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**Jennings, Linda J.**

IN THE COURT OF COMMON PLEAS
LUCAS COUNTY, OHIO

**CI2024-04181**

ESTATE OF BRENDA McNEIL, DECEASED
Through Estate Representative Jan Corthell,
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,

CASE NO.

JUDGE

**COMPLAINT**

**WITH JURY DEMAND**

**MOTION FOR EXTENSION OF AFFIDAVIT OF MERIT DEADLINE FILED HEREWITH**

NOBLE HEALTHCARE MANAGEMENT, 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

Defendants.

Plaintiff, the Estate of Brenda McNeil, Deceased, through Estate Representative Jan Corthell, for this Complaint against the above-named Defendant(s), states and avers upon information and belief:

## INTRODUCTION

1. This action involves multiple claims (medical negligence, recklessness, wrongful death, and Resident's Rights Law violations) involving Arbors at Oregon A.K.A. Oregon OPCO, LLC ("Facility's") inadequate care of Brenda McNeil and the corporate control of the facility leading to such inadequate care that led to Brenda McNeil's untimely and wrongful death on November 6, 2023.

2. The facility, Arbors at Oregon A.K.A. Oregon OPCO, LLC ("Arbors at Oregon"), and their corporate owners, injured and caused the death of 69-year-old Brenda McNeil.

3. Ms. McNeil was admitted to Arbors at Oregon on October 28, 2023 for rehabilitation following a fall she suffered in her assisted living apartment which resulted in brain bleed and a fractured hip. Upon admission, the facility was aware that Ms. McNeil was at a heightened risk for falls and brain bleeds due to her fall history, limited mobility, recent brain bleed, dependence on staff for assistance transferring to and from bed and with toileting. Ms. McNeil required a Hoyer lift for assistance with transfers to and from her bed.

4. On October 30, 2023, Arbors at Oregon's staff contacted Jan Corthell - Ms. McNeil's daughter – and informed her that Ms. McNeil was found unconscious in her room at Arbors at Oregon. Arbors at Oregon's staff did not explain how or why Ms. McNeil was in this state, however insinuated she may have had a seizure.

5. EMS took Ms. McNeil to St. Charles Hospital that same morning. The doctors at St. Charles Hospital performed CT imaging of her head and revealed that in fact Ms. McNeil had evidence of a new brain bleed, likely caused by a fall at Arbors at Oregon.

6. Ms. McNeil remained at St. Charles Hospital in the intensive care unit, however did not regain consciousness. She developed pneumonia in the hospital setting and declined rapidly, passing away on November 6, 2023.

7. The Lucas County Coroner performed an autopsy on Ms. McNeil and revealed her cause of death was accidental, with a primary cause of death listed as pneumonia due to right hip fracture and blunt head trauma.

8. Plaintiff requests a trial by jury.

9. 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**

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. Defendants employ, manage, and direct the care and service providers who were responsible for Brenda McNeil'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 Brenda McNeil's injuries and untimely and wrongful death on November 6, 2023.

19. 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.

20. 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.

21. 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.

22. 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**

23. The Defendants employ the care providers who were responsible for ensuring Brenda McNeil's care and safety.

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

25. Brenda McNeil and their family looked to the Defendants for care based upon their representations.

26. 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

27. 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.

28. 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

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

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

31. 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.

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

33. The 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.

34. As the result of this control, the 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 Brenda McNeil, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.2

35. 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 Brenda McNeil

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

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

38. The 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

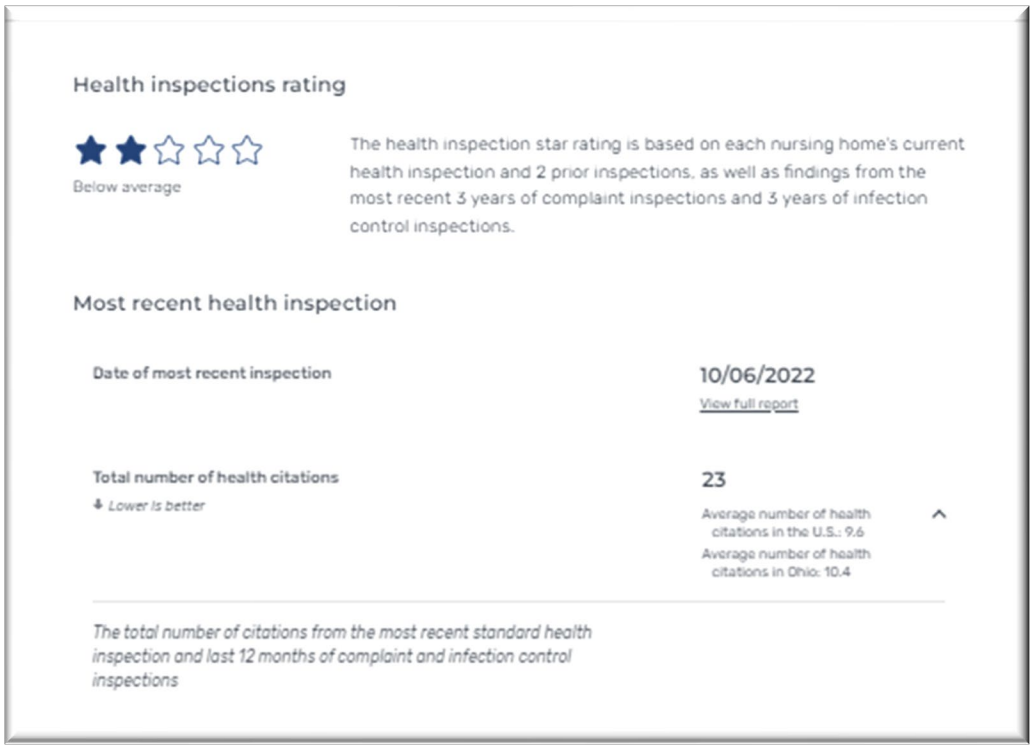
l. Arbors At Streetsboro
1645 Maplewood Dr, Streetsboro, OH 44241

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

39. The 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 Brenda McNeil 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.*

**Reporting Data – Nursing Home**

40. 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."

41. 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.

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

43. 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)**

44. 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.

45. 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.

46. 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 Resource Utilization Group score, or RUG score. Medicare has recently decided to phase-out the RUG score in favor of a new calculation called Patient-Driven Payment Model score, or PDPM score. At all times relevant to this matter, the RUG score was still in use by nursing homes.

47. Each resident's Resource Utilization Group score is contained in Section Z of their Minimum Data Set evaluations, meaning the total care needs of the residents in any facility at a specific time is available by totaling the residents' Resource Utilization Group scores from their Minimum Data Set evaluations.

48. Medicare has commissioned and made available to every nursing home studies and data showing the number of minutes of nursing and nursing aide care a person at a specific RUG level should be expected to require, which Medicare calls "expected staffing."

49. When these Resource Utilization Group 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**

50. In an effort to persuade the families of patients to become customers, 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.

51. 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 Defendants with regard to staffing the Facility.

52. 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.

**Systemic Understaffing and Brenda McNeil's Care**

53. The 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 Brenda McNeil during the period he was a resident at the facility.

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

55. This lack of sufficient staff directly resulted in Brenda McNeil 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 Brenda McNeil**

56. Defendants accepted Brenda McNeil as a nursing home resident for long-term care.

57. Defendants agreed to accept Brenda McNeil into their Facility and provide care to them in exchange for monetary payment.

58. The Facility knew Brenda McNeil required significant assistance with all Activities of Daily Living when it accepted them into their care, including assistance with any transfers to or from her bed.

59. The Facility knew Brenda McNeil required monitoring and fall prevention interventions in order to protect her from falls, and that any falls had a substantial risk of severe injury and death as a result of recurrent brain bleeding due to her recovery from a recent fall with brain bleeding.

60. Brenda McNeil endured mental and physical pain suffering and death as a direct and proximate result of Defendants' failure to provide adequate care due to understaffing the facility.

**FIRST CAUSE OF ACTION**
**(MEDICAL NEGLIGENCE / RECKLESSNESS)**

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

62. Brenda McNeil depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

63. The Defendants had a duty to provide proper care and treatment to Brenda McNeil and to avoid causing injury to Brenda McNeil

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

65. 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 Brenda McNeil;

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

f. Choosing to violate orders relating to care of Brenda McNeil;

g. Choosing to violate state and federal regulations governing care and staffing levels in nursing home facilities by which residents like Brenda McNeil 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 Brenda McNeil, as required by Ohio and federal regulations;

i. Choosing not to provide appropriate care to Brenda McNeil while they were a resident of the Facilities;

j. Allowing their nursing staff and other staff members to physically and verbally abuse Brenda McNeil; and

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

66. These actions constituted a conscious disregard for Brenda McNeil'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. The Defendants were aware of the great probability of the harm that could result from their willful, wanton, and/or reckless misconduct.

67. The Defendants' disregard for the rights and safety of residents like Brenda McNeil created circumstances under which it became substantially certain that serious injuries would result, entitling Plaintiff to awards for compensatory and punitive damages.

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

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

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

71. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., and Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

72. As a direct and proximate result of the negligent and/or willful, wanton and/or reckless actions of the Defendants described above, Brenda McNeil sustained permanent injury and loss including, but not limited to, conscious pain and suffering, disability, and death.

73. WHEREFORE, Plaintiff demands judgment against the Defendants in an amount more than Twenty-Five Thousand Dollars ($25,000.00), for conscious pain and suffering, loss of enjoyment, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

**SECOND CAUSE OF ACTION**
**(WRONGFUL DEATH)**

74. Plaintiff incorporate all other paragraphs of this Complaint as if fully rewritten herein.

75. Brenda McNeil depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

76. The Defendants had a duty to provide proper care and treatment to Brenda McNeil and to avoid causing injury to Brenda McNeil.

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

78. 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 Brenda McNeil;

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

f. Choosing to violate orders relating to care of Brenda McNeil;

g. Choosing to violate state and federal regulations governing care and staffing levels in nursing home facilities by which residents like Brenda McNeil 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 Brenda McNeil, as required by Ohio and federal regulations;

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

j. Allowing their nursing staff and other staff members to physically and verbally abuse Brenda McNeil; and

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

79. Defendants, directly or through their employees or agents, violated Brenda McNeil's rights as a resident of the Defendants' facilities, as enumerated in Ohio Revised Code section 3721.13, including, but not limited to:

a. The right to a safe and clean living environment;

b. The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

c. The right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care;

d. The right to have clothes and bed sheets changed as the need arises, to ensure the resident's comfort or sanitation;

e. The right to participate in decisions that affect the resident's life;

f. The right to have any significant change in the resident's health status reported to the resident's sponsor.

80. These violations are evidence of negligence and conscious disregard of Brenda McNeil's rights and safety, and give rise to a statutory cause of action.

81. Brenda McNeil endured conscious pain, suffering, and disability, and other harms and losses as the direct and proximate result of Defendants' violations of R.C. 3721.13.

82. These actions constituted a conscious disregard for Brenda McNeil'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.

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

84. The Defendants' disregard for the rights and safety of residents like Brenda McNeil created circumstances under which it became substantially certain that serious injuries would result.

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

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

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

88. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., and Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

89. As a direct and proximate result of the negligence / recklessness described above, Brenda McNeil sustained injuries that caused their untimely and wrongful death.

90. Brenda McNeil'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.

91. 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.

**THIRD CAUSE OF ACTION**
**(NURSING HOME RESIDENT RIGHTS VIOLATION R.C. 3721.13)**

92. Plaintiff incorporate all other paragraphs of this Complaint as if fully rewritten herein.

93. Defendants, directly or through their employees or agents, violated Brenda McNeil's rights as a resident of the Defendants' facilities, as enumerated in Ohio Revised Code section 3721.13, including, but not limited to:

a. The right to a safe and clean living environment;

b. The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

c. The right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care;

d. The right to have clothes and bed sheets changed as the need arises, to ensure the resident's comfort or sanitation;

e. The right to participate in decisions that affect the resident's life;

f. The right to have any significant change in the resident's health status reported to the resident's sponsor.

94. These violations are evidence of negligence and conscious disregard of Brenda McNeil's rights and safety, and give rise to a statutory cause of action.

95. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Brenda McNeil conscious pain, suffering, and disability, and other harms and losses including death.

96. WHEREFORE, Plaintiff demands judgment against the Defendants in an amount in excess of $25,000.00, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and / or equitable.

## FOURTH CAUSE OF ACTION
## (CIVIL CONSPIRACY)

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

98. Defendants and unknown additional potential co-conspirators had an express agreement, mutual understanding, or tacit agreement to, and/or their agents maliciously combined efforts to:

a. defraud residents and their families by delivering wholly inadequate care, contrary to their promises;

b. systemically understaff their facilities in violation of regulations, and for the purposes of their own profit at the expense of resident health and safety;

c. under-capitalize the facilities and syphon money to themselves and related entities for the purposes of their own profit at the expense of resident health and safety;

d. not providing the level of care, by understaffing the facility, paid for by taxpayer dollars;

e. as otherwise may be described in the Complaint or learned through discovery.

99. This understanding constitutes a malicious combination to injure residents of the Defendants' Facility, including Brenda McNeil.

100. In pursuance of this common plan or design to commit tortious acts, the Defendants actively took part in it, or furthered it by cooperation or request, or lent aid or encouragement to the wrongdoers, or ratified and adopted the wrongdoers' acts done for their benefit.

101. The conspiracy caused injury to Brenda McNeil, including death.

102. The negligent and / or reckless and / or fraudulent acts of the Defendants constitute unlawful acts independent from the conspiracy itself.

103. WHEREFORE, Plaintiff prays for judgment against Defendants, for damages in an amount of more than Twenty-Five Thousand Dollars ($25,000.00), together with punitive and exemplary damages, attorney fees and expenses, fees, interest, and costs incurred in this action, and any other relief this Court deems just and equitable to compensate Plaintiffs for the damages and injuries suffered.

**A TRIAL BY JURY IS HEREBY DEMANDED**

Respectfully Submitted,

*/s/ Matthew A. Mooney*

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***Counsel for Plaintiff***