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COMMON PLEAS COURT
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IN THE COURT OF COMMON PLEAS
LUCAS COUNTY, OHIO

ESTATE OF LUCY GARCIA, DECEASED
c/o Michael Hill Trial Law
815 Superior Avenue, Suite 623
Cleveland, Ohio 44114

Plaintiff,

vs.

ARBORS AT OREGON A.K.A. OREGON OPCO, LLC
904 Isaac Streets Drive
Oregon, OH 43616

Also serve c/o Registered Agent,
Corporation Service Company
1160 Dublin Rd., Ste. 400
Columbus OH 43215

and,

ARBORS AT OHIO
375 West Main St.
West Jefferson, OH 43162

and,

ARK OPCO GROUP, LLC
c/o Registered Agent,
Corporation Service Company
251 Little Falls Dr.
Wilmington DE 19808

and,

FCE ARBORS AT OREGON, LLC
c/o Registered Agent,
Corporation Service Company
1160 Dublin Road, Suite 400
Columbus OH 43215

and,

NOBLE HEALTHCARE MANAGEMENT,

CASE NO. CI2025-04257

JUDGE ERIC A. MARKS

AMENDED COMPLAINT

WITH JURY DEMAND

AFFIDAVIT OF MERIT ATTACHED HERETO

LLC)
c/o Registered Agent,)
Corporation Service Company)
1160 Dublin Road, Suite 400)
Columbus OH 43215)
)
and,)
)
PRESTIGE ADMINISTRATIVE SERVICES,)
LLC)
c/o Registered Agent,)
Corporation Service Company)
421 West Main Street, Suite 219)
Frankfort, KY 40601)
)
and,)
)
PRESTIGE HEALTHCARE, A.K.A.)
NORTHPOINT SENIOR SERVICES, LLC)
c/o Registered Agent,)
Corporation Service Company)
421 West Main Street, Suite 219)
Frankfort, KY 40601)
)
and,)
)
OREGON 904 PROPERTY HOLDINGS LLC)
c/o Registered Agent,)
Corporation Service Company)
1160 Dublin Road, Suite 400)
Columbus OH 43215)
)
and,)
)
ROBERT DAIBER, M.D.)
118 E Indiana Ave.)
Maumee, Ohio 43537)
)
and,)
)
JOSEPH PEYTON, D.O.)
118 E Indiana Ave.)
Maumee, Ohio 43537)
)
and,)
)
JOCELYN PARDEAU, NP)

111 Clinton St)
Maumee, OH 43537-2811)
and,)
)
PEYTON CARE PROFESSIONALS, LLC)
c/o Registered Agent,)
Charles J. Mira, J.D., CPA)
4841 Monroe Street, Suite 350)
Toledo OH 43623)
)
Defendants.)
)

Plaintiff, the Estate of Lucy Garcia, Deceased, for this Amended Complaint against the above-named Defendant(s), states and avers upon information and belief:

INTRODUCTION

1. This action involves the wrongful death of Lucy Garcia due to Arbors at Oregon A.K.A. Oregon OPCO, LLC ("Facility's") inadequate care of Lucy, and the corporate control of the facility leading to such inadequate care.

2. The facility, Arbors at Oregon A.K.A. Oregon OPCO, LLC ("Arbors at Oregon"), and their corporate owners, together with her medical providers, utterly neglected the care needs of 72-year-old Lucy Garcia, deprived Lucy of her basic human dignity, inflicted terrible misery and suffering upon her, and caused her horrific bodily injuries and death.

3. Lucy was admitted to Arbors at Oregon on January 25, 2023 for long term residential care following complications of a stroke. Lucy's stroke weakened the left side of her body and her left arm in particular. Upon admission, the facility was aware that Lucy needed the assistance of staff to get in and out of bed, to move herself around in bed, and with getting to the toilet, due to her left-sided weakness from the stroke.

4. Lucy maintained the majority of her mental faculties and was quite sharp, however did suffer from a degree of cognitive decline due to her stroke. On admission to Arbors at Oregon, she had a Brief Interview for Mental Status or "BIMs" score of 12 – reflecting moderate cognitive impairment. This increased her dependence on Arbors at Oregon's staff to assist her with her activities of daily living and protect her from potential harm.

5. When Lucy's family recognized she needed 24-hour nursing care in a safe environment, and they could no longer provide this for her, they approached Arbors at Oregon to provide for Lucy's numerous care needs. Arbors at Oregon's administration and admissions staff assured Lucy's family that Arbors at Oregon could meet her care needs, keep her safe, and assure her rights at a nursing home resident would be protected. Arbors at Oregon represented to Lucy's family that they had sufficient numbers of well-trained, qualified, and compassionate nursing staff to provide appropriate care to Lucy and all the other residents under their care.

6. However Arbors at Oregon's administration and admissions staff knew that resident needs were not being met at Arbors at Oregon, that residents were not being kept safe and in fact suffered from preventable injuries such as bedsores, infections, falls, and even death. Arbors at Oregon knew that the reason for these preventable injuries was due to having insufficient nursing staff to meet residents needs, nursing staff who were not adequately or appropriately trained to provide care to the residents, and nursing staff who were not compassionate to the needs and rights of the residents.

7. At the time the above representations were made to Lucy's family, Arbors at Oregon was aware that they had been investigated and cited for numerous health and safety violations, which was not disclosed to Lucy's family. Arbors at Oregon also had a

recent history of criminal neglect and abuse by nursing staff resulting in the homicide of a resident under their care, which was not disclosed to Lucy's family.

8. At the time the above representations were made to Lucy's family, Arbors at Oregon knew that Lucy's care needs also would not be met, she would not be treated with compassion, her rights as a nursing home resident would not be protected, and she would not be provided a safe living environment as a resident of Arbors at Oregon.

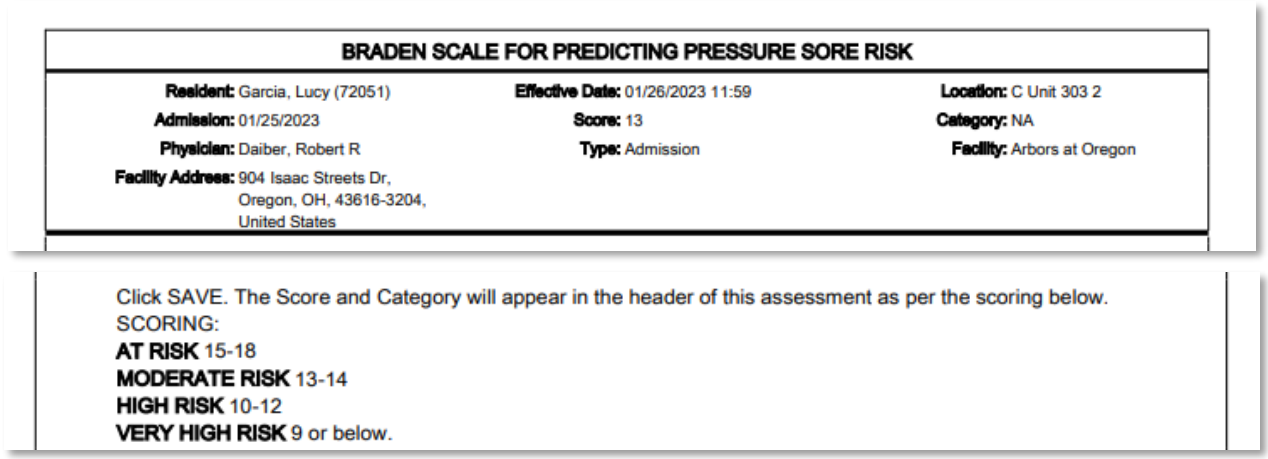
9. Lucy's family trusted that Arbors at Oregon's representations were truthful and believed Arbors at Oregon would take good care of Lucy, keep her safe, and provide for her care needs.

10. In spite of Lucy's limitations, she was not incontinent and could go to the toilet to relieve herself with the assistance of nursing staff. However Arbors at Oregon's staff began placing Lucy in adult diapers anyway. When Lucy or her friends and family told Arbors at Oregon's staff that she needed help getting to the bathroom to relieve herself, Arbors at Oregon's staff would tell Lucy she instead needed to soil herself in her adult diapers and wait for the staff to return and clean her up.

11. Arbors at Oregon's staff often left Lucy laying in soiled depends for extended periods of time, depriving her of her dignity and exposing her skin to her own bodily waste – which resulted in breakdown of the skin on her buttocks and coccyx.

12. Arbors at Oregon's nursing staff performed a Braden Scale assessment of Lucy to determine her risk for pressure sores, also known as bedsores, on January 26,

2023 – the day after her admission to the facility. On that day, Arbors at Oregon's nursing staff determined Lucy had a Braden score of 13 – a moderate risk for developing bedsores:



BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Resident: Garcia, Lucy (72051)	**Effective Date:** 01/26/2023 11:59	**Location:** C Unit 303 2
Admission: 01/25/2023	**Score:** 13	**Category:** NA
Physician: Daiber, Robert R	**Type:** Admission	**Facility:** Arbors at Oregon
Facility Address: 904 Isaac Streets Dr, Oregon, OH, 43616-3204, United States		

Click SAVE. The Score and Category will appear in the header of this assessment as per the scoring below.
SCORING:
AT RISK 15-18
MODERATE RISK 13-14
HIGH RISK 10-12
VERY HIGH RISK 9 or below.

Arbors at Oregon's assessment of Lucy's risk for developing bedsores on January 26, 2023

13. The best and most effective practice for preventing bedsores for a resident who is bedbound and needs the assistance of nursing staff to turn and reposition in bed is for staff to implement a turning schedule to rotate the patient in bed every two hours. This prevents at-risk areas of the patient's body from being exposed to pressure for lengthy periods of time which causes the death of skin and body tissues leading to bedsores.

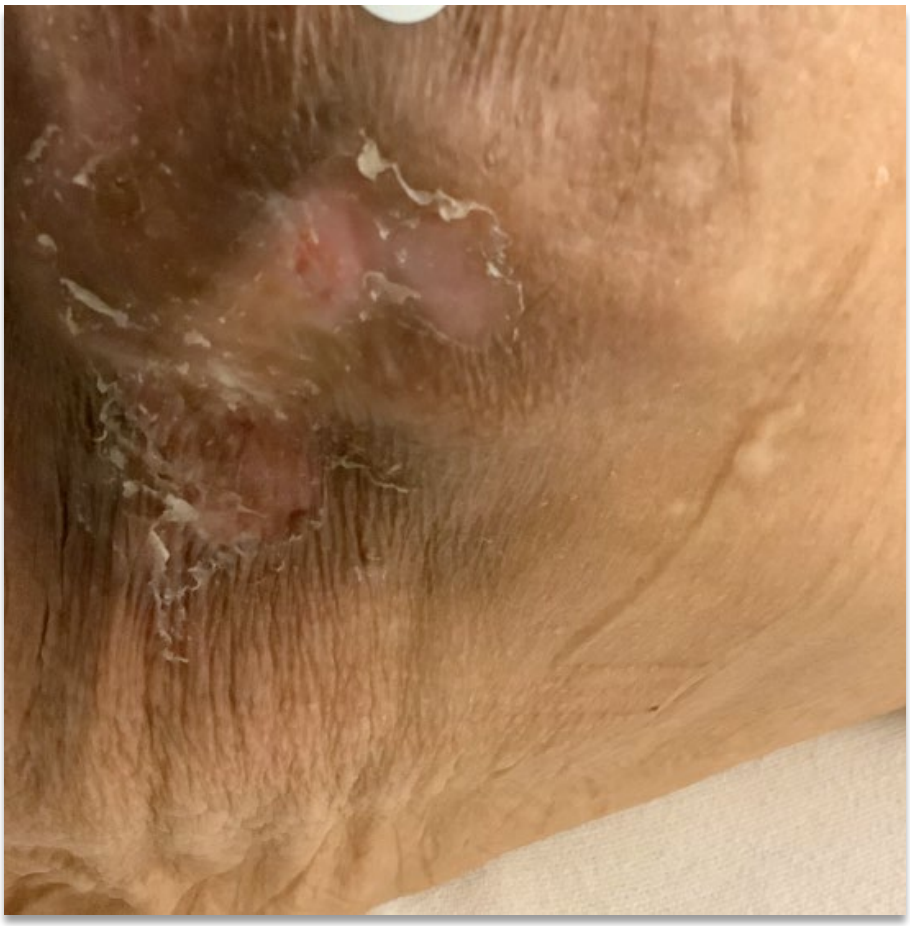
14. Arbors at Oregon's staff failed to implement and follow a turning schedule for Lucy, resulting in her being left laying in one position in bed for long periods of time and exposing the vulnerable areas of her body on her backside to excessive pressure.

15. Combined with Arbors at Oregon leaving Lucy in her soiled and wet adult diapers for lengthy periods of time, Arbors at Oregon's failing to turn and reposition Lucy regularly was a foreseeable setup for development of severe bedsores.

16. On March 5, 2024, Arbors at Oregon's staff noted that Lucy had a new sore on her coccyx which measured 1.5 cm long by 1 cm wide which was acquired "in-house." Arbors at Oregon's staff noted that this sore was an "abrasion" – not a bedsore.

17. When a resident develops a new bedsore while they are a resident of a skilled nursing facility, the facility must report the bedsore to the Centers for Medicare. Reporting a bedsore to Medicare negatively affects a facility's "Quality Measures" rating. Medicare makes this rating accessible to the public through its "Nursing Home Compare" tool online to help consumers select the best nursing home available.

18. On March 13, 2024, Arbors at Oregon documented that the "abrasion" was now 2.3 cm long by 2.7 cm wide and worsening. Arbors at Oregon's staff took a photograph of the wound:



19. The wound on Lucy's backside was not an "abrasion" but a bedsore, which was beginning to worsen.

20. Arbors at Oregon's nursing staff was trained and educated by the administration of the facility and the agents of the corporate entities controlling the facility to document bedsores as other types of wounds to avoid the facility having to report bedsores to Medicare and suffer a negative impact on their "Quality Measures" ratings. Arbors at Oregon's pattern and practice of failing to report bedsores to Medicare resulted in inflated "Quality Measures" ratings that deceived the public about the quality of care provided at the facility, and induced consumers to entrust their loved ones to Arbors at Oregon's care.

21. Arbors at Oregon also falsely portrayed to Lucy's family that the sore on her backside was an "abrasion," not a bedsore. Arbors at Oregon intended this misrepresentation to deceive and avoid scrutiny by Lucy's family of the care she received at Arbors at Oregon.

22. On March 25, 2024, Arbors at Oregon's nursing staff documented that the bedsore on Lucy's backside had "resolved," however the wound was still visible on her backside.

23. The next documentation of Lucy's wound appears May 30, 2024. Arbors at Oregon's nursing staff document that the wound began on May 29, 2024, however the wound has a large open hole into the layers of tissue beneath Lucy's skin and is visibly tunneling under the skin:

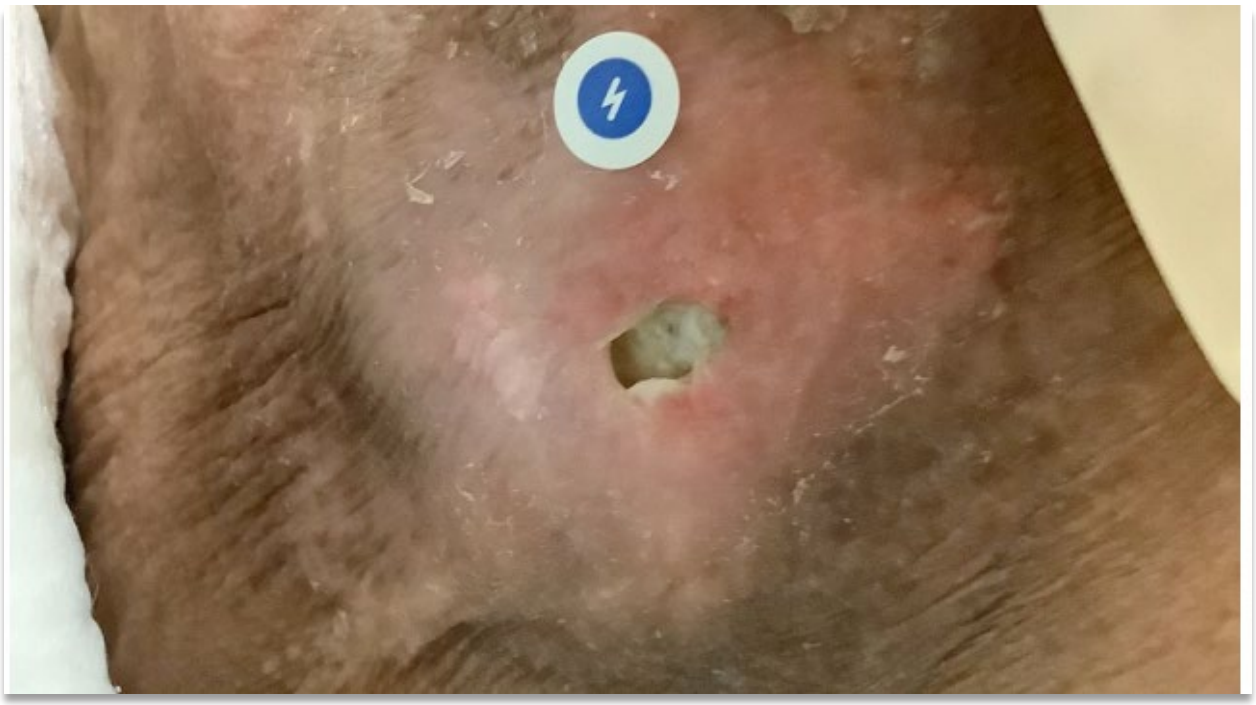


Image of Lucy's bedsore taken on May 30, 2024, at Arbors at Oregon showing an open wound with tunneling beneath her skin.

24. Arbors at Oregon's nursing staff still does not document that this wound is a bedsore, and instead leaves the documentation about the type of wound blank:

Skin & Wound Evaluation V7.0

Resident: Garcia, Lucy (72051)	**Effective Date:** 05/30/2024 07:08	**Location:** C Unit 303 2
Initial Admission: 10/21/2019	**Admission:** 01/25/2023	**Date of Birth:** 10/24/1951
Score: NA	**Category:** NA	**Physician:** Daiber, Robert R

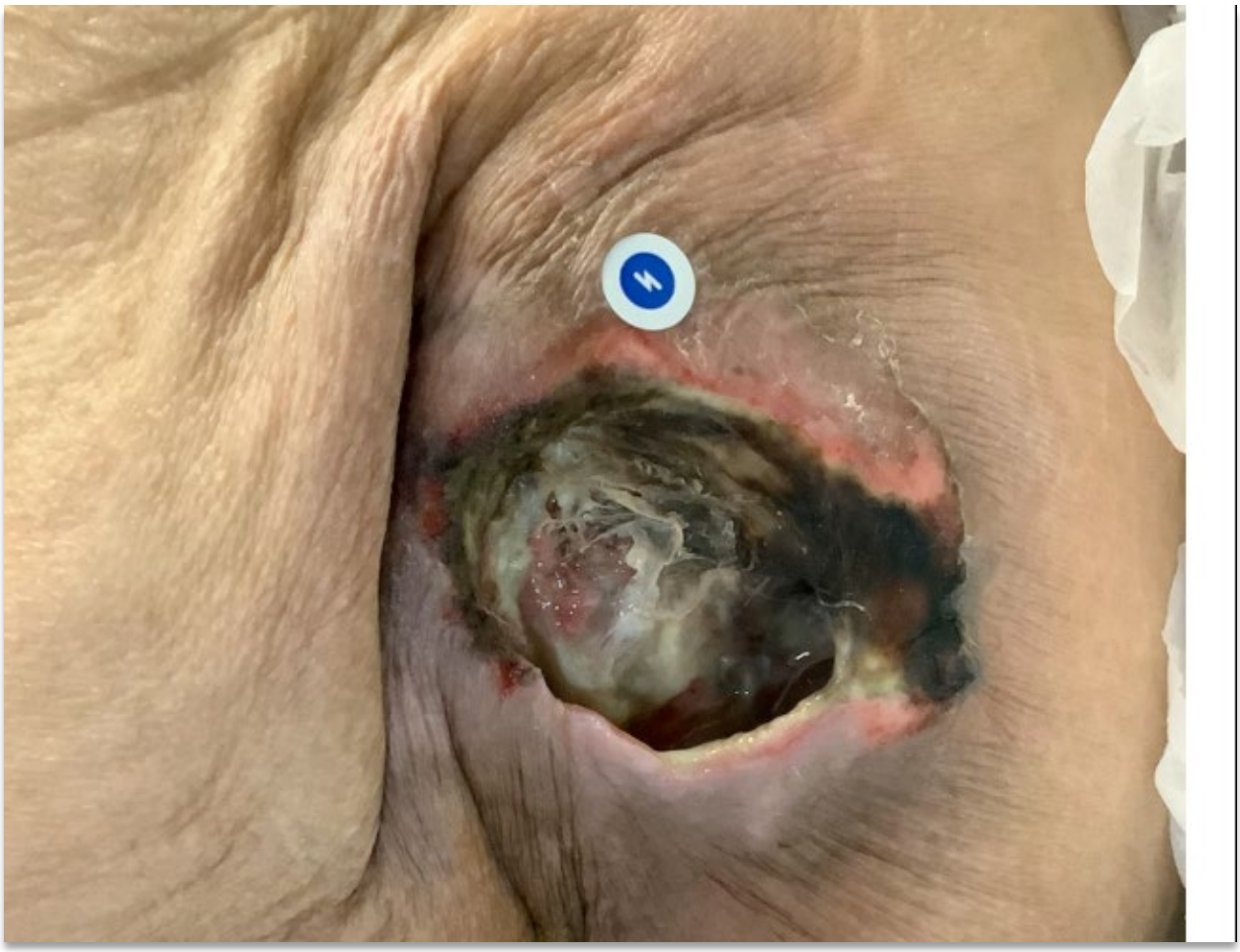
A. Describe

1. Type:

- ○ 1. Abrasion
- ○ 2. Abscess
- ○ 3. Arterial
- ○ 4. Blister
- ○ 5. Bruise
- ○ 6. Burn
- ○ 7. Cancer Lesion
- ○ 8. Diabetic
- ○ 9. Hematoma
- ○ 10. Hidradenitis Suppurativa
- ○ 11. Laceration
- ○ 12. Moisture Associated Skin Damage (MASD)
- ○ 13. Mole
- ○ 14. Open Lesion
- ○ 15. Pressure
- ○ 16. Pressure - Kennedy Terminal Ulcer
- ○ 17. Pressure - Medical Device Related Pressure Injury
- ○ 18. Rash
- ○ 19. Skin Tear
- ○ 20. Surgical
- ○ 21. Venous
- ○ 22. Other

25. Even though Arbors at Oregon's nursing staff document this is a "new" wound, Arbors at Oregon still does not tell Lucy's family that she has a bedsore on her backside.

26. Over the following weeks, Lucy's wound continued to grow wider and deeper as the tissue beneath her skin started to die off and expose muscle and bone in her backside. Arbors at Oregon's nursing staff do not document that this is a "pressure wound" until June 13, 2024, however Arbors at Oregon still does not tell Lucy's family about the bedsore:



Lucy's bedsore on June 13, 2024, at Arbors at Oregon, showing dead tissues and exposed muscle.

27. On June 19, 2024, Arbors at Oregon's nursing staff contacted Lucy's family and told them that Lucy was at the end of her life and needed to be put on hospice. Lucy's family came to the facility and found Lucy barely responsive.

28. Arbors at Oregon's unit manager took Lucy's sons into another area and insisted on making Lucy a hospice patient, however Lucy's sons asked how her condition deteriorated so rapidly when she was well enough to leave the facility and go to church just a few weeks prior on Memorial Day weekend. Arbors at Oregon would not explain how Lucy's condition deteriorated to this point. Arbors at Oregon still did not tell Lucy's family about her bedsore.

29. As Lucy's sons spoke with the unit manager, other family members in Lucy's room noticed a strong foul odor coming from Lucy. The family turned Lucy over in bed and saw a loose bandage on her backside which was peeling back, revealing her bedsore and causing pus to flow from the wound.

30. Lucy's family insisted that Lucy go to the hospital, however Arbors at Oregon was reluctant to call an ambulance and continued to insist that Lucy be made a hospice patient. Eventually Arbors at Oregon called an ambulance service to take Lucy to MercyHealth St. Charles Medical Center.

31. Upon arrival at St. Charles Medical Center, Lucy's care team removed the foam dressing over her backside and revealed she developed a Stage 4 bedsore at Arbors at Oregon – meaning all the tissue on her backside down to her bone had died off, including muscle. The open bedsore was exposed to Lucy's own feces and urine from Arbors at Oregon leaving her in soiled adult diapers, and the wound was infected with bacteria causing sepsis – a systemic infection of Lucy's body. The wound was so deep that

it exposed the bones in Lucy's back, which were also infected with bacteria causing osteomyelitis:

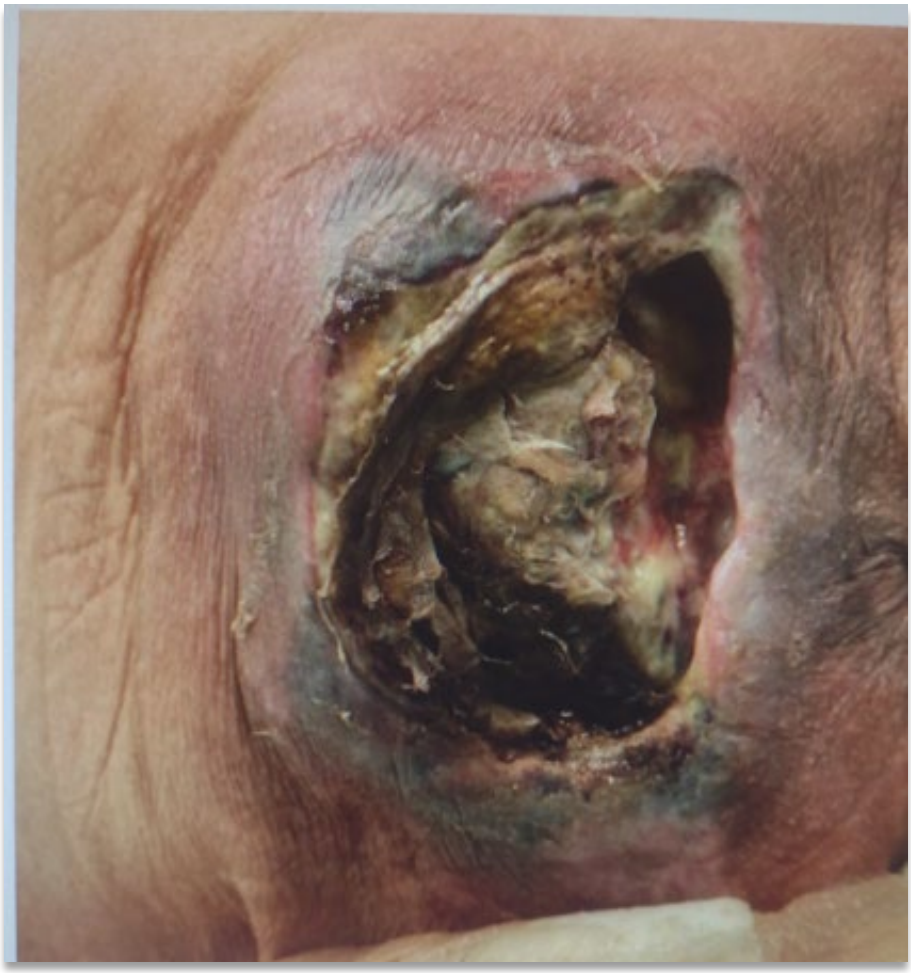


Image of Lucy's bedsore taken at St. Charles Medical Center on June 19, 2024, showing exposed bone and tunneling into Lucy's body

32. Lucy endured intensive treatment including IV antibiotics and surgical debridement of the Stage 4 bedsore, and underwent multiple painful bedside wound treatments including nurses packing dressing deep into the exposed cavities of her body in an attempt to heal the wound. However in spite of the best efforts of Lucy and her care team at St. Charles, she succumbed to the infection caused by the bedsore and passed away on July 2, 2024.

33. The Lucas County Coroner performed an autopsy on Lucy and reviewed her medical records from St. Charles Medical Center and Arbors at Oregon. The Coroner determined her cause of death was a homicide, with a primary cause of death listed as complications from the Stage 4 bedsore caused by medical neglect:

Cause of death and opinion:
Cause of death:COMPLICATIONS OF SACRAL PRESSURE ULCER (STAGE IV) (MONTH(S))
Due to: MEDICAL NEGLECT (MONTHS)
Significant conditions: Atherosclerotic, valvular, and hypertensive cardiovascular disease, left kidney pyelonephritis, cirrhotic liver, and diabetes
How injury occured: Caretaker neglect resulting in complications of a sacral pressure wound
Manner of death: Homicide
Opinion: It is my opinion that LUCY GARCIA died of COMPLICATIONS OF SACRAL PRESSURE ULCER (STAGE IV) due to MEDICAL NEGLECT. The following significant conditions were present: Atherosclerotic, valvular, and hypertensive cardiovascular disease, left kidney pyelonephritis, cirrhotic liver, and diabetes. Manner of death: Homicide - Caretaker neglect resulting in complications of a sacral pressure wound.

Ruling of the Lucas County Coroner detailing Lucy's cause of death, indicating caretaker neglect as the cause of Lucy's pressure wound.

34. Plaintiff requests a trial by jury.

35. The Affidavit of Merit of Dr. Kapil Gulati, MD is attached as **Exhibit 1.**

36. Plaintiff brings this action for compensation for the harms and losses sustained as the result of the negligence, recklessness, conscious disregard, reckless disregard, conduct by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct is likely to cause, at the time those services or that treatment or care were rendered, an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct, and other wrongful conduct described herein or discovered during litigation.

DEFENDANTS

37. Arbors at Oregon a.k.a. Oregon Opco, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

38. Ark Opco Group, LLC is a Delaware corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

39. Arbors at Ohio is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

40. FCE Arbors at Oregon, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

41. Noble Healthcare Management, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

42. Prestige Administrative Services, LLC is a Kentucky corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited

to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

43. Prestige Healthcare, a.k.a. Northpoint Senior Services, LLC is a Kentucky corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

44. Oregon 904 Property Holdings, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Arbors at Oregon.

45. Defendant, Robert Daiber, MD, is a physician licensed to practice medicine in the State of Ohio, who provided clinical oversight at Arbors at Oregon a.k.a. Oregon Opco, LLC and was responsible for providing treatment in accordance with the standard of care and who provided care to Lucy Garcia during the time frame that the allegations in the Complaint arose.

46. Defendant, Joseph Peyton, DO, is a physician licensed to practice medicine in the State of Ohio, who provided clinical oversight at Arbors at Oregon a.k.a. Oregon Opco, LLC and was responsible for providing treatment in accordance with the standard of care and who provided care to Lucy Garcia during the time frame that the allegations in the Complaint arose.

47. Defendant, Jocelyn Pardeau, NP, is a nurse practitioner licensed in advanced practice nursing in the State of Ohio, who provided clinical oversight at Arbors at Oregon a.k.a. Oregon Opco, LLC and was responsible for providing treatment in

accordance with the standard of care and who provided care to Lucy Garcia during the time frame that the allegations in the Complaint arose.

48. Defendant Peyton Care Professionals, LLC, is a provider of medical and advanced practice nursing services, at all times relevant was the employer of Robert Daiber, MD, Joseph Peyton, DO, and Jocelyn Pardeau, NP, was contracted to provide clinical oversight at Arbors at Oregon a.k.a. Oregon Opco, LLC and was responsible for providing treatment in accordance with the standard of care and who provided care to Lucy Garcia during the time frame that the allegations in the Complaint arose.

49. Defendants Arbors at Oregon a.k.a. Oregon Opco, LLC, Ark Opco Group, LLC, Arbors at Ohio, FCE Arbors at Oregon, LLC, Noble Healthcare Management, LLC, Prestige Administrative Services, LLC, Prestige Healthcare, a.k.a. Northpoint Senior Services, LLC, and Oregon 904 Property Holdings, LLC, ("Arbors Defendants") employ, manage, and direct the care and service providers who were responsible for Lucy Garcia's care, treatment, and safety at Arbors at Oregon while they were a resident there, and / or are responsible for creating unsafe conditions at the Facility through their control of the Facility management that directly led to Lucy Garcia's injuries and death on July 2, 2024.

50. The Arbors Defendants direct and control operations at the Facility and are therefore directly liable for mismanagement of the Facility without regard to piercing the corporate veil.

51. The Arbors Defendants' organization controls the other corporations in a way that is so complete that the corporations have no separate mind, will, or existence of their own, is exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity; and injury or unjust loss resulted to the

plaintiff from such control and wrong, meaning the Defendants should be held directly liable for such harms and losses.

52. Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Arbors at Oregon directly or through their domination and control of any putative entity license holder.

53. Arbors at Oregon ("Facility") hold themselves out to the public as providers of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees, commonly referred to as "nursing homes."

VICARIOUS LIABILITY

54. The Defendants employ the care providers who were responsible for ensuring Lucy Garcia's care and safety.

55. The Defendants manage, control, and/or employ the nursing staff at the Facility.

56. Lucy Garcia and their family looked to the Defendants for care based upon their representations.

57. The Defendants are vicariously liable for the negligent actions of their employees and agents (respondeat superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including visiting physicians and nurse practitioners contracted with any of the Defendants and / or provided to residents as default or house care providers.

JURISDICTION AND VENUE

58. This Court has Jurisdiction over Defendant(s) because, among other things, all Defendant(s) do, and all times relevant did, purposefully avail themselves of the laws of the State of Ohio, and/or committed tortious acts within the State of Ohio.

59. Venue is proper in Lucas County, Ohio under Civil Rule 3(B) because, among other reasons: (a) one or more Defendants reside, domicile, or carry on their principal place of business in that county; and (b) part of the claim for relief arose in that county.

COMMON FACTS

60. The Arbors Defendants hold themselves out to the public as providers of long-term nursing home, skilled nursing, and memory care services.

61. The Arbors Defendants' for-profit model means their primary goal is to maximize profit, measured by revenues minus expenses.

62. For nursing homes generally, the largest individual revenue source is residents (filling beds), and the largest individual expense is the cost of employing nursing staff to provide care to those residents. This creates a financial incentive to take on more residents with greater care needs than the nursing staff can properly care for, a violation of federal nursing home regulations regarding staffing levels.

63. The Arbors Defendants manage, control, and / or employ the nursing staff at Facility.

64. The Arbors Defendants exercise actual control over the Facilities' management and operations to maximize profits, including control over facility-level:

a. Policies and procedures, including regarding resident care;

b. Finances, including obtaining credit and loans, guaranteeing loans (both at the corporate and individual facility level), maintaining funds and banking, obtaining, owning, and leasing facility land and buildings, and capital expenditures.

c. Budgeting, including controlling the amount of funds available for staffing facilities;

d. Personnel management, including hiring and firing, or having authority to hire and fire, the supervisory and management personnel in each facility;

e. Supervision of management, care providers, and staff in each facility, including compliance with federal and state regulations;

f. Employment, such as setting pay scales, shifts, and time and vacation policies;

g. Systems for training, monitoring, and supervising staff;

h. Medical record systems and management;

i. Financial control systems, including budgeting and payment processing;

j. Marketing, including setting the image and expectations residents and their family should expect at the facility, and even the name of the facility;

k. Reporting procedures, including reporting to Medicare as to individual resident care and facility-wide issues.

65. As the result of this control, the Arbors Defendants make decisions that affect the day-to-day care of residents of the Facilities, such as the resources available for providing nursing staff and care to residents like Lucy Garcia, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

66. The Arbors Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that the facilities were sufficiently staffed to meet the individual needs of its residents, including Lucy Garcia

67. The Arbors Defendants engaged in a systemic practice to understaff the facilities to maximize profits at the expense of its residents' care.

68. This lack of sufficient staff directly resulted in Lucy Garcia not receiving basic and necessary services to prevent, among other things, neglect leading to their injuries and death.

69. The Arbors Defendants also exercise operational and managerial control, and apply this profits-over-safety model, at the following facilities in the State of Ohio:

a. Arbors At Carroll
3680 Dolson Court Nw, Carroll, OH 43112

b. Arbors At Delaware
2270 Warrensburg Road, Delaware, OH 43015

c. Arbors At Fairlawn
575 S Cleveland Massillon Road, Fairlawn, OH 44333

d. Arbors At Gallipolis
170 Pinecrest Drive, Gallipolis, OH 45631

e. Arbors At Marietta
400 Seventh Street, Marietta, OH 45750

f. Arbors At Mifflin
1600 Crider Rd, Mansfield, OH 44903

g. Arbors At Milford
5900 Meadowcreek Drive, Milford, OH 45150

h. Arbors At Minerva
400 Carolyn Court, Minerva, OH 44657

i. Arbors At Pomeroy
36759 Rocksprings Road, Pomeroy, OH 45769

j. Arbors At Springfield
1600 Saint Paris Pike, Springfield, OH 45504

k. Arbors At Stow
2910 L'ermitage Pl, Stow, OH 44224

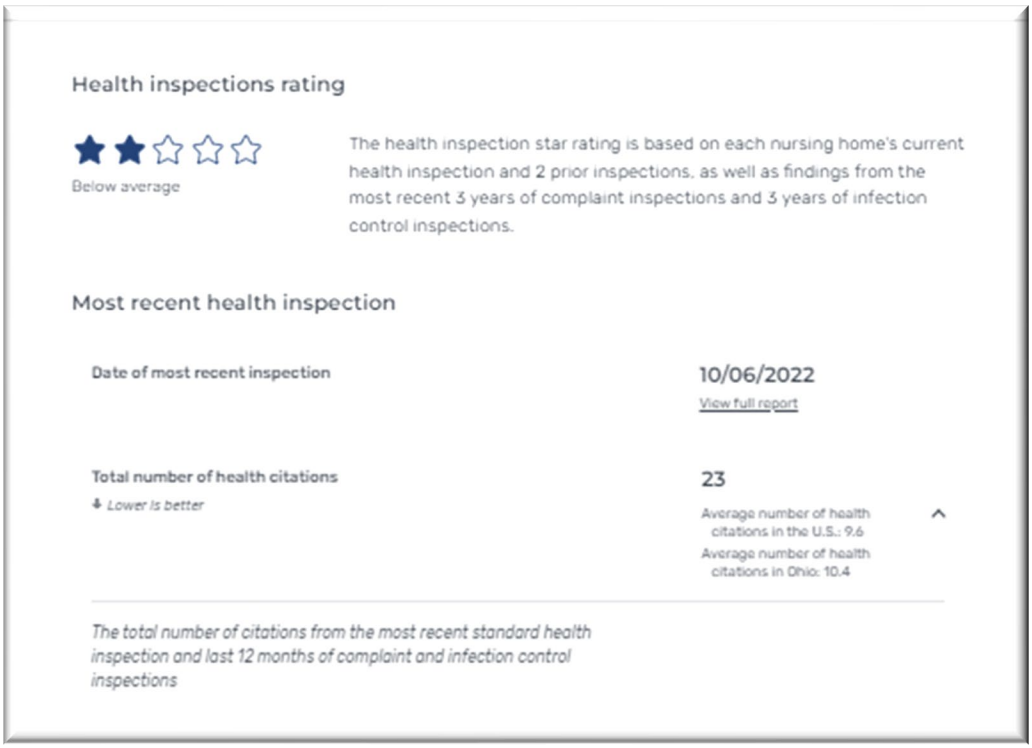
l. Arbors At Streetsboro
1645 Maplewood Dr, Streetsboro, OH 44241

m. Arbors At Sylvania
7120 Port Sylvania Drive, Toledo, OH 43617

n. Arbors At Woodsfield
37930 Airport Road, Woodsfield, OH 43793

o. Arbors West
375 West Main Street, West Jefferson, OH 43162

70. The Arbors Defendants' systemic understaffing of the Facility resulted in chronic failures to meet resident care needs, as denoted by a "2-star" ("below average") ranking for Health Inspections on the Medicare.gov Nursing Home Compare website with 23 (twenty three) citations for health deficiencies on the most recent health inspection. This is over twice the national average of 9.6 citations. This lack of sufficient staff directly resulted in Lucy Garcia not receiving basic and necessary services to prevent, among other things, neglect leading to her injuries and death



Nursing Home Compare star-ratings for Arbors at Oregon, showing 2-star "below average" rating for health inspection results, taken from Medciare.gov/care-compare on October 8, 2024.

71. At all times relevant the Arbors Defendants knew that their pattern and practice of systemic understaffing resulted in an environment where residents' needs were not met, where residents' rights were violated, and where residents were not kept safe from injury or harm while under the care of the Arbors at Oregon.

72. At all times relevant the Arbors Defendants knew that their patterns and practice of systemic understaffing was causing harm to their residents, resulting in increased instances of falls, infections, bedsores, and other injuries among their residents, and that these injuries and harms even resulted in death of residents due to neglect by the caregivers at Arbors at Oregon.

73. At all times relevant the Arbors Defendants knew that federal law required that instances of injury to residents at the Arbors at Oregon be reported to the Centers for

Medicare and Medicaid Services, which would negatively impact the facility's "Quality Measures" rating on the publicly available Medicare Nursing Home Compare webpage.

Reporting Data – Nursing Home

74. The Defendants are required to report significant amounts of data to the federal agency that oversees operations of nursing homes receiving federal or state funding, the Centers for Medicare and Medicaid Services, or "Medicare."

75. The data the Defendants submit to Medicare regarding its facility includes data on its residents (numbers, care needs, and bed days), its finances, and its nurse and nursing aide staffing levels as compared to resident care needs.

76. This data is certified correct by the Defendants and / or submitted under penalty of perjury and / or civil or criminal penalties.

77. Medicare uses some of this data submitted by Defendants to produce its nursing home 5-star rating system, also known as "Nursing Home Compare."

Nursing Home Resident Care Needs and Staffing Levels (MDS and RUG/PDPM Scores)

78. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Arbors at Oregon and others operated and / or controlled by Defendants—is required to provide detailed information regarding the health status, care and treatment, and services provided to each resident in the facility using a questionnaire called the Minimum Data Set, or MDS. This evaluation is done for all nursing home residents regardless of whether their care is being paid for by Medicare.

79. Nursing homes like Arbors at Oregon are required to evaluate every resident using the Minimum Data Set questionnaire shortly after the time of admission, every 90

days thereafter, when a resident has a significant improvement or decline in health (physical, mental, or psychosocial), and upon discharge.

80. Based on this Minimum Data Set, each resident's individual care needs (called "acuity level") are assigned into a group signifying how much nursing or staff care the resident requires, called a Patient-Driven Payment Model score, or PDPM score. The PDPM score is calculated for physical therapy, occupational therapy, speech-language pathology, non-therapy ancillary services, and nursing services.

81. Each resident's PDPM score for nursing services is contained in the patient's Minimum Data Set evaluations, meaning the total nursing care needs of the residents in any facility at a specific time is available by totaling the residents' PDPM scores from various sections of the Minimum Data Set evaluations corresponding to increased needs for nursing care.

82. When these PDPM scores are combined for all residents in a nursing home facility, the nursing home knows exactly how many minutes of nursing and nursing aide care should be provided, on average, to meet the expected care needs of their residents.

Misleading Advertising

83. In an effort to persuade the families of patients to become customers, The Arbors Defendants make promises to the families of such potential residents that they will provide a level of care that they know they are incapable of providing.

84. The intent and outcome of this misleading practice is to cause residents, their families, and external care providers to believe the nursing facility is much better staffed to provide the promised care than what is actually the practice of the Arbors Defendants with regard to staffing the Facility.

85. The Arbors Defendants know their systemic understaffing of the Facility results in chronic failures to meet resident care needs, and that the failure to meet resident care needs results in instances of injuries, bedsores, falls, and infections. These must be reported to Medicare by law which in turn reduces the Facility's "Quality Measures" score.

86. The Arbors Defendants know a facility with a low "Quality Measures" score will likely not be chosen by families and care providers for patients, and so the Arbors Defendants manipulate the "Quality Measures" score by reclassifying certain injuries and incidents as non-reportable injuries and incidents. For example, a pressure wound or bedsore can be identified as something else – such as a skin tear or abrasion – resulting in the bedsore not getting reported to Medicare and the "Quality Measures" score not being impacted.

87. The intent and outcome of this misleading practice is to drastically limit the budget and overhead needed to run a safe facility in order to maximize profits and syphon resources at the expense of patient safety, while maintaining the illusion that the care provided by the facility and patient outcomes are as good or better than competitors.

Systemic Understaffing and Lucy Garcia's Care

88. The Arbors Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Arbors at Oregon was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Lucy Garcia during the period he was a resident at the facility.

89. The Arbors Defendants engaged in a systemic practice to understaff Arbors at Oregon to maximize profits at the expense of its residents' care.

90. This lack of sufficient staff directly resulted in Lucy Garcia not receiving basic and necessary services, assessments, and interventions to prevent, among other

things, neglect leading to their injuries at Arbors at Oregon during the period they were a resident at the Facility.

Manipulating Quality Measures, and Lucy Garcia's Care

91. The Arbors Defendants knew that Arbors at Oregon was not sufficiently staffed, and as a result the residents at the Facility suffered increased falls, bedsores, infections, and injuries.

92. Defendants engaged in a systemic practice to manipulate data sent to Medicare by underreporting falls, bedsores, infections, and injuries among their residents, which artificially inflated their "Quality Measures" rating.

93. Lucy Garcia's family and providers relied on these misleading and inflated "Quality Measures" ratings to choose Arbors at Oregon for Lucy's care, and would not have chosen the Facility if the Arbors Defendants accurately reported instances of falls, bedsores, infections, and injuries to Medicare.

94. The Arbors Defendants' pattern and practice of insufficient staffing and manipulating "Quality Measures" ratings to conceal this fact directly resulted in Lucy Garcia not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at Arbors at Oregon during the period they were a resident at the Facility.

Defendants' Negligence and Recklessness with Lucy Garcia

95. The Arbors Defendants accepted Lucy Garcia as a nursing home resident for long-term care.

96. The Arbors Defendants agreed to accept Lucy Garcia into their Facility and provide care to them in exchange for monetary payment.

97. The Facility knew Lucy Garcia required significant assistance with all Activities of Daily Living when it accepted her into their care, including assistance with toileting, assistance transferring to and from bed, and assistance repositioning in bed to avoid bedsores.

98. The Facility agreed to provide appropriate care to Lucy Garcia and was bound to assist Lucy Garcia to protect her from developing bedsores while under their care.

99. Lucy Garcia suffered premature death as a direct and proximate result of Defendants' failure to provide adequate care due to understaffing the facility.

FIRST CAUSE OF ACTION
(WRONGFUL DEATH)

100. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

101. Lucy Garcia depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

102. The Defendants had a duty to provide proper care and treatment to Lucy Garcia and to avoid causing injury to Lucy Garcia.

103. The Defendants, including their medical and nursing staff, failed to provide proper care and treatment to Lucy Garcia, which they knew or should have known they required, and their negligence was the direct and proximate cause of the injuries that Lucy Garcia suffered.

104. The Defendants' failure to provide proper care and treatment included, but is not limited to:

a. Choosing to put inadequate prevention and response interventions in place to prevent injuries;

b. Choosing to provide inadequate resident observation, supervision, and monitoring;

c. Choosing to provide improper training to staff members regarding resident monitoring, assessment, response, and treatment;

d. Choosing to provide too few, and / or underqualified nursing staff members for resident needs at each facility to protect and provide adequate care to residents like Lucy Garcia;

e. Choosing to not provide accurate, adequate, or timely information to Lucy Garcia's family;

f. Choosing to violate orders relating to care of Lucy Garcia;

g. Choosing to violate state and federal regulations governing care and staffing levels in nursing home facilities by which residents like Lucy Garcia are a member of the class of persons intended to be protected from injuries like those they suffered;

h. Failing to ensure the rights and safety of its residents, including Lucy Garcia, as required by Ohio and federal regulations;

i. Choosing not to provide appropriate care to Lucy Garcia while they were a resident of the Facility;

j. Allowing their nursing staff and other staff members to physically and verbally abuse Lucy Garcia; and

k. Such other acts or omissions described in this Complaint or discovered in litigation.

105. These actions constituted a conscious disregard for Lucy Garcia's rights and safety with a great probability of causing substantial harm from this misconduct, by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct was likely to cause, at the time those services or that treatment or care were rendered, constituting an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct.

106. The Defendants were aware of the great probability of the harm that could result from their willful, wanton, and/or reckless misconduct.

107. The Defendants are directly liable for their own willful, wanton, and/or reckless misconduct.

108. The Defendants are also vicariously liable for their employees' and agents' willful, wanton, and/or reckless misconduct.

109. The Defendants and their medical and nursing staff provided care to Lucy Garcia that fell below the standard of care expected of medical care and nursing home organizations, under the same or similar circumstances.

110. As a direct and proximate result of the negligence / recklessness described above, Lucy Garcia sustained permanent injury and loss, including, but not limited to, conscious pain and suffering, disability, and death.

111. Plaintiff brings this Cause of Action pursuant to Ohio's Wrongful Death Statute, Ohio Revised Code section 2125 et seq., for the benefit of Lucy Garcia's heirs and next of kin who have suffered loss and damage due to Lucy Garcia's wrongful and untimely death.

112. As a direct and proximate result of the negligence/recklessness described above, Lucy Garcia sustained physical injuries that caused their untimely and wrongful death.

113. Lucy Garcia's next-of-kin suffered damages as set forth in the Ohio Wrongful Death statute, R.C. 2125.01 et seq., including mental anguish and grief and loss of Decedent's society and companionship.

114. WHEREFORE, Plaintiff demands judgment against Defendants, in an amount more than $25,000.00 to compensate the decedent's next of kin and heirs at law,

together with costs of suit, attorneys' fees and expenses, and any other relief the court finds is appropriate and / or equitable.

A TRIAL BY JURY IS HEREBY DEMANDED

Respectfully Submitted,

/s/ Matthew A. Mooney
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Counsel for Plaintiff

STATE OF OHIO)
) **AFFIDAVIT OF MERIT**
CUYAHOGA COUNTY)

Affiant KAPIL GULATI, MD, having been first duly sworn, states:

1. I am an adult, have no known disability preventing my truthful testimony, and have personal knowledge of the matters contained within this affidavit.

2. I am a full-time practicing physician in the field of Internal Medicine, licensed in the state of Ohio, board certified in Internal Medicine, spending more than 50% of my professional time providing direct patient care.

3. Through my specialized knowledge, skill, training, experience, and education, I am familiar with the standard of care applicable to the medical and nursing care and treatment that was provided to Lucy Garcia while a resident of Arbors at Oregon aka Oregon Opco, LLC, Ark Opco Group, LLC, FCE Arbors at Oregon, LLC, Noble Healthcare Management, LLC, Prestige Administrative Services, LLC, Prestige Healthcare aka Northpoint Senior Services, LLC, Arbors at Ohio, Oregon 904 Property Holdings, LLC, Robert Daiber, M.D., Joseph Peyton, D.O., Jocelyn Pardeau, NP, and Peyton Care Professionals, LLC.

4. I have reviewed all medical records reasonably available to the Estate of Lucy Garcia concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Arbors at Oregon aka Oregon Opco, LLC, Ark Opco Group, LLC, FCE Arbors at Oregon, LLC, Noble Healthcare Management, LLC, Prestige Administrative Services, LLC, Prestige Healthcare aka Northpoint Senior Services, LLC, Arbors at Ohio, Oregon 904 Property Holdings, LLC, Robert Daiber, M.D., Joseph Peyton, D.O., Jocelyn Pardeau, NP, and Peyton Care Professionals, LLC, breached the standard of care and the breach caused Lucy Garcia's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

KAPIL GULATI, MD

SWORN TO BEFORE ME and subscribed in my presence this 22nd day of October, 2024.

NOTARY PUBLIC

My commission has no expiration date pursuant to R.C. § 147.03