Sharon	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	Nancy	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	Damen	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	Beverly	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	Henri	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	Paul	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	Hugh	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	Eddie	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	Ronald	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	Robert	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
46	10/17/2024 11:42:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
47	11/1/2024 14:08:36	Mercy San Juan Medical Cen	[redacted]	[redacted]
48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
57	12/18/2024 13:53:40	Mercy San Juan Medical Cen	[redacted]	[redacted]
58	12/18/2024 21:12:58	Mercy San Juan Medical Cen	[redacted]	[redacted]
59	12/25/2024 6:11:47	Mercy San Juan Medical Cen	[redacted]	[redacted]
60	12/26/2024 12:13:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
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62	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	1/6/2025 10:53:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	1/15/2025 10:53:21	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	1/19/2025 0:58:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	1/19/2025 1:05:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
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68	1/20/2025 4:39:55	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	1/21/2025 9:46:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
70	1/21/2025 13:58:51	Mercy San Juan Medical Cen	[redacted]	[redacted]
71	1/21/2025 16:03:39	Mercy San Juan Medical Cen	[redacted]	[redacted]

1/27/2025 16:07:09

Mercy San Juan Medical Cen

	Timestamp	Billing Party	Decedent First Name	Decedent Last Name
1	5/31/2022 14:55:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
2	6/2/2022 19:12:25	Mercy San Juan Medical Cen	[redacted]	[redacted]
3	6/19/2022 14:39:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
4	7/10/2022 1:42:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
5	10/4/2022 12:12:52	Mercy San Juan Medical Cen	[redacted]	[redacted]
6	10/21/2022 18:12:00	Mercy San Juan Medical Cen	[redacted]	[redacted]
7	11/6/2022 23:14:35	Mercy San Juan Medical Cen	[redacted]	[redacted]
8	12/25/2022 6:02:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
9	12/29/2022 19:36:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
10	1/1/2023 18:20:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
12	3/4/2023 20:09:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
13	3/15/2023 12:47:28	Mercy San Juan Medical Cen	[redacted]	[redacted]
14	3/26/2023 13:16:16	Mercy San Juan Medical Cen	[redacted]	[redacted]
15	3/28/2023 12:50:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
16	3/28/2023 12:53:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
17	3/29/2023 12:21:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
18	4/30/2023 15:30:18	Mercy San Juan Medical Cen	[redacted]	[redacted]
20	12/28/2023 13:12:42	Mercy San Juan Medical Cen	[redacted]	[redacted]
21	1/5/2024 13:27:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
22	1/26/2024 14:30:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
23	1/29/2024 12:36:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
24	2/27/2024 16:22:27	Mercy San Juan Medical Cen	[redacted]	[redacted]
25	3/21/2024 11:34:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
26	5/1/2024 10:59:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
28	5/19/2024 0:57:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
29	5/28/2024 11:33:39	Mercy San Juan Medical Cen	[redacted]	[redacted]
30	6/9/2024 19:54:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
31	6/14/2024 7:19:17	Mercy San Juan Medical Cen	[redacted]	[redacted]
32	6/14/2024 11:37:30	Mercy San Juan Medical Cen	[redacted]	[redacted]
33	6/27/2024 16:16:41	Mercy San Juan Medical Cen	[redacted]	[redacted]
34	7/10/2024 17:26:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
35	7/16/2024 9:07:22	Mercy San Juan Medical Cen	[redacted]	[redacted]
36	7/28/2024 1:42:56	Mercy San Juan Medical Cen	[redacted]	[redacted]
37	8/9/2024 15:31:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
38	8/10/2024 6:08:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
39	8/11/2024 3:44:31	Mercy San Juan Medical Cen	[redacted]	[redacted]
40	8/12/2024 13:32:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
41	9/27/2024 1:42:04	Mercy San Juan Medical Cen	[redacted]	[redacted]
42	10/8/2024 12:06:56	Mercy San Juan Medical Cen	[redacted]	[redacted]

43	10/10/2024 12:32:49	Mercy San Juan Medical Cen	[redacted]	[redacted]
44	10/10/2024 12:48:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
45	10/16/2024 11:16:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
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48	11/5/2024 11:20:46	Mercy San Juan Medical Cen	[redacted]	[redacted]
49	11/18/2024 1:51:12	Mercy San Juan Medical Cen	[redacted]	[redacted]
50	11/18/2024 1:53:34	Mercy San Juan Medical Cen	[redacted]	[redacted]
52	12/4/2024 11:31:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
53	12/5/2024 0:51:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
54	12/5/2024 18:40:13	Mercy San Juan Medical Cen	[redacted]	[redacted]
55	12/6/2024 15:46:19	Mercy San Juan Medical Cen	[redacted]	[redacted]
56	12/16/2024 14:10:50	Mercy San Juan Medical Cen	[redacted]	[redacted]
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62	1/2/2025 11:49:24	Mercy San Juan Medical Cen	[redacted]	[redacted]
63	1/6/2025 10:53:10	Mercy San Juan Medical Cen	[redacted]	[redacted]
64	1/15/2025 10:53:21	Mercy San Juan Medical Cen	[redacted]	[redacted]
65	1/19/2025 0:58:06	Mercy San Juan Medical Cen	[redacted]	[redacted]
66	1/19/2025 1:05:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
67	1/19/2025 1:07:51	Mercy San Juan Medical Cen	[redacted]	[redacted]
68	1/21/2025 9:46:29	Mercy San Juan Medical Cen	[redacted]	[redacted]
69	1/23/2025 7:53:23	Mercy San Juan Medical Cen	[redacted]	[redacted]
70	1/23/2025 23:34:32	Mercy San Juan Medical Cen	[redacted]	[redacted]
71	1/24/2025 8:56:48	Mercy San Juan Medical Cen	[redacted]	[redacted]
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73	1/26/2025 7:01:43	Mercy San Juan Medical Cen	[redacted]	[redacted]
74	1/26/2025 7:02:45	Mercy San Juan Medical Cen	[redacted]	[redacted]
75	1/26/2025 8:01:33	Mercy San Juan Medical Cen	[redacted]	[redacted]
76	1/27/2025 10:15:14	Mercy San Juan Medical Cen	[redacted]	[redacted]
77	1/27/2025 10:16:38	Mercy San Juan Medical Cen	[redacted]	[redacted]
78	1/27/2025 14:35:02	Mercy San Juan Medical Cen	[redacted]	[redacted]
79	1/27/2025 16:05:39	Mercy San Juan Medical Cen	[redacted]	[redacted]

Release Form

☒ East Lawn Greenback and I80 FD-1242 5757 Greenback Lane Sacramento, CA 95841 (916) 732-2020	☐ East Lawn Elk Grove FD-1455 9189 E. Stockton Blvd Elk Grove, CA 95624 (916) 732-2031	☐ East Lawn South Sacramento FD-136 3939 Fruitridge Road Sacramento, CA 95820 (916) 732-2026	☐ East Lawn East Sacramento FD-2340 3939 Folsom Blvd Sacramento, CA 95819 (916) 732-2000

To: Mercy San Juan

Address: Carmichael

Please release the remains of: Jessie Marie Peterson

Date of Birth: 8-15-1991

Date of Death: 4-8-2023

(60) (7)

DECEDENT RELEASED
FROM HOLDING FACILITY
4-9-24 4-15-24
DATE IN DATE OUT
MEDICAL # MSJMC

Signature: Ginger J Congi Relationship: Mother

Printed Name: Ginger J Congi

Address: 4040 Whitney Vista Lane
Rocklin, CA [illegible] 95677 Phone: 916 712-7206

Signature: Relationship:

Printed Name:

Address: Phone:

Signature: Relationship:

Printed Name.

Address: Phone:

SNC001156

EXHIBIT 13

Michelle Iarusso, Esq. (SBN 280483)
IARUSSO LEGAL, A.P.C.
87 N. Raymond Avenue, Suite 809
Pasadena, CA 91103
Telephone: (646) 415-4422
Facsimile: (626) 466-9058
E-mail: *michelle@iarusso.legal*

Attorney for Plaintiff,
Valerie Gray

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

VALERIE GRAY, an individual,

Plaintiff,

vs.

DIGNITITY HEALTH, a domestic nonprofit; **MERCY SAN JUAN MEDICAL CENTER**, a nonprofit hospital; and **DOES 1 through 50**, inclusive;

Defendants.

Case No. 34-2022-00315771

FIRST AMENDED COMPLAINT FOR DAMAGES FOR:

1. Negligence
2. Negligent Hiring and Supervision
3. Negligent Misrepresentation
4. Negligent Infliction of Emotional Distress

JURY TRIAL REQUESTED

BY FAX

THE PARTIES

1. Plaintiff VALERIE GRAY ("Plaintiff"), at all relevant times herein, was and is a citizen of the State of California and a resident of the County of Sacramento.

2. Defendant DIGNITY HEALTH ("Defendant," or "Dignity Health") is a domestic nonprofit university affiliated with Mercy San Juan Medical Center. At all relevant times herein, Dignity was and is a public entity in California operating in the County of Sacramento.

3. Defendant MERCY SAN JUAN MEDICAL CENTER ("Defendant," or "Mercy San Juan Medical Center") is a nonprofit hospital affiliated with Dignity Health. At all relevant times herein, Mercy San Juan Medical Center was and is a nonprofit hospital

operating in the County of Sacramento.

4. Upon information and belief, Defendants Dignity Health and Mercy San Juan Medical Center are, and at all times herein mentioned were, incorporated entities existing under the laws of California.

5. Defendants DOES 1 through 50 are individuals and agents, employees, officers, management, administrative personnel, coroners, investigators, and/or other employees, staff, agents, or contractors of defendants. The names of these employees and/or entities causing the injury, damage, or loss are unknown at this time.

6. The names and capacities, whether individual, corporate, or otherwise, of DOES 1 through 50 are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will amend this complaint to show their true names and capacities when the same have been ascertained.

7. Plaintiff is informed and believes, and thereon alleges, that each such fictitiously named Defendant is responsible in some manner for the occurrences herein alleged, and that Plaintiff's damages herein alleged were proximately caused by such Defendants.

8. The foregoing named Defendants, including all DOE Defendants, are collectively referred from time to time herein as "Defendants."

JURISDICTION AND VENUE

9. Defendants' wrongful and negligent conduct, along with the alleged actions, inactions, and omissions that are the subject of this action, occurred in Sacramento County, California; the performance was to be performed in the County of Sacramento; and the amount in controversy exceeds $25,000.00. Therefore, jurisdiction and venue is proper in Sacramento Superior Court in the Central District.

FACTUAL ALLEGATIONS

10. Plaintiff Valerie Gray had a son, Michael Gray. They had a close, loving relationship and resided in the same home. Despite having mental health issues, Michael was close with his mother, often helping her with tasks around the house. He particularly enjoyed maintaining his mother's garden and would help his grandparents on their farm, especially as they aged.

11. Michael was very independent, so much so that he often stayed at his friends' homes for several weeks at a time. Plaintiff was always able to contact her son while he was away and staying with friends.

12. In early July 2021, Michael Gray was staying with a friend. On July 7, 2021, Plaintiff Valeria Gray called her son several times, but he did not answer. Other relatives started to call Michael Gray as well but received no response.

13. In late July 2021, Plaintiff began to grow worried about her son, so she called the police. In early August 2021, Plaintiff reported Michael Gray missing.

14. Detective Mark Francis was assigned to Plaintiff's case. When Plaintiff received her son's bank statement in the mail, she forwarded it to Detective Mark Francis. The bank statement showed that the last time Michael Gray used his bank was in early July at a 7-11 on Elk Horn Blvd.

15. On August 13, 2021, around 12:00 PM, Plaintiff received a call from Detective Mark Francis, who stated that he went to the 7-11 on Elk Horn Blvd and spoke to an individual who remembered seeing Michael Gray. They stated that when Michael Gray left the store, he passed out in the parking lot. Detective Mark Francis informed Plaintiff that her son was taken to Mercy San Juan Medical Center in Carmichael and told Plaintiff to contact Gary Gibson who was a hospital administrator. Detective Mark Francis also provided Plaintiff with a medical reference number.

16. After her conversation with Detective Mark Francis on August 13, 2021, Plaintiff called Mercy San Juan Medical Center and asked to speak with Gary Gibson. The woman who answered the phone was frantic and stated that no one by the name of Gary Gibson worked at Mercy San Juan Medical Center. Plaintiff called Mercy San Juan Medical Center again on August 13, 2021, but no one answered.

17. On August 13, 2021, Plaintiff received a call from a sheriff deputy who informed her that Michael Gray was taken to Mercy San Juan Medical Center on July 10, 2021, where he died of a heart attack. The sheriff deputy expressed her confusion as to why a coroner was not called until August 13, 2021, when Michael Gray died on July 10, 2021. She also informed Plaintiff that she obtained Plaintiff's phone number from Michael Gray's phone.

18. At this time, Plaintiff was in a state of shock and severe mental anguish. She could not understand why she was not contacted when her son had his phone, wallet, ID, and with him

at the time of his death.

19. On August 14, 2021, around 12:00 PM, Plaintiff and her son went to Mercy San Juan Medical Center to pick Michael Gray's belongings. After three hours of waiting at the hospital, a security guard finally came out and gave Plaintiff a bag with a sticker stating that the bag contained Michael Gray's clothes, shoes, phone, and wallet.

20. When Plaintiff opened the bag, she found that Michael Gray's phone and wallet were missing. Plaintiff then called her father and asked him to speak with Detective Mark Francis and tell him that the phone and wallet were missing. Detective Mark Francis gave Plaintiff's father a phone number to call.

21. Plaintiff called the number provided by Detective Mark Francis and Gary Gibson answered her call. Plaintiff's father also called Gary Gibson and told him that he would send the police to Mercy San Juan Medical Center if they did not receive Michael Gray's phone and wallet.

22. Gary Gibson then called Plaintiff and told her that he would bring her the phone and wallet. At this point, the Plaintiff felt that Mercy San Juan Medical Center was trying to keep these items from her.

23. Gary Gibson brought Plaintiff a bag with Michael Gray's phone and wallet and confessed to Plaintiff and her son that it was Mercy San Juan Medical Center's fault that Plaintiff was not contacted regarding the death of her son Michael Gray. Plaintiff responded by saying that this was wrong and that she would do something about it. Gary Gibson told Plaintiff that she had every right to do so.

24. Plaintiff believed that Mercy San Juan Medical Center would have kept her son's phone and wallet if her father hadn't threatened to call the police.

25. Plaintiff asked Detective Mark Francis if he thought her son would still be missing if she had not filed a report. He said yes.

26. Mercy San Juan Medical Center treated the decedent Michael Gray as a John Doe despite having his cell phone and identification with his current home address.

27. Mercy San Juan Medical Center put the decedent's body into offsite storage where it was neither autopsied nor preserved.

28. During the approximately one month that the decedent's body was in storage, Plaintiff Gray was beside herself with worry and fear for the fate of her son.

29. It was not until approximately one month after his death that the hospital made

arrangements to have the decedent's body picked up by the coroner due to the efforts of the sheriff to locate the decedent on behalf of his family.

30. The Defendant, Mercy San Juan Medical Center, failed to handle and take care of the body of the deceased Michael Gray.

31. Plaintiff Gray was emotionally devastated and in shock upon learning of Michael Gray's death and then the breakdown and mishandling of her son's body. She was not able to say her last goodbyes to her son nor have a celebration of life with an open casket due to the state of the decedent's corpse.

32. To add insult to injury, Plaintiff contacted Dignity Health, the university affiliated with Mercy San Juan Medical Center, about the negligence with which her deceased son was treated. The hospital sent her a letter claiming that "a chaplain" had called Plaintiff to notify her about the death of her son, but had mistakenly called the wrong number and failed to leave a message or follow up. This unknown chaplain was never identified by the hospital. Dignity Health's claim that the hospital attempted to contact Plaintiff directly contradicts the statement of Gary Gibson, who stated that the hospital was at fault for not contacting Plaintiff.

FIRST CAUSE OF ACTION

NEGLIGENCE

(Against ALL Defendants)

33. Plaintiff realleges and incorporates by reference every allegation contained in this Complaint as though fully set forth in this paragraph.

34. Plaintiff contends that Defendant Mercy San Juan Medical Center owed her a duty to make reasonable efforts to locate the decedent's next of kin and to take proper care of the decedent's remains, both of which they failed to do.

35. As has been noted, the California Legislature is "aware that for cultural and religious reasons, the [interment] or other disposition of the deceased's body is an extremely important emotional catharsis for the family and friends of the deceased." (Shelton v. City of Westminster (1982) 138 Cal. App. 3d 610, 625 [188 Cal. Rptr. 205] (dis. opn. of Wiener, J.).)

36. To this end, Health and Safety Code section 7100 provides that "[t]he right to control the disposition of the remains of a deceased person, including the location and conditions of interment, unless other directions have been given by the decedent, vests in, and the duty of

interment and the liability for the reasonable costs of interment of the remains devolves upon the following in the order named: (4) The surviving competent parent or parents of the decedent. If one of the surviving competent parents is absent, the remaining competent parent shall be vested with the rights and duties of this section after reasonable efforts have been unsuccessful in locating the absent surviving competent parent."

37. The court held in *Davila v. County of Los Angeles* (1996) 50 Cal.App.4th 143, 140-143, 57 Cal.Rptr.2d 651, the rights granted by the several statutes discussed above would have no meaning unless they are read to impose upon the Coroner a duty to act with reasonable diligence in attempting to identify a body placed in their custody and then to attempt with reasonable diligence to locate some family member.

38. Plaintiff claims that she was harmed because Defendant Mercy San Juan Medical Center failed to act with reasonable diligence in attempting to identify a body placed in its custody and failed to act with reasonable diligence to locate a family member.

39. One alleged phone call is not reasonable diligence. The party that Mercy San Juan Medical Center contacted may have not had that number any longer or, for that matter, check their voicemail.

40. As a proximate result of the Defendant's breach of their duty, Plaintiff suffered severe emotional distress and Defendant's negligence was a substantial factor in causing Plaintiff's serious emotional distress.

41. As a further proximate result of the improper action and inaction of Defendants, and each of them, Plaintiff suffered great pain, including suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame. The full nature and extent of said injuries are not known to Plaintiff, and leave is requested to amend this complaint to conform to proof at the time of trial. Plaintiff is informed and believes and thereon alleges that said injuries are permanent and, by reason of the foregoing, Plaintiff has suffered general damages in an unknown amount.

42. As a further proximate result of the improper action and inaction of Defendants, and each of them, Plaintiff has incurred and will incur medical and other related expenses, the full nature and extent and amount of which are not yet known to Plaintiff, and leave is requested to amend this complaint to conform to proof at the time of trial.

SECOND CAUSE OF ACTION

NEGLIGENT HIRING AND SUPERVISION

(Against ALL Defendants)

43. Plaintiff realleges and incorporates by reference every allegation contained in this Complaint as though fully set forth in this paragraph.

44. Defendants failed to take reasonable steps to ensure that their employees acted in accordance with the rights, duties, and responsibilities of a hospital in their care of the remains of a deceased loved one.

45. Defendants and each of them committed the negligence alleged herein against Plaintiff maliciously, fraudulently, and oppressively with the wrongful intent of injuring Plaintiff for an improper and evil motive which constitutes a malicious and conscious disregard of Plaintiff's rights. Plaintiff is thereby entitled to punitive damages from Defendants in an amount to be determined at trial.

THIRD CAUSE OF ACTION

NEGLIGENT MISREPRESENTATION

(Against ALL Defendants)

46. Plaintiff realleges and incorporates by reference every allegation contained in this Complaint as though fully set forth in this paragraph.

47. As alleged herein, Defendants misrepresented to Plaintiff that they had contacted her and the County coroner regarding the death of Michael Gray.

48. Defendants, and each of them, committed said negligence alleged herein against Plaintiff maliciously, fraudulently, and oppressively with the wrongful intent of injuring Plaintiff for an improper and evil motive which constitutes a malicious and conscious disregard of Plaintiff's rights. Plaintiff is thereby entitled to punitive damages from Defendants in an amount to be determined at trial.

FOURTH CAUSE OF ACTION

NEGLIFENT INFLICTION OF EMOTIONAL DISTRESS

(Against ALL Defendants)

49. Plaintiff realleges and incorporates by reference every allegation contained in this

Complaint as though fully set forth in this paragraph.

50. Plaintiff alleges, alternatively, that Defendants, and each of them, knew or should have known that their failure to exercise due care in doing the acts alleged above with respect to Plaintiff would cause her severe emotional distress. As a proximate result of the conduct of Defendants, and each of them, and the consequences proximately caused by it, as herein above alleged, Plaintiff suffered severe emotional distress and mental suffering all to her damage in a sum according to proof.

51. Defendants, and each of them, committed said negligent infliction of emotional distress alleged herein against Plaintiff maliciously, fraudulently, and oppressively with the wrongful intent of injuring Plaintiff for an improper and evil motive which constitutes a malicious and conscious disregard of Plaintiff's rights. Plaintiff is thereby entitled to punitive damages from Defendants in an amount to be determined at trial.

PRAYER OF RELIEF

WHEREFORE, Plaintiffs pray for judgment and order as follows:

(1) For general damages in an amount to be established according to proof at trial;

(2) For specific damages in an amount to be established according to proof at trial;

(3) For costs of the suit;

(4) Punitive and Exemplary Damages as allowed by law; and

(5) For such other and further relief as this Court deems just and proper.

JURY TRIAL DEMAND

Plaintiffs hereby demand a jury trial for all applicable claims set forth herein.

DATED: March 22, 2022

IARUSSO LEGAL, APC

By: _____

Michelle Iarusso, Esq
Attorney for Plaintiffs

EXHIBIT 14

3052023286056
STATE FILE NUMBER

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 3/06)

3202334013448
LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

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

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months	Days	IF UNDER 24 HOURS Hours	Minutes	6. SEX
12/17/1956	66					M

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP* (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
UNK	UNK	☐ YES ☐ NO ☒ UNK	UNKNOWN	05/27/2023	0900

13. EDUCATION – Highest Level/Degree (see worksheet on back)	14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
UNKNOWN	☐ YES UNKNOWN ☐ NO	UNKNOWN

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

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location): UNK

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
UNK	UNK	UNK	UNK	UNK

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
PHIL MANNING, FUNERAL DIRECTOR	35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP*–FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
UNKNOWN	UNKNOWN	UNKNOWN	
31. NAME OF FATHER/PARENT–FIRST	**32. MIDDLE**	**33. LAST**	**34. BIRTH STATE**
UNKNOWN	UNKNOWN	UNKNOWN	UNK
35. NAME OF MOTHER/PARENT–FIRST	**36. MIDDLE**	**37. LAST (BIRTH NAME)**	**38. BIRTH STATE**
UNKNOWN	UNKNOWN	UNKNOWN	UNK

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION
01/02/2024	CREMATIONS ONLY 35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

41. TYPE OF DISPOSITION(S)	42. SIGNATURE OF EMBALMER	43. LICENSE NUMBER
TEMPORARY ENVAULTMENT	▸ NOT EMBALMED	-

44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER	46. SIGNATURE OF LOCAL REGISTRAR	47. DATE mm/dd/ccyy
CREMATIONS ONLY	FD2208	▸ OLIVIA KASIRYE MD	01/02/2024

PLACE OF DEATH

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

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SACRAMENTO	1650 CREEKSIDE DRIVE	FOLSOM

CAUSE OF DEATH

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

		Time Interval Between Onset and Death	108. DEATH REPORTED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(A) SEPSIS	(AT) DAYS	☐ YES ☒ NO REFERRAL NUMBER
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B) FAILURE TO THRIVE	(BT) MOS	109. BIOPSY PERFORMED? ☐ YES ☒ NO
	(C) METASTATIC BLADDER CANCER	(CT) MOS	110. AUTOPSY PERFORMED? ☐ YES ☒ NO
	(D)	(DT)	111. USED IN DETERMINING CAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
NONE

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113A. DECEDENT PREGNANT IN LAST YEAR?
NO	☐ YES ☒ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.		115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
Decedent Attended Since	Decedent Last Seen Alive	▸ TERRI ELLEN BIGLER, MD	G78179	12/29/2023
(A) mm/dd/ccyy: 05/13/2023	(B) mm/dd/ccyy: 05/27/2023	118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE: GAGAN PREET GARCHA, MD 1700 PRAIRIE CITY RD, FOLSOM, CA 95630		

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending Investigation ☐ Could not be determined	120. INJURED AT WORK? ☐ YES ☐ NO ☐ UNK	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)

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

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

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

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸		

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

CERTIFIED COPY OF VITAL RECORDS

EXHIBIT 15

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 3/06)

STATE FILE NUMBER

LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT–FIRST (Given): TONYA
2. MIDDLE: -
3. LAST (Family): WALKER
AKA, ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)
4. DATE OF BIRTH mm/dd/ccyy: 07/09/1972
5. AGE Yrs.: 51
IF UNDER ONE YEAR: Months / Days
IF UNDER 24 HOURS: Hours / Minutes
6. SEX: F
7. DATE OF DEATH mm/dd/ccyy: 11/02/2023
8. HOUR (24 Hours): 0311
9. BIRTH STATE/FOREIGN COUNTRY: UNK
10. SOCIAL SECURITY NUMBER: UNK
11. EVER IN U.S. ARMED FORCES? ☐ YES ☐ NO ☒ UNK
12. MARITAL STATUS/SRDP* (at Time of Death): UNKNOWN
13. EDUCATION – Highest Level/Degree (see worksheet on back): UNKNOWN
14/15. WAS DECEDENT HISPANIC/LATINO/A/SPANISH? (If yes, see worksheet on back) ☐ YES UNKNOWN ☐ NO
16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back): UNKNOWN
17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED: UNKNOWN
18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.): UNKNOWN
19. YEARS IN OCCUPATION: UNK

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location): UNK
21. CITY: UNK
22. COUNTY/PROVINCE: UNK
23. ZIP CODE: UNK
24. YEARS IN COUNTY: UNK
25. STATE/FOREIGN COUNTRY: UNK

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP: PHIL MANNING, FUNERAL DIRECTOR
27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip): 35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP*–FIRST: UNKNOWN
29. MIDDLE: UNKNOWN
30. LAST (BIRTH NAME): UNKNOWN
31. NAME OF FATHER/PARENT–FIRST: UNKNOWN
32. MIDDLE: UNKNOWN
33. LAST: UNKNOWN
34. BIRTH STATE: UNK
35. NAME OF MOTHER/PARENT–FIRST: UNKNOWN
36. MIDDLE: UNKNOWN
37. LAST (BIRTH NAME): UNKNOWN
38. BIRTH STATE: UNK

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy: 04/16/2024
40. PLACE OF FINAL DISPOSITION: CREMATIONS ONLY 35 QUINTA COURT SUITE C, SACRAMENTO, CA 95823
43. LICENSE NUMBER: -
41. TYPE OF DISPOSITION(S): TEMPORARY ENVAULTMENT
42. SIGNATURE OF EMBALMER: ▸ NOT EMBALMED
47. DATE mm/dd/ccyy: 04/16/2024
44. NAME OF FUNERAL ESTABLISHMENT: CREMATIONS ONLY
45. LICENSE NUMBER: FD2208
46. SIGNATURE OF LOCAL REGISTRAR: ▸ OLIVIA KASIRYE MD

PLACE OF DEATH

101. PLACE OF DEATH: MERCY GENERAL HOSPITAL
102. IF HOSPITAL, SPECIFY ONE: ☒ IP ☐ ER/OP ☐ DOA
103. IF OTHER THAN HOSPITAL, SPECIFY ONE: ☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other
104. COUNTY: SACRAMENTO
105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location): 4001 J STREET
106. CITY: SACRAMENTO

CAUSE OF DEATH

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

IMMEDIATE CAUSE (Final disease or condition resulting in death) → (A) CARDIAC ARREST

Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

(B) SHOCK

(C) RENAL FAILURE

(D) ASPIRATION PNEUMONIA

Time Interval Between Onset and Death: (A) MINS; (B) DAYS; (C) DAYS; (D) DAYS

108. DEATH REPORTED TO CORONER? ☐ YES ☒ NO — REFERRAL NUMBER

109. BIOPSY PERFORMED? ☐ YES ☒ NO

110. AUTOPSY PERFORMED? ☐ YES ☒ NO

111. USED IN DETERMINING CAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107: NONE

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.): NO

113A. DECEDENT PREGNANT IN LAST YEAR? ☐ YES ☒ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.
Decedent Attended Since (A) mm/dd/ccyy: 10/31/2023
Decedent Last Seen Alive (B) mm/dd/ccyy: 11/02/2023

115. SIGNATURE AND TITLE OF CERTIFIER: ▸ KOMALDEEP SINGH, MD
116. LICENSE NUMBER: A173957
117. DATE mm/dd/ccyy: 04/15/2024
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE: ETHAN THO PHAN, MD 4001 J STREET, SACRAMENTO, CA 95819

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.
MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending Investigation ☐ Could not be determined
120. INJURED AT WORK? ☐ YES ☐ NO ☐ UNK
121. INJURY DATE mm/dd/ccyy:
122. HOUR (24 Ho
123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.):
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury):
125. LOCATION OF INJURY (Street and number, or location, and city, and zip):
126. SIGNATURE OF CORONER / DEPUTY CORONER:
127. DATE mm/dd/ccyy:
128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER:

STATE REGISTRAR

A	B	C	D	E	PRINTED ON: 05/31/2024 09:17 AM BY LOFTON, JAMES (JLOFTON)	FAX AUTH.#	CENSUS T

EXHIBIT 16

BMD-003A

ATTORNEY OR PARTY WITHOUT ATTORNEY: STATE BAR NUMBER: 221261 NAME: Jamie A. Pearson, Esq. FIRM NAME: UBALDI & MCPHERSON STREET ADDRESS: 555 University Avenue, Suite 140 CITY: SACRAMENTO STATE: CA ZIP CODE: 95825 TELEPHONE NO.: (916) 265-4555 FAX NO.: (916) 265-4568 E-MAIL ADDRESS: lsmith@umllp.com ATTORNEY FOR (name): Petitioner Dignity Health dba Mercy San Juan Medical Center	FOR COURT USE ONLY **ELECTRONICALLY FILED** Superior Court of California County of Sacramento 09/30/2024 By: M. Dysle Deputy
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO STREET ADDRESS: 3341 Power Inn Road MAILING ADDRESS: 3341 Power Inn Road CITY AND ZIP CODE: Sacramento, 95826 BRANCH NAME: William R. Ridgeway Family Relations Courthouse	
IN THE MATTER OF (name): BRENDA L. S[redacted]	CASE NUMBER: 24PR002912
DECLARATION IN SUPPORT OF PETITION TO ESTABLISH FACT, TIME, AND PLACE OF DEATH	HEARING DATE AND TIME: DEPT.:

(Name of declarant): Laura Lukin declares as follows:

1. I make the statements in this declaration based on my personal knowledge or on the contents of the documents identified in item 5. *("Personal knowledge" of a fact is knowledge that is **not** gained from another person's statements to you about that fact.)*
2. a. I am at least 18 years of age.
   b. I reside at *(street address and city)*: Work Address: 4400 Duckhorn Drive, Suite 200, Sacramento, CA 94834

   County: Sacramento State: California
3. *(Name of deceased person)*: BRENDA L. S[redacted] died at
   approximately *(time)*: 12:46 [X] a.m. [ ] p.m. on *(date)*: 03/28/2023 at the following place:
   a. City, town, township, or other *(identify "other" if known)*: Mercy San Juan Medical Center, 6501 Coyle Ave., Carmichael
   b. [X] County: Sacramento State (U.S.): California
   c. [ ] State or province: Country:
4. Facts showing when and where the person named in item 3 died and explaining how I have personal knowledge of those facts
   [X] are stated in the space below [ ] are stated in Attachment 4 to this declaration.
   (If you are relying solely on the contents of the documents identified in item 5, please advise in the space below.)

   Ms. S[redacted] died at Mercy San Juan Medical Center on March 28, 2023 and has been in the custody, control, and possession of Petitioner since that time. No next of kin can be located. A death certificate is needed for her remains to be released to the Coroner.

BMD-003A

IN THE MATTER OF *(name)*: BRENDA L. S[redacted]	CASE NUMBER:

5. [X] Attached are true and correct copies of the following documents *(check each box that applies)*:

   a. [ ] Police report dated *(date of each)*:

   b. [ ] Coroner's report dated *(date)*:

   c. [ ] Private physician's report dated *(date of each)*:

   d. [X] Other documents dated *(describe and give the date of each document; "Other documents" could include school or college records, vaccination certificates and other medical records, employment records, documents showing sources of support other than employment, family correspondence, diaries, photographs, and other similar family records)*:

   Custodian of Records Declaration for Mercy San Juan Medical Center records plus Mercy San Juan Medical Center records

   [ ] Continued on Attachment 5d.

6. The death of the person named in item 3, or the date, time, or place of death [X] is not [ ] is important to a court case or proceeding that is now pending and described below. *(If you selected "is," briefly describe the proceeding and provide the case name and number, the name and address of the court where the proceeding is pending, the names of all parties to the proceeding, and the names, addresses, and telephone numbers of their attorneys. **Note: A court order made on a petition under Health and Safety Code section 103450, et seq., may not be effective against claims of persons or organizations not given notice of the petition for the order.)***

   [ ] Continued on Attachment 6.

7. Number of pages attached: 16

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 9/27/24

Laura Lukin, Regional Laboratory Support Supervisor for Pathology Services & Decedent Affairs, on behalf of Petitioner Dignity Health dba Mercy San Juan Medical Center

(TYPE OR PRINT NAME OF DECLARANT)

▶ laura lukin

(SIGNATURE OF DECLARANT)

MC-025

SHORT TITLE: IN THE MATTER OF BRENDA L. S[redacted]	CASE NUMBER:

ATTACHMENT (Number): 4

(This Attachment may be used with any Judicial Council form.)

I, LAURA LUKIN, declare as follows:

1. I am employed by CommonSpirit Health as Regional Laboratory Support Supervisor for Pathology Services and am Supervisor of Decedent Affairs. I have held these positions since March of 2022. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. Part of my duties include supervising the Regional Morgue for the Sacramento area CommonSpirit Health/Dignity Health hospitals. Mercy San Juan Medical Center is one of these hospitals. The morgue located within Mercy San Juan Medical Center is very small. Because of this, CommonSpirit Health/Dignity Health has contracted with Sacramento Mortuary Transport ("SMT") to transport deceased patients from Mercy San Juan Medical Center to SMT's facility in South Sacramento until such time as the deceased patients can be released for their final resting places. The deceased patients who have been moved to SMT's facility are still considered "patients" of CommonSpirit/Dignity Health and remain within the system's custody and control. A death certificate is necessary for any deceased patient to be released from CommonSpirit Health/Dignity Health's custody and control and SMT's facility.

3. I am responsible for obtaining death certificates for deceased CommonSpirit Health/Dignity Health patients who have been moved to SMT's facility. In order to accomplish this, it is necessary for me to access the medical records of the deceased patients. Therefore, I have access to Brenda L. S[redacted] medical records from Mercy San Juan Medical Center. I have reviewed Ms. S[redacted] medical records, including those medical records that have been included as supporting evidence for this Petition. My personal knowledge of the date, time, and place of Ms. S[redacted] death are based on my review of the medical records attached to this Petition. The remains of Brenda L. S[redacted] are currently located at SMT's facility, but remain within the custody and control of CommonSpirit Health/Dignity Health.

4. Brenda L. S[redacted] died at Mercy San Juan Medical Center, located at 6501 Coyle Avenue, Carmichael, CA, 95608, on March 28, 2023. She was brought into the Emergency Department on the evening of March 27, 2023 after being found unresponsive at her hemodialysis center. Ms. S[redacted] coded in the Emergency Department and was intubated. She passed away at 0046 hours on March 28, 2023.

5. According to Ms. S[redacted] attending physician, the causes of death were: cardiopulmonary arrest (minutes); acute hypoxemic respiratory failure requiring endotracheal intubation (hours); shock-hypovolemic versus septic (hours); and acute to subacute infarct (days).

6. Ms. S[redacted] had multiple previous presentations to Mercy San Juan Medical Center prior to March 27, 2023. In January of 2023, social workers noted that Ms. S[redacted] had been living in a Skilled Nursing Facility called Mission Carmichael in Carmichael since October of 2021. She had been homeless for most of her life. As of January 2023, Ms. S[redacted] had not seen her husband Shayne S[redacted] for 6 or 7 years. He is also homeless. Ms. S[redacted] named her father-in-law James S[redacted] as surrogate decision maker, but when he was contacted by hospital staff, he sounded confused and stated he did not know who Ms. S[redacted] was. She presented back to Mercy San Juan Medical Center in February of 2023, and a LexisNexis search did not find any family. Ms. S[redacted] returned in early March of 2023, and again, no family contacts could be located.

7. On March 19, 2024, Decedent Affairs called husband Shayne[redacted] The telephone number was disconnected. Decedent Affairs also attempted to call Ms. S[redacted] father-in-law, James, but his telephone number was also disconnected. Decedent Affairs telephoned Ms. S[redacted] primary care physician, Dr. Polskiy, at (916) 979-0621, in order to discover if Dr. Polskiy had any other information on Ms. S[redacted] next of kin or emergency contact. Decedent Affairs had to leave a voice-mail message. No one from Dr. Polskiy's office has returned the voice-mail message.

8. The COVID-19 pandemic impacted the process of obtaining death certificates for CommonSpirit Health/Dignity Health patients. The pandemic created a backlog of patients being held at SMT's facility. This backlog, and the associated staffing issues that arose in order to address the backlog, are the reasons why Ms. S[redacted] death certificate was not entered within a year of his death.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 27 day of September, 2024, at Sacramento, California.

LAURA LUKIN

(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)

CUSTODIAN OF RECORDS DECLARATION

I, STEPHANIE GONZALES, declare as follows:

1. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. I am an authorized custodian of records for the records maintained on patients treated at Mercy San Juan Medical Center. My title is Manager of Health Information Management.

3. A patient chart is maintained on each patient treated at Mercy San Juan Medical Center. This chart is maintained by the Health Information Management Department at Mercy San Juan Medical Center.

4. The documents and entries in documents pertaining to a patient are prepared at or near the time of their occurrence by persons with knowledge of the circumstances or events.

5. The Mercy San Juan Medical Center medical records attached to this declaration are true and correct copies of documents from the patient chart of Brenda L. S[redacted], date of birth [redacted]/1970, for care and treatment she received at Mercy San Juan Medical Center in March of 2023. These records are maintained in the regular course of business by Mercy San Juan Medical Center.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 24th day of September, 2024.

STEPHANIE GONZALES

Electronically Signed By:
Mukhtar, Nadeem DO
On 04/02/23 07:53
Co Signature By:
Modify Signature By:
Mukhtar, Nadeem DO
On 04/02/23 06:38

Completed Action List:

* Perform by Mukhtar, Nadeem DO on April 02, 2023 6:25 PDT
* Modify by Mukhtar, Nadeem DO on April 02, 2023 6:38 PDT
* Modify by Mukhtar, Nadeem DO on April 02, 2023 7:50 PDT
* Modify by Mukhtar, Nadeem DO on April 02, 2023 7:53 PDT
* Sign by Mukhtar, Nadeem DO on April 02, 2023 7:53 PDT Requested by Mukhtar, Nadeem DO on April 02, 2023 6:25 PDT
* VERIFY by Mukhtar, Nadeem DO on April 02, 2023 7:53 PDT

Notification of Death
03/28/23 00:46 PDT Performed by Ponce, Luis RN
Entered on 03/28/23 01:44 PDT

Notification

Notifications: Medical examiner, Organ bank, Other: Dr. radler to contact spouse for notification of death
Pronounced by: Radler, David
Contact Information: Unable to obtain
Potential Medical Examiner Case: No
Comment: 0058 body released by White, Badge 38
Autopsy Requested: No
Candidate to Donate per Organ Bank: Eyes, Tissue
Organ Donation Approval: Other: donor services will contact next of kin
Date/Time Organ Bank Notified: 03/28/23 01:20
Organ Bank Member Notified: Yolanda R
Ref # 1307347
Release of Remains: Yes
Release of Decedent: Yes

Release of Remains

Family consent signature: Please see attached SW notes, I called

Family consent print: [redacted] on 3/19/24

Family consent date: and both phones were disconnected.

Witness signature: _____

Witness consent print: I also attempted to call Pt's. listed

Witness consent date: PCP for NOK or emergency contact

Release of Decedent info, they also did not pick up.

Mortuary rep sig: _____

Mortuary rep print: Dr. Polskiy (916) 979-0621

Mortuary rep date: _____

Release Witness sig: _____

Release Witness print: _____

Release Witness date: _____

EXHIBIT 17

BMD-003A

ATTORNEY OR PARTY WITHOUT ATTORNEY: STATE BAR NUMBER: 221261 NAME: Jamie A. Pearson, Esq. FIRM NAME: UBALDI & MCPHERSON STREET ADDRESS: 555 University Avenue, Suite 140 CITY: SACRAMENTO STATE: CA ZIP CODE: 95825 TELEPHONE NO.: (916) 265-4555 FAX NO.: (916) 265-4568 E-MAIL ADDRESS: lsmith@umllp.com ATTORNEY FOR (name): Petitioner Dignity Health dba Mercy San Juan Medical Center	FOR COURT USE ONLY **ELECTRONICALLY FILED** Superior Court of California County of Sacramento 10/23/2024 By: M. Dysle Deputy
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO STREET ADDRESS: 3341 Power Inn Road MAILING ADDRESS: 3341 Power Inn Road CITY AND ZIP CODE: Sacramento, 95826 BRANCH NAME: William R. Ridgeway Family Relations Courthouse	
IN THE MATTER OF (name): ANTHONY [redacted] J [redacted]	CASE NUMBER: 24PR003135
DECLARATION IN SUPPORT OF PETITION TO ESTABLISH FACT, TIME, AND PLACE OF DEATH	HEARING DATE AND TIME: 10/31/2024 1:30pm DEPT.: 129

(Name of declarant): Laura Lukin declares as follows:

1. I make the statements in this declaration based on my personal knowledge or on the contents of the documents identified in item 5. *("Personal knowledge" of a fact is knowledge that is **not** gained from another person's statements to you about that fact.)*
2. a. I am at least 18 years of age.
   b. I reside at *(street address and city):* Work Address: 4400 Duckhorn Drive, Suite 200, Sacramento, CA 94834

   County: Sacramento State: California
3. *(Name of deceased person):* ANTHONY [redacted] J [redacted] died at
   approximately *(time):* 6:52 [ ] a.m. [X] p.m. on *(date):* 03/14/2023 at the following place:
   a. City, town, township, or other *(identify "other" if known)* Mercy San Juan Medical Center, 6501 Coyle Ave., Carmichael
   b. [X] County: Sacramento State (U.S.): California
   c. [ ] State or province: Country:
4. Facts showing when and where the person named in item 3 died and explaining how I have personal knowledge of those facts
   [X] are stated in the space below [X] are stated in Attachment 4 to this declaration.
   (If you are relying solely on the contents of the documents identified in item 5, please advise in the space below.)

   I am relying solely on the contents of the documents identified in item 5 for information concerning the date, time, cause of death for Mr. J[redacted]. Mr. J[redacted] died at Mercy San Juan Medical Center on March 14, 2023 and has remained in Petitioner's custody, control, and possession since that date. Petitioner would like to refer this matter to the Coroner's Indigent Cremation Program, but a death certificate is required in order for his remains to be released. See Attachment 4 for more information.

BMD-003A

IN THE MATTER OF *(name)*: ANTHONY [redacted]	CASE NUMBER:

5. [X] Attached are true and correct copies of the following documents *(check each box that applies)*:

   a. [ ] Police report dated *(date of each)*:

   b. [ ] Coroner's report dated *(date)*:

   c. [ ] Private physician's report dated *(date of each)*:

   d. [X] Other documents dated *(describe and give the date of each document; "Other documents" could include school or college records, vaccination certificates and other medical records, employment records, documents showing sources of support other than employment, family correspondence, diaries, photographs, and other similar family records)*:

   Custodian of records declaration for Mercy San Juan Medical Center records, plus Mercy San Juan Medical Center records

   [ ] Continued on Attachment 5d.

6. The death of the person named in Item 3, or the date, time, or place of death [X] is not [ ] is important to a court case or proceeding that is now pending and described below. *(If you selected "is," briefly describe the proceeding and provide the case name and number, the name and address of the court where the proceeding is pending, the names of all parties to the proceeding, and the names, addresses, and telephone numbers of their attorneys. **Note: A court order made on a petition under Health and Safety Code section 103460, et seq., may not be effective against claims of persons or organizations not given notice of the petition for the order.**)*

   [ ] Continued on Attachment 6.

7. Number of pages attached: 12

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 10/23/24

Laura Lukin, Regional Laboratory Support Supervisor for Pathology Services & Decedent Affairs, on behalf of Petitioner Dignity Health dba Mercy San Juan Medical Center

(TYPE OR PRINT NAME OF DECLARANT)

▶ Laura Lukin

(SIGNATURE OF DECLARANT)

MC-025

SHORT TITLE: IN THE MATTER OF ANTHONY [redacted]	CASE NUMBER:

ATTACHMENT (Number): 4

(This Attachment may be used with any Judicial Council form.)

I, LAURA LUKIN, declare as follows:

1. I am employed by CommonSpirit Health as Regional Laboratory Support Supervisor for Pathology Services and am Supervisor of Decedent Affairs. I have held these positions since March of 2022. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. Part of my duties include supervising the Regional Morgue for the Sacramento area CommonSpirit Health/Dignity Health hospitals. Mercy San Juan Medical Center is one of these hospitals. The morgue located within Mercy San Juan Medical Center is very small. Because of this, CommonSpirit Health/Dignity Health has contracted with Sacramento Mortuary Transport ("SMT") to transport deceased patients from Mercy San Juan Medical Center to SMT's facility in South Sacramento until such time as the deceased patients can be released for their final resting places. The deceased patients who have been moved to SMT's facility are still considered "patients" of CommonSpirit/Dignity Health and remain within the system's custody and control. A death certificate is necessary for any deceased patient to be released from CommonSpirit Health/Dignity Health's custody and control and SMT's facility.

3. I am responsible for obtaining death certificates for deceased CommonSpirit Health/Dignity Health patients who have been moved to SMT's facility. In order to accomplish this, it is necessary for me to access the medical records of the deceased patients. Therefore, I have access to Anthony [redacted] medical records from Mercy San Juan Medical Center. I have reviewed Mr. [redacted] medical records, including those records that have been included as supporting evidence for this Petition. My personal knowledge of the date, time, and place of Mr. [redacted] death are based on my review of the medical records attached to this Petition. The remains of Anthony [redacted] are currently located at SMT's facility, but remain within the custody and control of CommonSpirit Health/Dignity Health.

4. Anthony [redacted] died at Mercy San Juan Medical Center, located at 6501 Coyle Avenue, Carmichael, CA. 95608, on March 14, 2023. Mr. [redacted] was transferred to Mercy San Juan Medical Center from U.C. Davis Med Center on February 8, 2023, after having suffered some sort of physical assault that resulted in head trauma. He was a patient for over a month at Mercy San Juan Medical Center. At one point, his care and team and his brother Raymond [redacted] made the decision to place Mr. [redacted] on hospice. Mr. [redacted] died at 1852 hours on March 14, 2023.

5. His attending physician listed the discharge diagnoses as cardiopulmonary arrest; failure to thrive; history of nonsustained ventricular tachycardia with elevated troponin during his hospitalization at U.C. Davis Med Center. Please see the first page of Dr. Mukhtar's Discharge Summary for more details, which is attached to my Declaration.

6. During Mr. [redacted] hospitalization at Mercy San Juan Medical Center, hospital staff were in contact with his brother, Raymond [redacted] According to Raymond, Mr. [redacted] has no children and no spouse or ex-spouses. According to the social work notes, Mr. [redacted] stated he did not have much contact with Mr. [redacted] because Raymond lived in downtown and had no transportation to see Mr. [redacted] and that travel was difficult because Raymond was disabled.

7. On April 11, 2024, Decedent Affairs called Raymond [redacted] at [redacted]. Raymond stated he was the only family left. He confirmed he was disabled, and stated he was not able to use transportation. During the telephone call, it was evident that Raymond [redacted] was having memory issues; he had lapses of memory during the telephone call with Decedent Affairs. It is the intention of Decedent Affairs to refer Mr. [redacted] to the Coroner's indigent cremation program. Given brother Raymond [redacted] memory issues, it is not clear if Raymond [redacted] can fill out the forms required for the indigent cremation program. In order for Mr. [redacted] remains to be released, a death certificate is required.

8. The COVID-19 pandemic impacted the process of obtaining death certificates for CommonSpirit Health/Dignity Health patients. The pandemic created a backlog of patients being held at SMT's facility. This backlog, and the associated staffing issues that arose in order to address the backlog, are the reasons why Mr. [redacted] death certificate was not entered within a year of his death.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 23 day of October, 2024, at Sacramento, California.

lauralu

LAURA LUKIN

(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)

CUSTODIAN OF RECORDS DECLARATION

I, STEPHANIE GONZALES, declare as follows:

1. I make this declaration on the basis of my own personal knowledge, and if called upon to testify to the facts stated herein, I could and would competently do so.

2. I am an authorized custodian of records for the records maintained on patients treated at Mercy San Juan Medical Center. My title is Manager of Health Information Management.

3. A patient chart is maintained on each patient treated at Mercy San Juan Medical Center. This chart is maintained by the Health Information Management Department at Mercy San Juan Medical Center.

4. The documents and entries in documents pertaining to a patient are prepared at or near the time of their occurrence by persons with knowledge of the circumstances or events.

5. The Mercy San Juan Medical Center medical records attached to this declaration are true and correct copies of documents from the patient chart of Anthony [redacted] J[redacted], date of birth [redacted]1960, for care and treatment she received at Mercy San Juan Medical Center in March of 2023. These records are maintained in the regular course of business by Mercy San Juan Medical Center.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct and that I executed this declaration on the 26th day of September, 2024.

S Gonzales

STEPHANIE GONZALES

Electronically Signed By:
Mukhtar, Nadeem DO
On 03/15/23 07:24
Co Signature By:
Modify Signature By:
Mukhtar, Nadeem DO
On 03/15/23 07:06

Completed Action List:

* Perform by Mukhtar, Nadeem DO on March 14, 2023 19:14 PDT
* Modify by Mukhtar, Nadeem DO on March 15, 2023 7:06 PDT
* Modify by Mukhtar, Nadeem DO on March 15, 2023 7:14 PDT
* Modify by Mukhtar, Nadeem DO on March 15, 2023 7:15 PDT
* Modify by Mukhtar, Nadeem DO on March 15, 2023 7:16 PDT
* Modify by Mukhtar, Nadeem DO on March 15, 2023 7:24 PDT
* Sign by Mukhtar, Nadeem DO on March 15, 2023 7:24 PDT Requested by Mukhtar, Nadeem DO on March 14, 2023 19:14 PDT
* VERIFY by Mukhtar, Nadeem DO on March 15, 2023 7:24 PDT

Notification of Death
03/14/23 19:35 PDT Performed by Watson, Allison
Entered on 03/14/23 19:37 PDT

Updated on
03/14/23 23:53 PDT by Watson, Allison
03/14/23 23:53 PDT by Watson, Allison
03/14/23 21:18 PDT by Hanlon, Brigitte RN
03/14/23 21:25 PDT by Hanlon, Brigitte RN

Notification

Notifications: Other: Nurse Practitioner
Pronounced by: Baba, Dennis
Date/Time of Death: 03/14/23 18:52
Name of Attending Notified of Death: Baba, Dennis
Date/Time Attending Notified of Death: 03/14/23 18:45
Relationship to Deceased: Brother
Name of Family Member Notified of Death: Raymond [redacted], brother
Date/Time Family Notified of Death: 03/14/23 18:52
Family Phone Number Expiration Record: [redacted]
Contact Information: Yes
Potential Medical Examiner Case: No
Candidate to Donate per Organ Bank: Eyes, Tissue
Date/Time Organ Bank Notified: 03/14/23 21:24
Organ Bank Member Notified: case #13061572
Release of Remains: Yes
Release of Decedent: Yes
Clothes Grid
Pants: To security
Other: To security
Comment: shoes and belt

Release of Remains

Family consent signature: Pt previously homeless

Family consent print: 4/11/24: Called brother Raymond, sounds ill

Family consent date: and having memory lapses. Stated brother

Witness signature: wants to be cremated, please see

Witness consent print: attached call log for details.

Witness consent date: _____

Release of Decedent

Mortuary rep sig: _____

Mortuary rep print: _____

Mortuary rep date: _____

Release Witness sig: _____

Release Witness print: _____

Patient Name	Anthony [redacted]
DOB	[redacted]/1960
DOD/TOD	3/14/2023, 18:52
MRN	10093435

- 4/11/2024 **Raymond** [redacted], Brother
  - Called brother, stated that his brother Anthony passed, and when I asked for NOK he stated that he is the only one left in California. I am going to be referring to the Coroner for indigent cremation, however it should be noted that Raymond is disabled, unable to use transportation, and was having lapses of memory on our phone call. He might be unable to fill out the indigent cremation forms.

EXHIBIT 18

INDEPENDENT CONTRACTOR AGREEMENT (NON-CLINICAL, BA)

TRANSPORTATION AND STORAGE SERVICES AGREEMENT

THIS INDEPENDENT CONTRACTOR AGREEMENT ("***Agreement***") is made and entered into by and between the Dignity Health and/or Dignity Community Care affiliated entity(ies) identified in the Key Informational Terms below (each, an "***Affiliate***"), and the independent contractor identified in the Key Informational Terms below ("***Contractor***"). Contractor and Affiliate (each a "***Party***" and collectively the "***Parties***") agree as follows:

KEY INFORMATIONAL TERMS

A. Dignity Health/Dignity Community Care Affiliate(s).

Dignity Health, a California nonprofit public benefit corporation, doing business as Mercy San Juan Medical Center, Mercy General Hospital, and Mercy Hospital of Folsom.

Dignity Community Care, a Colorado nonprofit corporation, doing business as Methodist Hospital of Sacramento and Woodland Memorial Hospital.

State in which Affiliates are located: California ("***State***")

B. Affiliate's Notice Address.

Senior Director of Laboratories
Dignity Health Greater Sacramento Area
4400 Duckhorn Drive, Suite 200
Sacramento, CA 95834

Copy to: CommonSpirit Health Legal Team
3400 Data Drive
Rancho Cordova, CA 95670

C. Contractor's Name and Description.

Mortuary Support Services of Northern California, a California corporation, d/b/a Sacramento Mortuary Transport

D. Contractor's Notice Address.

35 Quinta Court, Suite C
Sacramento, CA 95823

E. Term. This Agreement commences on October 1, 2021 (the "***Effective Date***") and expires on September 30, 2023 (the "***Expiration Date***").

F. Without Cause Termination. Number of days' notice required for without cause termination: 30

G. Parts. This Agreement is comprised of the following parts:

(i) **Part I** Dignity Health/Dignity Community Care Terms and Conditions
(ii) **Part II** Services and Fees
(iii) **Part III** Business Associate Exhibit
(iv) **Part IV** Insurance Requirements

IN WITNESS WHEREOF, Affiliate and Contractor execute this Agreement as of the dates below.

AFFILIATE

Dignity Health, a California nonprofit public benefit corporation, on behalf of Mercy San Juan Medical Center, Mercy General Hospital, Mercy Hospital of Folsom; and

Dignity Community Care, a Colorado nonprofit corporation, on behalf of Methodist Hospital of Sacramento and Woodland Memorial Hospital

DocuSigned by:
Todd Strumwasser
EEA8DD3EA4BF4AD...

Printed Name: Todd Strumwasser, MD
Title: SVP, Northern California Division
Date: Sep 11, 2021

CONTRACTOR

Mortuary Support Services of Northern California, a California corporation, d/b/a Sacramento Mortuary Transport

DocuSigned by:
Michael Lofton
3708F36E0420450...

Printed Name: Robert Michael Lofton
Title: President/CEO
Date: Sep 9, 2021

Part I

INDEPENDENT CONTRACTOR AGREEMENT (NON-CLINICAL, BA)
DIGNITY HEALTH/DIGNITY COMMUNITY CARE TERMS AND CONDITIONS

1. CONTRACTOR'S OBLIGATIONS

1.1 Services. Contractor and/or employees or agents of Contractor that provide Services as defined below under this Agreement or otherwise have access to Dignity Health or Dignity Community Care confidential information ("***Personnel***") shall perform the services set forth in Part II (the "***Services***") in accordance with the terms of this Agreement.

1.2 Time and Manner of Performance. Contractor shall ensure that only fully qualified Personnel perform Services under this Agreement, and such Personnel shall perform Services diligently and in a timely manner, according to the highest applicable standards. Affiliate reserves the right to refuse to use any Personnel assigned to provide Services under this Agreement and to have removed from its premises any Personnel.

1.3 Warranties. Contractor represents and warrants that:

a. Contractor and Personnel, if applicable, have and shall maintain all licenses and/or certifications necessary to do business and perform the Services in the State. Contractor shall provide Affiliate with a copy of such license(s) upon request and shall promptly notify Affiliate in the event of any limitation or loss or termination of such license(s) and certification(s).

b. Contractor and Personnel are not and at no time have been excluded from participating in Medicare, Medicaid, or any other Federal healthcare program, as defined at 42 U.S.C. Section 1320a-7b(f) (each, a "***Federal Healthcare Program***"). Contractor shall no less than monthly check the OIG List of Excluded Contractors and the General Services Administration list of parties excluded from participation in Federal Healthcare Programs to ensure that neither Contractor nor any Personnel appear on said lists. Contractor shall immediately notify Affiliate of any threatened or actual exclusion from any Federal Healthcare Program. In the event that any Contractor or Personnel is excluded from participating in any Federal Healthcare Program, this Agreement shall automatically terminate as of the date of such exclusion (unless such Personnel is immediately removed from performing Services under this Agreement). Contractor shall indemnify and hold harmless Affiliate for, from, and against any and all claims, liabilities, losses, damages, penalties, and costs, including reasonable attorneys' fees and costs, incurred by Affiliate arising directly or indirectly, out of any violation of this Section by Contractor, or due to the exclusion of any Contractor or Personnel from any Federal Healthcare Program.

c. Within 180 days prior to the Effective Date, Contractor engaged an independent entity to conduct background screenings and Contractor and Personnel successfully passed in accordance with the standards set forth in Appendix B of Dignity Health Policy 120.1.019, a copy of which is available from Affiliate. Contractor and Personnel shall successfully complete such background screenings on an annual basis during the term hereof. Contractor shall provide proof of compliance with this Section prior to commencing Services and no less than annually thereafter.

d. No doctor of medicine, osteopathy, podiatry, optometry, dentistry, or chiropractic (or any family member thereof) possesses any form of ownership or investment interest in Contractor. Contractor has no compensation arrangement with any of the aforementioned medical professionals that in any way varies based upon the value or volume of referrals or other business generated by such medical professional (or any family member) to Affiliate.

1.4 Laws and Standards. Contractor shall comply with the following, as amended from time to time, to the extent applicable to the provision of Services under this Agreement: (a) Affiliate's corporate integrity program and any Dignity Health and/or Dignity Community Care Corporate Integrity Agreement(s), as applicable; (b) Dignity Health and/or Dignity Community Care Standards of Conduct, as applicable; (c) all applicable federal, state, and local laws and regulations (collectively, "***Laws***"); and (d) the policies, procedures, and rules of Affiliate (the "***Affiliate Rules***").

1.5 Medicare Records. To the extent required by Laws, Contractor shall make available, upon written request from Affiliate, the Secretary of Health and Human Services, the Comptroller General of the United States, or any other authorized agency, this Agreement and Contractor's books, documents, and records ("***Contractor's Records***"). Contractor shall preserve and make available Contractor's Records for a period of four years after the end of the term of this Agreement. If Contractor is requested to disclose Contractor's Records pursuant to this Section, Contractor shall notify Affiliate of the nature and scope of such request, and Contractor shall make available to Affiliate all such Contractor's Records.

1.6 Use of Affiliate Premises. Contractor shall not use any part of the Affiliate premises as an office for private business. Contractor and Personnel shall only enter those areas of Affiliate's facility that are necessary for the performance of Contractor's Services.

1.7 Health Screening and Immunization. If the provision of Services requires Contractor and/or Personnel to be present in a clinical procedural area or to have direct contact with patients, Contractor, at Contractor's expense, shall assure that Contractor and all Personnel meet all health screening and immunization requirements in accordance with Affiliate's policies prior to providing Services. Contactor shall provide written documentation of compliance with this Section prior to commencing Services and at least annually thereafter.

2. COMPENSATION

2.1 Reports. Contractor shall submit to Affiliate, on a periodic basis as agreed by the Parties, a report in a form reasonably acceptable to Affiliate that accurately documents Services provided by Contractor (the "***Report***").

2.2 Payment. Affiliate shall, within 30 days after receiving an undisputed Report, pay to Contractor the fees set forth in Part II for Services performed by Contractor.

2.3 Sole Compensation. Contractor agrees that the compensation, as specified above, is the sole and exclusive compensation for Services provided pursuant to this Agreement.

3. TERMINATION

3.1 Termination Without Cause. Each Party may terminate this Agreement without cause, expense, or penalty effective upon expiration of the number of days' prior written notice set forth in Section F of the Key Informational Terms above.

3.2 Termination Upon Breach. Each Party may terminate this Agreement upon any breach by the other Party if such breach is not cured to the satisfaction of the non-breaching Party within 10 days after written notice of such breach is given by the non-breaching Party.

3.3 Effect of Termination or Expiration. Upon termination or expiration of this Agreement, all rights and obligations of the Parties shall cease except those rights and obligations that have accrued and remain unsatisfied prior to the date of termination or expiration, and those rights and obligations that expressly survive termination or expiration of this Agreement. The following Sections of this Part I shall survive expiration or termination of the Agreement: 1.5 (Medicare Records), 4 (Protected Information), 5 (Insurance and Indemnification), 6.3 (Dispute Resolution), and 6.8 (Notices).

4. PROTECTED INFORMATION

4.1 HIPAA. Contractor shall be a business associate of Affiliate and comply with the HIPAA provision set forth in Part III.

4.2 Confidential Information. Contractor shall not use or disclose any Confidential Information (as defined below) for any purpose not expressly permitted by this Agreement without the prior written consent of Affiliate. Contractor shall protect Confidential Information from unauthorized use, access, or disclosure with no less than reasonable care. "***Confidential Information***" means any proprietary or confidential information of Affiliate or any other Dignity Health and/or Dignity Community Care affiliate, any Affiliate patient's protected health information, as defined by HIPAA, and any information, records, and proceedings of Affiliate and/or Medical Staff committees and peer review bodies. Confidential Information also includes proprietary or confidential information of any third party that may be in Affiliate's possession.

4.3 Work Product. Contractor acknowledges and agrees Affiliate shall have sole title to and exclusive ownership of all reports, deliverables, and other work product (collectively the "***Work Product***"). The Work Product shall be deemed a "work made for hire" as that term is defined under Section 101 of the U.S. Copyright Act and Affiliate shall be considered the person for whom the work was prepared for the purpose of determining authorship of any copyright in the Work Product. To the extent a Work Product is not a *work made for hire* under U.S law or any other jurisdiction, Contractor hereby assigns all right, title, and interest in the Work Product to Affiliate and retains no interest therein. Contractor agrees to execute any instruments requested by Affiliate during or after completion of the Services to (i) transfer to Affiliate any rights Contractor may retain in the Work Product, and (ii) enable Affiliate perfect its rights, title, and interest in the Work Product.

5. INSURANCE AND INDEMNIFICATION

5.1 Insurance Requirements. Contractor shall comply with the insurance requirements set forth in Part IV of this Agreement.

5.2 Mutual Indemnification. Each Party shall defend, indemnify, and hold the other Party harmless for, from, and against any and all claims, liabilities, losses, damages, penalties, and costs, including reasonable attorneys' fees and costs, incurred by the indemnified Party and arising out of or resulting from any actual or alleged (a) negligent or willful acts or omissions, (b) breach of this Agreement, or (c) violation of Laws, by the indemnifying Party or the indemnifying Party's employees or agents. This Section 5.2 shall not apply to any action brought by one Party against the other Party.

6. MISCELLANEOUS PROVISIONS

6.1 Assignment. Except for the foregoing, Contractor may not assign or transfer its rights and duties under this Agreement without first obtaining the written consent of Affiliate. This Agreement shall be binding upon the parties hereto and upon their successors, and, subject to the terms and conditions hereof, their assigns.

6.2 Counterparts, Signatures. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. When signed in pen ink, this Agreement may be delivered by facsimile or by scanned email attachment, and said copies shall be treated as original. Amendments to this Agreement shall be similarly executed by the Parties.

6.3 Dispute Resolution. In the event of any dispute or claim arising out of or related to this Agreement (each, a "***Dispute***") the Parties shall, as soon as reasonably practicable after one Party gives written notice of a Dispute to the other Party (the "***Dispute Notice***"), meet and confer in good faith regarding such Dispute at such time and place as mutually agreed upon by the Parties. If any Dispute is not resolved to the mutual satisfaction of the Parties within 10 business days after delivery of the Dispute Notice (or such other period as may be agreed upon by the Parties in writing), the Parties shall submit such Dispute to arbitration conducted in the County in which Affiliate is located by JAMS, Inc. in accordance with its commercial arbitration rules. The Parties waive the right to seek specific performance or any other form of injunctive or other equitable relief or remedy arising out of this Agreement, except that such remedies may be utilized for purposes of enforcing this Section 6.3 and Sections 1.5 (Medicare Records) and 4 (Protected Information) of this Part I. The prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements, in addition to any other relief to which that Party may be entitled. All disputes shall be governed by the laws of the State.

6.4 Entire Agreement, Amendment. This Agreement is the entire understanding and agreement of the Parties regarding its subject matter, and supersedes any prior oral or written agreements, representations, or discussions between the Parties with respect to such subject matter. This Agreement may be amended only by mutual agreement set forth in writing, signed and dated by the Parties.

6.5 Independent Contractor. The Parties shall at all times be independent contractors in performing under this Agreement.

6.6 No Conflicting Obligations. Contractor represents and warrants that it is not a party to any arrangement that may materially interfere with Contractor's obligations under this Agreement, and Contractor shall immediately notify Affiliate if Contractor becomes involved in any such arrangement.

6.7 Non-Discrimination. Contractor and Affiliate shall be in full compliance with Section 504 of the Rehabilitation Act of 1973, Titles VI and VII of the 1964 Civil Rights Act, and regulations issued pursuant thereto. Neither Contractor nor Affiliate shall differentiate or discriminate in the provision of services on any basis prohibited by Laws or Affiliate Rules.

6.8 Notices. Notices under this Agreement shall be given in writing and delivered by either: (a) personal delivery, in which case such notice shall be deemed given on the date of delivery; (b) next business day courier service (*e.g.*, FedEx, UPS, or similar service), in which case such notice shall be deemed given on the business day following the date of deposit with the courier service; or (c) U.S. mail, first class, postage prepaid, registered or certified, return receipt requested, in which case such notice shall be deemed given on the third business day following the date of deposit with the United States Postal Service. Notices shall be delivered to the notice addresses set forth in the Key Informational Terms above.

6.9 Referrals. Nothing in this Agreement or in any other written or oral agreement between Affiliate and Contractor contemplates or requires the admission or referral of any patients or business to Affiliate or any affiliate of Affiliate.

6.10 Waiver. No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of such provision or any other provision. Any waiver granted by a Party must be in writing and shall apply solely to the specific instance expressly stated.

6.11 California Title 22 Compliance. If Affiliate is an acute care hospital located in California only: Without limiting the obligations of Contractor, Affiliate shall retain administrative responsibility for its operation, as required by Title 22, California Code of Regulations, Section 70713.

Part II

INDEPENDENT CONTRACTOR AGREEMENT (NON-CLINICAL BA)
SERVICES AND FEES

a. Description of Services.

Upon Affiliate's request, Contractor shall transport human remains between the Affiliates and/or between an Affiliate and an autopsy services provider contracted with the Hospital, and/or provide or arrange for the storage of human remains at a storage facility that is properly licensed and operated under the laws of California (the "***Services***"). Affiliate may request the Services by telephone call to Contractor. Contractor shall make best efforts to arrive at Affiliate to pick up the human remains within twenty-four (24) hours of receiving Affiliate's request, and shall transport and deliver the human remains to the drop-off location designated by Affiliate, and/or provide or arrange for the storage of the human remains.

b. Fees.

Affiliates shall pay Contractor for the Services in accordance with the fee schedule below. No guarantee is made by Affiliates as to the quantity of Services to be performed under this Agreement. In addition, each Affiliate in its sole discretion reserves the right to retain other individuals or companies to provide similar services.

Fee to transport deceased between Affiliate, between an Affiliate and an autopsy services provider contracted with Affiliate, or between an Affiliate/contracted autopsy services provider and Contractor's contracted licensed storage facility (based on body weight)	
Removal Fees, per decedent, based on deceased's weight:	
Less than 300 lbs (includes transportation to refrigeration facility)	$100.00
300 lbs and over (includes transportation to refrigeration facility)	$185.00
Daily Storage fee to store deceased at Contractor's contracted licensed storage facility:	
Per decedent, per day, up to 60 days (begins on day of removal)	$15.00
Per decedent, per day, greater than 60 days (begins on day 61 of storage)	$0.00
Inter-Facility Transfer (between Affiliates), per decedent	$100.00

Part III

INDEPENDENT CONTRACTOR AGREEMENT (NON-CLINICAL BA)

BUSINESS ASSOCIATE EXHIBIT

The parties agree that, under this HIPAA Business Associate Exhibit, Mortuary Support Services of Northern California (**"Business Associate"**) shall have all the rights and obligations of a "Business Associate" as defined in HIPAA (defined below), and Mercy General Hospital, Mercy San Juan Medical Center, Mercy Hospital of Folsom, Methodist Hospital of Sacramento, and Woodland Memorial Hospital, each a member of the CommonSpirit Health Organized Health Care Arrangement (OHCA) (**"Covered Entity"**) shall have all the rights and obligations of a "Covered Entity," as defined in HIPAA. This Exhibit will apply to all services Business Associate provides now or in the future to Covered Entity and to CommonSpirit Health OHCA members. The OHCA members are listed at https://www.catholichealthinitiatives.org/content/dam/chi-national/website/corp-resp-/11.16.20%20CommonSpirit%20Health%20OHCA%20November%2016%202020.pdf

1. General Provisions, Including Definitions. This Exhibit is intended to apply to all services provided to Covered Entity by Business Associate under the Agreement (defined below), whether or not such engagement has been formally reduced to writing, and this Exhibit supersedes any form of business associate agreement or provision that the parties may have heretofore entered into with respect to the subject matter herein. The provisions of this Exhibit shall remain effective as long as Business Associate creates, receives, maintains or transmits PHI on behalf of Covered Entity, no matter whether the Agreement (as defined below) remains effective or not. All capitalized terms not defined in this Exhibit shall have the meaning ascribed to them by HIPAA, including Business Associate, Covered Entity, Data Aggregation, and Designated Record Set.

(a) **"Agreement"** shall mean the agreement to which this Exhibit is attached or incorporated within by reference.

(b) **"Breach"** shall mean the acquisition, access, Use, or Disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI.

(c) **"California Breach"** shall mean, with respect solely to information created, received, maintained, or transmitted by Business Associate from or on behalf of any California facilities, the unlawful or unauthorized access to, and use or disclosure of, Individuals' medical information, as the term "medical information" is defined at California Civil Code Section 56.05.

(d) **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-005), and the rules, guidance and regulations promulgated thereunder, as amended from time to time, including 45 Code of Federal Regulations, Parts 160 and 164.

(e) **"Individual"** shall have the meaning given to such term under HIPAA and shall include a person who qualifies as a personal representative.

(f) **"Protected Health Information"** (**"PHI"**) shall have the meaning given to such term under HIPAA, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity. PHI includes, without limitation, electronic PHI (**"ePHI"**).

(g) **"Secretary"** shall mean the Secretary of the U.S. Department of Health and Human Services or her/his designee.

(h) **"Unsuccessful Security Incident"** shall mean any attempted but unsuccessful access of system operations in an information system by a Packer Internet Groper (PING) program or other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, acquisition, Use, or Disclosure of PHI.

(i) **"State"** shall mean the state in which Covered Entity is located. If this Exhibit applies to more than one Covered Entity, as indicated in the opening paragraph, in more than one state, "State" shall mean the state in which each Covered Entity is located, respectively.

(j) **"Subpart E"** shall mean 45 Code of Federal Regulations, Part 164, Subpart E, which consists of Sections 164.500 et seq., as amended from time to time.

2. Permitted Uses and Disclosures by Business Associate

(a) **For Covered Entities**. Except as otherwise limited in the Agreement and this Exhibit, Business Associate (i) shall create, receive, maintain, transmit, access, Use or Disclose PHI for the benefit of Covered Entity and to perform functions, activities, or services as specified herein and any other agreements between the parties involving PHI, and (ii) shall not Use or Disclose PHI in a manner that would violate HIPAA if done by Covered Entity. To the extent Business Associate is to carry out one or more of Covered Entity's obligations under Subpart E, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligations.

(b) **Minimum Necessary**. Business Associate shall request, Use, or Disclose only the minimum amount of PHI necessary to perform the specified functions, activities or services, in accordance with HIPAA's minimum necessary requirements. In the event of inadvertent access by Business Associate to more than the minimum necessary amount of Covered Entity's PHI, Business Associate will: (i) treat all such PHI in accordance with the Agreement and this Exhibit; (ii) promptly notify Covered Entity, in accordance with Section 3(d) below, of such access; (iii) erase, delete, or return such PHI as quickly as possible; and (iv) take all necessary actions to prevent further unauthorized access to PHI beyond the minimum necessary amount.

(c) **Management of Business Associate**. Except as otherwise limited in the Agreement and this Exhibit, Business Associate may Use or Disclose PHI for its proper management and administration or to carry out its legal responsibilities, provided that (i) the Disclosure is required by law, or (ii) Business Associate obtains reasonable assurances from the person to whom the PHI is Disclosed that such information shall remain confidential and be Used or further Disclosed solely as required by law or for the purpose of assisting Business Associate to meet Business Associate's obligations under the Agreement. Business Associate shall require any person to whom PHI is Disclosed under this Subsection to notify Business Associate of any instance of which it is aware in which the confidentiality or security of the PHI has been breached or its integrity compromised.

(d) **Data Aggregation**. Business Associate may Use PHI to provide Data Aggregation services solely for Covered Entity, consistent with HIPAA.

(e) **Compliance with State Laws**. Business Associate may Use, Disclose and access PHI only as permitted by State law, unless such State law is contrary to HIPAA and is preempted by HIPAA in accordance with 45 Code of Federal Regulations Sections 160.201 et seq.

3. Obligations of Business Associate

(a) **Use and Disclosure**. Business Associate shall not Use or Disclose PHI other than as permitted or required by the Agreement, this Exhibit, or as required by law.

(b) **Safeguards**. Business Associate shall use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Exhibit. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. If Business Associate conducts credit card transactions (i) such safeguards shall consist of or include the recommendations of the Payment Card Industry Data Security Standards, found at https://www.pcisecuritystandards.org and (ii) Business Associate shall not store security code (i.e., CVC) information or credit card information in any form. Also, if Business Associate regularly extends, renews, or continues credit to individuals, or regularly allows individuals to defer payment for services, including setting up payment plans in connection with one or more covered accounts, as the term is defined by the Federal Trade Commission's Red Flag Rules, Business Associate warrants that it shall comply with the Red Flag Rules and, specifically, have in place and implement a written identity theft prevention program designed to identify, detect, mitigate, and respond to suspicious activities that could indicate that identity theft has occurred in Business Associate's business practice.

(c) **Mitigation**. Business Associate shall promptly mitigate, at Business Associate's expense and to the extent practicable, any harmful effect of a Use or Disclosure of PHI by Business Associate in violation of this Exhibit. Such mitigation shall be done with the advice and close cooperation of Covered Entity.

(d) Notify Covered Entity. Business Associate shall promptly notify Covered Entity by telephone **and** by email of any Security Incident, Breach, or California Breach in writing in the most expedient time possible, and not to exceed five (5) calendar days in the event of a Security Incident, Breach or California Breach, following Business Associate's initial awareness of such Security Incident, Breach, or California Breach. Notwithstanding any notice provisions in the Agreement, such notice shall be made to CommonSpirit Health's Chief Privacy Officer, at both the phone number and email below. Without limitation, Security Incidents shall include ransomware attacks and Business Associate's knowledge of other types of infectious malware on Business Associate's computer systems. However, this Section constitutes advance and ongoing notice of Unsuccessful Security Incidents, for which no further notice is necessary. Business Associate shall cooperate in good faith with Covered Entity in the investigation of any Breach, California Breach, or Security Incident.

Any notice required under this BAA to be given to a party shall be made to:

If to Covered Entity:	If to Business Associate:
Dignity Health Attn: Privacy Officer Telephone No.: 760-608-3504 Email: PrivacyOffice@commonspirit.org	Mortuary Support Services of Northern California Attn: President/CEO Telephone No.: 925-354-3011 Email: Michael@mssnorcal.com

(e) Risk Assessment and Breach Notification. Following receipt of notification from Business Associate of a Breach or California Breach, Covered Entity shall ensure a Breach risk assessment is conducted to determine whether PHI has been compromised and notification to affected Individuals is required. Business Associate shall cooperate with Covered Entity in the investigation of the event, the conduct of a Breach risk assessment, and notification of Individuals as required by HIPAA. Covered Entity may delegate any or all aspects of the investigation, Breach risk assessment, and notification of Individuals to Business Associate. If Business Associate will provide any required notification(s), Business Associate shall provide such notification timely and provide Covered Entity with documentation of Business Associate's actions, including documentation of the names and addresses of those to whom the notifications were provided.

(f) Cloud Services. Business Associate may use a subcontractor for data hosting, where such subcontractor receives, has access to, creates, maintains, or transmits PHI (a "**Cloud Service Provider**"), only on the following conditions: (i) Use of the Cloud Service Provider is subject to prior approval by Covered Entity, which approval will require a cybersecurity risk assessment, in which Business Associate will co-operate in gathering information and documentation, and (ii) Use of a Cloud Service Provider is contingent on Business Associate committing contractually to be responsible for its own adherence to certain minimum security standards of Covered Entity and Business Associate's truthful representation that it has contractually obligated its Cloud Service Provider to adhere to the minimum security standards of Covered Entity.

(g) Access. If Business Associate holds PHI in Designated Record Sets as determined by Business Associate or Covered Entity, Business Associate shall provide prompt access to the PHI to Covered Entity whenever so requested by Covered Entity, or, if directed by Covered Entity, to an Individual in order to meet the requirements of HIPAA and State Law, as applicable. If requested, such access shall be in electronic format. If an Individual requests directly from Business Associate: (i) to inspect or copy his/her PHI, or (ii) Disclosure of PHI to a third party, Business Associate shall promptly notify Covered Entity's Chief Privacy Officer of such request in accordance with Section 3(d) above and await such officer's denial or approval of the request.

(h) Amendments. Business Associate shall promptly make amendment(s) to PHI requested by Covered Entity and shall do so in the time and manner requested by Covered Entity to enable it/them to comply with HIPAA and State Law, as applicable. If an Individual requests an amendment to his/her PHI directly by Business Associate, Business Associate shall promptly notify Covered Entity's Chief Privacy Officer of such request in accordance with Section 3(d) above and await such officer's denial or approval of the request.

(i) Internal Records. Business Associate shall promptly make its internal practices, books, and records relating to the Use, Disclosure, or security of PHI that Business Associate received from, maintained or created for or on behalf of Covered Entity, available to the Secretary, in a time and manner designated by the Secretary, to enable the Secretary to determine compliance with HIPAA.

(j) Accountings. Business Associate shall document all Disclosures of PHI and information related to such Disclosures as required under HIPAA in order that it may provide an accounting of such Disclosures as

Covered Entity directs. Business Associate shall: (i) Provide an accounting as required under HIPAA to those Individuals who direct their requests to Business Associate; or (ii) Provide the accounting information required under HIPAA to Covered Entity, if so requested, in the time and manner specified by Covered Entity.

(k) Destruction. If, during the term of the Agreement, Business Associate wishes to destroy the PHI, it shall notify Covered Entity in writing about its intent to destroy data at least ten (10) business days before such date of destruction and shall comply with the requirements for destruction of PHI found in Section 5(a) of this Exhibit. If Covered Entity requests the return of any PHI, Business Associate shall comply as requested.

(l) HIPAA Compliance. Business Associate shall comply with 45 Code of Federal Regulations Part 164, Subpart C with respect to ePHI. Business Associate shall maintain policies and procedures, conduct ongoing risk assessment and risk management of its security program, identify a security official, and train and discipline its work force in compliance with the relevant portions of the Privacy and Security Regulations. Covered Entity shall have the right to request written copies of Business Associate's policies, procedures, programs, and training materials no more often than once per calendar year and Business Associate shall provide all such requested information within fifteen (15) business days of any request by Covered Entity. Business Associate shall maintain all documentation required under HIPAA for a period of six (6) years.

(m) Business Associates. Business Associate shall ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits PHI on behalf of Business Associate, agrees in a written contract with Business Associate to the same restrictions and conditions that apply to Business Associate with respect to such information. In performing services under this Exhibit, Business Associate shall use agents, employees or subcontractors that are domiciled only within the United States of America and its territories. Notwithstanding anything to the contrary in the Agreement or this Exhibit, Business Associate shall not use any agent or subcontractor to perform any service requiring access to PHI under this Exhibit without the express written consent of an authorized representative of Covered Entity.

(n) Sale of PHI. Except as otherwise permitted by HIPAA, Business Associate shall not directly or indirectly sell or receive remuneration in exchange for any of Covered Entity's PHI unless Covered Entity or Business Associate, with Covered Entity's express written consent, obtains a valid, signed authorization from the Individual whose PHI is at issue that specifically allows that Individual's PHI to be further exchanged for remuneration by the entity receiving the PHI.

4. Effect of Breach of Obligations. If Business Associate breaches any of its obligations, Covered Entity shall have the option to do the following:

(a) Cure. Provide Business Associate an opportunity to cure the breach, to the extent curable, and end the violation within a reasonable time specified by Covered Entity. If Business Associate does not cure the breach or end the violation as and within the time specified by Covered Entity, or if the breach is not curable, Covered Entity may terminate its obligations to Business Associate, including, but not limited to, its future payment obligations, if any, and obligations to provide information, materials, equipment or resources to Business Associate; or

(b) Termination. Immediately terminate the Agreement and any other agreements between Business Associate and Covered Entity involving PHI, if Covered Entity reasonably determines that Business Associate: (i) has acted with gross negligence in performing its obligations; (ii) is itself or causes Covered Entity to be in violation of the law; (iii) willfully has violated or is violating the privacy and security provisions of this Exhibit or HIPAA; or (iv) is unable to provide, if requested, written assurances to Covered Entity of its ability to protect the confidentiality and security of the PHI.

5. Effect of Termination

(a) Disposition of PHI. Upon termination of this Exhibit and subject to Section 5(b) below, Business Associate shall promptly return to Covered Entity a copy of all PHI, including derivatives thereof, and shall take all reasonable steps to promptly destroy all other PHI held by Business Associate by: (i) shredding; (ii) securely erasing, or (iii) otherwise modifying the information in those records to make it unreadable or undecipherable through any means. This provision shall apply to all PHI in the possession of Business Associate and agents of Business Associate. At Covered Entity's request, Business Associate shall certify in writing that it has complied with the requirements of this Section.

(b) Infeasible; Survival. If Business Associate believes the return or destruction of PHI is infeasible, Business Associate shall promptly notify Covered Entity of the conditions that make such return or destruction

infeasible. Upon mutual determination by the parties that return or destruction of PHI is infeasible, the obligations of Business Associate under this Exhibit shall survive the termination of this Exhibit. Business Associate shall limit the further Use or Disclosure of all PHI to the purposes that make its return or destruction infeasible. If Business Associate subsequently wishes to destroy PHI, Business Associate shall notify Covered Entity in writing about its intent to destroy data at least ten (10) business days before such date of destruction and shall comply with Section 5(a) above. If Covered Entity requests the return of any PHI, Business Associate shall comply as requested.

6. **Credit Monitoring.** In the event that either Covered Entity or Business Associate is required by law to notify Individuals whose PHI was inappropriately accessed, Used, or Disclosed by Business Associate, its employees, subcontractors, or its agents, and the PHI contains: (i) the Individual's first initial or first name, last name, and social security number; (ii) the Individual's first initial or first name, last name, and driver's license or state identification card; (iii) the Individual's first initial or first name, last name, account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an Individual's financial account; or (iv) the Individual's first initial or first name, last name, and PHI, then Business Associate and Covered Entity shall work together to structure a credit monitoring offering commensurate to the risk posed by the Breach and Business Associate shall pay the costs of credit monitoring for one year or a longer time period if required by law for such individuals and the costs and fees related to timely notification in accordance with law.

7. **Amendment**. The parties agree to promptly modify or amend this Exhibit to permit the parties to comply with any new laws, rules or regulations that may subsequently be enacted or issued.

8. **General**. The Agreement (and attachments thereto) and this Exhibit are intended to be construed in harmony with each other, but in the event that any provision in this Exhibit conflicts with the provisions of the Agreement, or its other attachments, the provisions in this Exhibit shall be deemed to control and such conflicting provision or part thereof shall be deemed removed and replaced with the governing provision herein to the extent necessary to reconcile the conflict. This Exhibit supersedes and replaces all previous oral or written business associate agreements or exhibits between Business Associate and Covered Entity pertaining to protection of PHI.

9. **No Third-Party** Beneficiaries. There are no third-party beneficiaries of this Exhibit.

10. **Independent Contractor**. Business Associate and Covered Entity expressly acknowledge and agree that Business Associate is an independent contractor and shall not for any purpose be deemed to be an agent, employee, servant, partner, or joint venturer of Covered Entity.

11. **Indemnity.** Business Associate shall promptly and fully defend, indemnify and hold harmless Covered Entity, its subsidiaries, affiliates and respective officers, directors, agents and employees (**"Indemnified Parties"**) against any claim, demand, liability, loss, fine, penalty, assessment, cost, judgment, award or attorney's fees (including the reasonable costs of Covered Entity's in-house counsel), related to (i) the breach of this Exhibit by Business Associate, (ii) the negligent acts or omissions of Business Associate or any employee, subcontractor, or agent of Business Associate, (iii) any related Breach, California Breach, Security Incident or any cost of notification or remediation relating to notifications required by law, and (iii) any action to enforce this Section (collectively, **"Claims"**). The Claims covered by this Section shall include Claims made or recovered against the Indemnified Parties and Claims issued in favor of a third party. This Section shall survive the expiration or termination of this Exhibit.

Part IV

INDEPENDENT CONTRACTOR AGREEMENT (NON-CLINICAL, BA)

INSURANCE REQUIREMENTS

Contractor shall obtain and continuously maintain during the term hereof and for not less than three years following the Expiration Date or earlier termination of this Agreement the following insurance coverages naming Contractor and Personnel as named insureds:

1) Commercial and general liability insurance with an annual limit of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. Affiliate shall be named as an additional insured.
2) Workers' compensation insurance, as required by Laws.
3) If workers' compensation insurance is required by Laws, then Contractor shall also obtain and maintain employer's liability insurance with an annual limit of not less than $1,000,000 per occurrence.
4) Business automobile liability insurance covering hired, owned, and non-owned vehicles used to provide Services under the Agreement, if applicable, with a limit of not less than $1,000,000 combined single limit per accident. Affiliate shall be named as an additional insured.
5) Errors and omissions insurance with an annual limit of not less than $1,000,000 per claim and $2,000,000 aggregate.

No required policy shall contain a deductible or retention in excess of $10,000.

For each required policy, Contractor shall provide Affiliate with (1) certificates of insurance prior to the Effective Date and as of each annual renewal during the term of this Agreement, and (2) endorsements evidencing Affiliate's status as an additional insured, as required above. In the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policy, Contractor shall give written notice thereof to Affiliate not more than ten (10) days following Contractor's receipt of such notification.

EXHIBIT 19

SUBJECT: **GSD Laboratories Morgue Policy and Procedure**

DEPARTMENTS: Pathology, Nursing, Security

SITES: MET, MGH, MHF, MSJ, and WMH

DATE APPROVED: 3/1/2022

APPROVERS: Oswal MD, Hemlata; Rodriguez MD, Rafael; Wang MD, Kim; Wilton MD, Maaya; Wong MD, Anna

PURPOSE: To outline the pathology responsibilities for post mortem procedures.

PROCEDURE OBJECTIVES:
This procedure defines the pathology department handling of post mortem patients, autopsy as requested, death certificate, donor services and disposition of the body to a mortuary or other locations. Complete paperwork required and chain of custody of the body is further defined by this procedure.

EQUIPMENT: Gurney, patient lift, hover mat.

SAFETY PRECAUTIONS: Universal Safety Precautions.

PROCEDURE:
Nursing /ANS

1. Nursing is responsible for preparing the deceased patient, removing jewelry/valuables, placement of body in shroud, completing the required documentation, and requesting a morgue transport. Non-removable jewelry is to be documented by the nurse on form. Forms: Notification of Death (NOD) and Face sheet are completed by Nursing. Nursing will contact security to secure valuables. Nursing will follow the facility specific Post-Mortem Policy for detailed instructions. No personal items will be transported with the patient. If autopsy is requested obtain 2 witness signatures and submit Autopsy release form to pathology.

2. Families wishing to view the deceased will be offered the opportunity before the deceased is transported to the morgue.

3. Deceased may be picked up directly from hospital room by a licensed funeral director, or licensed Transportation Company. In so doing, the local facility post-mortem policy and procedure will be followed.

4. During regular business hours, 0700 to 1500, Monday through Friday, Pathology staff will operate the morgue. After hours (Mon-Fri 1500 to 0700 and Fri 1500 until Monday 0700), the Administrative Nursing Supervisor (ANS) or Delegate assigned by local facility will supervise and operate the morgue.

    4.1. Administrative Nursing Supervisor working night shift is responsible for night shift decedent pickups by calling Morgue Transport services (888-974-3923).

5. When the deceased is ready for Morgue Transport, Nursing will enter a Morgue Transport request into Teletracking and notify pathology or follow the transport procedure the local facility has defined.

THIS DOES NOT SUPERCEDE FACILITY POST-MORTEM CARE POLICIES
Patient Transportation/ANS

1. After receiving transportation request via dispatch from Teletracking, Patient Transportation staff or assigned delegate will go to pathology or ANS to obtain morgue keys, check for available morgue space, and obtain printed NOD/Face sheet copies from ANS or facility assigned delegate if after hours.

2. Local facility designated transporters will bring covered morgue stretcher to the nursing unit. Staff will wear gown and gloves during the transfer process. Designated transportation staff and nurse will jointly check to ensure that all jewelry is removed, check 2 patient identifiers (name and date of birth), and review the Notification of Death form and Facesheet for completion with special attention to the following:

    2.1. Morgue Release of Remains from Unit/Floor:

    2.2. Name of patient
    2.3. Date and time of death
    2.4. Time in Morgue
    2.5. Patient's weight and if bariatric
    2.6. Notice of Death (NOD)
    2.7. Jewelry/Personal items removed
    2.8. Wrist ID/Toe Tag Verification paperwork on floor
    2.9. Autopsy requirement
    2.10. Coroner's case (if yes, has body been released by Coroner?)
    2.11. Donor information and checking if clear to release
    2.12. Copy of Face sheet
    2.13. Name of mortuary, if known

3. At least two members of hospital staff will transport the deceased to the morgue when possible. Facility designated patient transportation will routinely dispatch 2 staff for Morgue transports except during nights if only one patient transporter is present. In that case, patient transporter will notify nursing unit and request that Nursing staff assist with the transport. Staff will use patient safe handling equipment (hover mat) and supplies as necessary to safely move the deceased from location to location. (Refer to Nursing department Policy and Procedures for safe moving and transport.)

4. Designated patient transportation staff will transport deceased patient to the morgue and place in available locker (if applicable). If after hours, Patient Transportation staff will attach NOD and Face sheet to deceased body, outside of locker, and place copies in the pathology lab to be forwarded to the regional morgue coordinator. During regular business hours, pathology staff will make those copies and attach to deceased body, outside of locker, and forward to the regional morgue office.

Fetal and Infant Remains

1. If the deceased is an infant, staff will transfer the infant to the morgue. The staff will contact pathology or ANS to obtain access to the morgue. The Staff will then deliver all documents to the pathology lab staff or the ANS. Staff delivering body to the Morgue will complete the Morgue log book.

Pathology

Decedent Affairs

Abandoned Body – Sacramento County Resident

1. Next of kin has not responded to either telephone contacts or phone number is disconnected.

2. After 3 phone attempts or disconnected number with no call back, the case will be referred to the coroner's office and a death certificate is started.

3. Fax letter to coroner with information and documentation of the dates of attempted contact. Communicate that death certificate is filed and attach death/discharge summary and fax to coroner to request them to pick up body.

Abandoned Body – Out of Sacramento County Resident

1. Contact specific County Coroner for procedures after unsuccessful attempts to reach the next of kin

Patient with No Next of Kin/legal decision maker for disposition – Sacramento County

1. Assure diligent search is done for next of kin – check social work notes/ social work available to assist with getting info via Lexis Nexis access.

2. Complete death certificate process with Evergreen Memorial.

3. Once death certificate filed, contact Public Administrator for referral and complete their intake form.

4. Fax form, face sheet, death/discharge summary to Public Administrator.

5. Public administrator will notify by fax/phone when deputy is assigned.

6. Public administrator will continue diligent search – if found will ask hospital to contact for arrangements – if not found, Public administrator will contact Coroner to pick up body.

Patient with No Next of Kin/legal decision maker for disposition – Out of Sacramento County Resident

1. Contact specific county coroner or public administrator office for instructions. Some counties do have their own form. Other counties have agreements with a specific funeral home and will coordinate with them to pick up body.

Other Issues – Miscellaneous

1. If patients whose family/next of kin live out of area/state, refer them to local funeral home in their area and the funeral home should work with them on transportation.

2. If the family is out of area but in California and has financial constraints, refer to Coroner for indigent cremation resources. Coroner will send them the form to complete.

3. Patients who have legal next of kin/power of attorney for death arrangements, but no funds and verify patient has no assets will be referred to the Coroner for Indigent Cremation. Always inform family that indigent cremation does not give them the remains – the cremations are done collectively.

4. If family is out of state or they are adoptive parents as children or divorced, the indigent cremation is not available – adoptive parents of child does not apply to adult unless there is a written power of attorney.

Death Certificate Filing

1. Contact GSD Morgue Coordinator at the Regional Morgue Office to file electronically with Sacramento County. The Physician will be contacted for cause of death completion and signature.

2. There may be a request for assistance if there is a serious delay of completion by the Physician or the office is not cooperative. If this is the case remind the Physician and/or office the law requirements for completion of death certificates as well as the effect on family dissatisfaction and distress.

3. Submit an Event Report for those situations that are not resolved promptly so that there can be medical staff peer review.

<u>Other Pathology Responsibilities</u>

1. Pathology regional morgue coordinator is responsible for the following:
    - 1.1. Daily monitoring of deceased in the morgue.
    - 1.2. Calling mortuary when patient is ready for release.
    - 1.3. Arrange for release of bodies to funeral homes.
    - 1.4. Notifying ANS or Director of Social Services.

1.5. Notify the attending practitioner and/or their medical staff of scheduled autopsy and document contact in the patient electronic medical record as a “Called Report”.

2. Pathology staff will make three (3) copies of the Notification of Death (NOD) form and Face sheet. Once the Morgue log is completed, the originals are to be stapled to the backside of the Morgue log. One copy of the Notification of Death and the Face sheet are to be stapled to the outside of shroud. The next set of copies is to be secured to the locker door where the deceased is stored (if applicable). The last sets of copies are given to pathology to be forwarded to the regional morgue office. If jewelry or other items could not be removed by nursing staff and is still with the deceased, this must be documented.

3. Pathology will facilitate the release of the deceased to the appropriate destination. Pathology shall document the status of morgue activities, which includes delivery of deceased to the morgue, or release directly to a Mortuary at the regional morgue office. During regular business hours, pathology will review NOD forms and if a mortuary/funeral home is identified, pathology will contact the establishment and make arrangement for pickup.

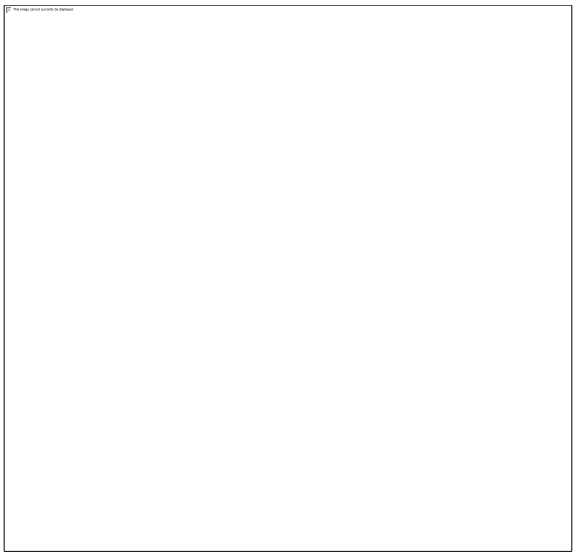
4. Pathology will also make arrangements with offsite storage to facilitate open morgue lockers during nights and weekends as needed. Minimum of one open morgue locker on nights and two open morgue lockers to begin weekends. ANS can contact offsite storage as needed to free up additional morgue lockers after hours.
   4.1. For storage and transport call morgue transport services at 888-974-3923**.**

5. Pathology may contact the Social Services Department for follow-up with coroner cases, unresolved situations, family concerns, no family, or no financial means for burial.
   Contact the Regional Director of Clinical Social Work at 916-453-4603.

6. Prior to releasing the body to a funeral home, a completed Authorized Release and original Release of Remains form must be presented. Both forms are placed in the Morgue log for retention. Coroners will document in Morgue Log before removing deceased.

7. During Pathology business hours (Mon-Fri 700-1500), Pathology lab staff will assist with the release of the body to the authorized entity. After hours and weekends, the release of the body to the authorized entity is completed by the ANS and/or Nursing Shift Manager.

   Pathology staff and licensed funeral director or licensed transportation company verifies correct patient, i.e., check patient’s wristband / toe tag), the paper attached to the shroud must match wristband. All forms related to tissue donation and Autopsy or Coroner’s case must be finalized and signature completed. When questioning release approval on status of Sierra Donor services, refer to ‘clear for release’ form (see image below) attached to the paperwork located inside the Morgue book as that will indicate the most recent updated status.



If forms are not completed, the deceased cannot be released. The pathology regional morgue coordinator will contact the appropriate agency, and inquire how to complete the documentation, and ready the decease for release to the funeral home. When speaking with the Coroner's office, always ask for last name and badge number, and document this information.

8. Pathology/lab staff will complete the Greater Sacramento Division (GSD) Disclosure of Protected Health Information (PHI) form any time patient information is released by telephone, or copies of the NOD or Face sheet are given out. Completed form is forwarded to the regional morgue office. Face sheet will be sent to the Pastoral Care department.

9. In the event the morgue cannot accommodate the number of deceased, the outside storage facility, will be contacted by the regional morgue office and a request will be made to transport the deceased to their off-site storage facility. Document on the NOD form, the date of transfer, and the name of the storage facility. In the Morgue Log, document: the date, time and signature of the representative from the storage facility. Do not write the name of the storage facility in the area reserved for the mortuary.

10. In the event of power failures, lack of locker space, or refrigeration failures, pathology will utilize an outside storage facility to hold deceased patients until adequate space is available. Any unresolved problems regarding morgue procedures should be referred to the Regional Pathology Manager/designee or to the ANS or ANS Director.

Donor Services

1. Any autopsy room usage for donor harvesting is arranged through regional pathology morgue staff by Donor Services. Any Surgical rooms arranged for donor services will be coordinated with Main Operating Room.

2. The hospital operator will direct mortuary, and family telephone calls to the Pathology Regional Morgue Coordinator (916-515-4045).

Security

1. Access to the Morgue shall only be provided by the Pathology Department or the ANS at each facility.

CONTACT NUMBERS:

Morgue Transport Services
- (888) 974-3923

Sacramento County Public Administrator
- (916) 875-4491
- Fax (916) 875-3187

Sacramento County Coroner- Abandoned Body and Indigent Cremation
- (916) 874-9320 Option “0”
- Fax (916) 874-9257

Regional Pathology Support Supervisor
- (916) 515-4010

Regional Morgue Coordinator
- (916) 515-4045

Regional Director of Clinical Social Work
- (916) 453-4603

Yolo County Clerk-Recorder
- (530) 666-8100

Nevada County Coroner
- (530) 265-1321

Pathology Labs:
- MGH (916)453-4900
- MSJ (916) 537-5275
- MET (916) 423-6191
- WMH (530) 669-5630
- MHF (916) 983-7473

ANS:
MGH (916) 453-4433
MSJ (916) 537-3195
MET (916) 681-1819
WMH (530) 662-3961 ext 4442
MHF (916) 983-7288

ASSOCIATED DOCUMENTS:

Mercy General Hospital: Post Mortem Care
Mercy San Juan Medical Center: Post-Mortem Care
Methodist Hospital of Sacramento: Post Mortem Care Protocol
Woodland Memorial Hospital: Death Pronouncement/Postmortem Care/Removal of Patient's Bodies
Mercy Hospital of Folsom: Post Mortem Care

Notification of Death-Generated by Cerner
Face sheet example-Generated by Cerner
Autopsy Release Form-PS-G-MHS-635
Disclosure of PHI Form-PS-X-MGH-210

EXHIBIT 20

From: "John A. Mason" <john@gurneelaw.com>
Date: April 2, 2025 at 1:29:28 PM PDT
To: "Greenberg, Marc R." <Marc.Greenberg@tuckerellis.com>
Cc: "Candace H. Shirley" <CShirley@gurneelaw.com>, Martha Squibbs <martha@gurneelaw.com>
Subject: RE: Cremations Only

Marc:

I will try to answer your questions as best I can given the information I have at present.

Laura Lukin is correct that the bodies in question were in the custody and control of the hospital and were being held at SMT's facility because the hospital's own morgue has limited capacity. This was per a contract between the hospital and SMT. SMT does not need a license to provide transportation and refrigerated storage services. However, SMT leases its storage facility from Cremations Only, which is a licensed funeral establishment.

Cremations Only should not have been identified as the location of temporary envaultment. That was an error and it should have said Sacramento Mortuary Transport. After the hospital asked SMT to help it out by filing some DC's and permits after the hospital lost its own EDRS filing privileges, SMT subbed those requests out to Cremations Only because SMT does not have EDRS filing privileges and, as a storage facility, is not able to file DCs and permits in any event. The person from Cremations Only who prepared and filed the permit and DC for Jessie Peterson was James Lofton, whose signature is in Box 9A. It is standard in the industry for the filer to sign that box, even though it's a rare case

indeed when a mortuary is actually the one who has he legal right to control disposition under Health & Safety Code section 7100. I don't know why the form is like that. I also don' know why the form includes a certification that the manner of disposition is one of those permitted under H&S Code section 103055 when temporary envaultment is not listed in that statute. Yet, H&S section 103050 states that a permit must be filed within 8 days even cases of temporary envaultment.

Regarding Phil Manning, who is the licensed funeral director of Cremations Only, being identified as the "Informant" in box 7A, that was another error. The informant should have been listed as Laura Luken or someone else at Mercy since it had custody and control of the remains why they were in temporary envaultment at SMT as well as possession of the vital statistics information necessary to file a DC and permit. Mercy should have filed the permit for temporary envaultment as required under section 103050 within 8 days of death, but for some reason it failed to do so with respect to Ms. Peterson. It was only months later, after Mercy informed SMT that it had not done so for Ms. Peterson and some other decedents it was holding at SMT, that SMT first became aware of this and agreed to have Cremations Only file the permits and DCs for the hospital.

John

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From: Greenberg, Marc R. <Marc.Greenberg@tuckerellis.com>
Sent: Tuesday, April 1, 2025 4:15 PM
To: John A. Mason <john@gurneelaw.com>
Subject: RE: Cremations Only

I have a structural question:

The contract was between Dignity Health and SMT.

The contract states that the bodies will be stored at "Contractor's licensed storage facility." The only licensed storage facility is Cremations Only, which is presumably why Cremations Only and not SMT is listed on all of the death certificates as the location of the temporary Envaultment. The Declaration of Laura Lukin in various court filings states that the bodies are in the custody and control of the hospital and held in storage at SMT's facility. But SMT is not licensed to hold bodies and is not listed on the death certificate for Ms. Peterson as the place of temporary Envaultment. Similarly, the Permit prepared by your client is for a transfer on April 5, 2024, Jessie was transferred to Cremations Only on April 9, 2023. The Affirmation on the Permit is signed by Phil Manning and states that he has the right to control disposition pursuant to Health and Safety Code Section 7100.

It seems to me that a Permit was needed in April 2023, but never obtained.

A death certificate for Jessie Peterson should have been prepare in April 2023, but wasn't done until your client drafted it in April 2024.

Mr. Manning claims to control the disposition and Laura Lukin claims to controls the disposition.

Happy to discuss but this seems out of order.

Marc

Marc R. Greenberg | Partner | Tucker Ellis LLP

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CLEVELAND, COLUMBUS, CHICAGO, ST. LOUIS, LOS ANGELES, ORANGE COUNTY, SAN FRANCISCO, ATLANTA, NEW JERSEY, WASHINGTON D.C.

From: John A. Mason <john@gurneelaw.com>
Sent: Tuesday, April 1, 2025 3:57 PM
To: Greenberg, Marc R. <Marc.Greenberg@tuckerellis.com>
Subject: RE: Cremations Only

<<< EXTERNAL EMAIL >>>

Apparently at one point they were sent by fax and at other times emails. Hopefully the transmittals are all still available but I can't say that for sure at this point.

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From: Greenberg, Marc R. <Marc.Greenberg@tuckerellis.com>
Sent: Tuesday, April 1, 2025 3:50 PM

To: John A. Mason <john@gurneelaw.com>
Subject: RE: Cremations Only

I assume they have those emails if someday we request them?

Marc

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From: John A. Mason <john@gurneelaw.com>
Sent: Tuesday, April 1, 2025 3:45 PM
To: Greenberg, Marc R. <Marc.Greenberg@tuckerellis.com>
Subject: RE: Cremations Only

<<< EXTERNAL EMAIL >>>

Yes they were.

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From: Greenberg, Marc R. <Marc.Greenberg@tuckerellis.com>
Sent: Tuesday, April 1, 2025 2:14 PM
To: John A. Mason <john@gurneelaw.com>
Subject: Cremations Only

John,

Your client produced an email from May 2, 2023 transmitting the first inventory list for Woodland Memorial, Bruceville Terrace, Mercy Folsom, Mercy San Juan, Mercy General and Methodists. (SNC 000039.) Additionally, your client produced hundreds of other inventory sheets. Were the inventory sheets regularly sent to someone at Dignity?

Thank you,

Marc

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