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Mike Foley
CLERK OF COURTS MONTGOMERY COUNTY OHIO

IN THE COURT OF COMMON PLEAS
MONTGOMERY COUNTY, OHIO

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|---|---|
| ESTATE OF EDITH MARIE ADKINS,<br>DECEASED<br>Through Estate Representative Ted Gudorf<br>c/o Michael Hill Trial Law<br>815 Superior Avenue, Suite 623<br>Cleveland, OH 44114<br><br>Plaintiff,<br><br>vs.<br><br>ENGLEWOOD HEALTH AND REHAB AKA<br>CT OHIO ENGLEWOOD, LLC<br>425 Lauricella Court<br>Englewood, OH 45322<br><br>and<br><br>FLYER 4 OPERATIONS HOLDINGS, LLC<br>c/o Registered Agent:<br>Capitol Services, Inc.<br>108 Lakeland Avenue<br>Dover, DE 19901<br><br>and<br><br>ACM HASHEM HOLDINGS, LLC<br>c/o Registered Agent:<br>National Registered Agents, Inc.<br>1209 Orange Street<br>Wilmington, DE 19801<br><br>and<br><br>FLYER 4 HOLDINGS, LLC<br>c/o Registered Agent:<br>Capitol Services, Inc.<br>108 Lakeland Avenue<br>Dover, DE 19901<br><br>and | CASE NO.<br><br>JUDGE<br><br>**COMPLAINT**<br><br>**WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED HEREON**<br><br>**MOTION TO EXTEND DEADLINE TO FILE AFFIDAVIT OF MERIT FILED CONCURRENTLY** |

FTK FLYER OH, LLC )
c/o Registered Agent: )
VCORP Agent Services, Inc. )
25 Robert Pitt Drive, Suite 204 )
Monsey, NY 10952 )
)
and )
)
NPNH1, LLC )
c/o Registered Agent: )
Ezra Birnbaum )
5225 Collins Avenue #1501 )
Miami Beach, FL 33140 )
)
and )
)
SHS KEREN, LLC )
c/o Registered Agent: )
Shaye Hirsch )
100 Merrick Road, Suite 401W )
Rockville Centre, NY 11570 )
)
and )
)
ENGLEWOOD PROPERTY, LLC AKA )
ENGLEWOOD PROPERTY LANDLORD, LLC )
c/o Registered Agent: )
Englewood Health and Rehab )
PO Box 340 )
Englewood, OH 45322 )
)
and )
)
NAFTALI ZANZIPER )
The Portopiccolo Group, LLC )
980 Sylvan Ave #2 )
Englewood Cliffs, NJ 07632 )
)
and )
)
SIMCHA HYMAN )
The Portopiccolo Group, LLC )
980 Sylvan Ave #2 )
Englewood Cliffs, NJ 07632 )
)
and )
)

THE PORTOPICCOLO GROUP, LLC )
980 Sylvan Ave #2 )
Englewood Cliffs, NJ 07632 )
)
Defendants. )

Plaintiff, the Estate of Edith Marie Adkins, Deceased, through Estate Representative Ted Gudorf, for this Complaint against the above-named Defendants, states and avers upon information and belief:

## INTRODUCTION

1. This action involves multiple claims (medical negligence, recklessness, wrongful death, Resident's Rights Law violations, civil conspiracy, and fraud) involving Englewood Health and Rehab aka CT Ohio Englewood, LLC's (the "Facility") inadequate care of Edith Adkins and the corporate control of the facility leading to such inadequate care that led to Edith Adkins' untimely and wrongful death on January 12, 2024.

2. This is a negligence and wrongful death case against Englewood Health and Rehab, also known as CT Ohio Englewood, LLC, for failing to properly assess Edith Adkins' fall risk and implement timely interventions to prevent her from sustaining repeated falls, amongst other failures. Edith Adkins fell at least 18 times over the course of approximately six months while under Englewood Health and Rehab's care. Several of these falls resulted in multiple injuries, including a laceration to the back of her head, skin tears, and ultimately a subdural hematoma that led to her death on January 12, 2024.

3. The Montgomery County Coroner determined that the sole cause of Edith Adkins' death was a fall suffered at Englewood Health and Rehab on January 3, 2024. This is the official and only cause of death recognized by the state of Ohio.

4. Plaintiff requests a trial by jury.

5. An Affidavit of Merit is attached.

6. 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**

7. Englewood Health and Rehab aka CT Ohio Englewood, LLC is a Georgia 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

8. Flyer 4 Operations Holdings, 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

9. ACM Hashem Holdings, 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

10. Flyer 4 Holdings, 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

11. FTK Flyer OH, LLC is a New York 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

12. NPNH1, LLC is a Florida 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

13. SHS Karen, LLC is a New York 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

14. Englewood Property, LLC aka Englewood Property Landlord, 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 Englewood Health and Rehab aka CT Ohio Englewood, LLC.

15. Naftali Zanziper is an owner of CT Ohio Englewood, LLC dba Englewood Health and Rehab who assumed operational and managerial control of Englewood Health and Rehab in 2022 and exercised direct operational and managerial control over the facility while Edith Adkins was a resident. Consistent with Zanziper's operations of more than 100 other nursing homes across the United States, many of which were purchased during the Covid-19 pandemic, Zanziper, his business partner Simcha Hyman, and The Portopiccolo Group, LLC have intentionally and systemically reduced nurse staffing, reduced budgets for supplies, equipment, food, and staffing, and undercapitalized the facility to decrease costs and increase profits for their own personal benefits at the expense of resident safety and life. These decisions were made not only negligently but knowingly and intentionally and directly caused Edith Adkins to suffer substandard and nonexistent care leading to violations of her resident rights and 18 documented falls, the final fall causing her to suffer a massive brain bleed causing her death.

16. Simcha Hyman assumed operational and managerial control of Englewood Health and Rehab in 2022 and exercised direct operational and managerial control over the facility while Edith Adkins was a resident. Consistent with Hyman's operations of more than 100 other nursing homes across the United States, many of which were purchased during the Covid-19 pandemic, Hyman, his business partner Naftali Zanziper, and The Portopiccolo Group, LLC have intentionally and systemically reduced nurse staffing, reduced budgets for supplies, equipment, food, and staffing, and undercapitalized the facility to decrease costs and increase profits for their own personal benefits at the expense of resident safety and life. These decisions were made not only

negligently but knowingly and intentionally and directly caused Edith Adkins to suffer substandard and nonexistent care leading to violations of her resident rights and 18 documented falls, the final fall causing her to suffer a massive brain bleed causing her death.

17. The Portopiccolo Group, LLC is an investment company and private equity firm headquartered in New Jersey that controls, manages, and operates more than 100 nursing homes throughout the country under the direction of its principals and key decision makers Simcha Hyman and Naftali Zanziper that greatly increased its portfolio of nursing homes during the Covid-19 pandemic, including assuming operational control of CT Ohio Englewood, LLC dba Englewood Health and Rehab. The Portopiccolo Group pursues its monetary interests through a complicated network of limited liability companies and related entity corporations through the affiliated entity name recognized by Centers for Medicare and Medicaid Services (the arm of the federal government that regulates nursing homes) as simply Simcha Hyman and Naftali Zanziper, which is the registered affiliated name of CT Ohio Englewood, LLC dba Englewood Health and Rehab. Hyman and Zanziper own, manage, and or operate approximately 130 nursing homes in 11 states across the United States. These decisions were made not only negligently but knowingly and intentionally and directly caused Edith Adkins to suffer substandard and nonexistent care leading to violations of her resident rights and 18 documented falls, the final fall causing her to suffer a massive brain bleed causing her death.

18. The Defendants employ, manage, and direct the care and service providers who were responsible for Edith Adkins' care, treatment, and safety at Englewood Health and Rehab aka CT Ohio Englewood, LLC while she was 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 Edith Adkins' injuries and untimely and wrongful death on January 12, 2024.

19. The 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. The Defendant 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 and piercing corporate veils are an appropriate remedy here if the individuals owners/members of the various corporate entities are not already personally liable for their direct acts.

21. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Englewood Health and Rehab aka CT Ohio Englewood, LLC directly or through their domination and control of any putative entity license holder.

**VICARIOUS LIABILITY**

22. The Defendants employ the care providers who were responsible for ensuring Edith Adkins' care and safety.

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

24. Edith Adkins and her family looked to the Defendants for care based upon their representations.

25. 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 Hosp. & Family Health Ctr.*, 68 Ohio St.3d 435, 628 N.E.2d 46 (1994), 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

26. This Court has Jurisdiction over Defendants because, among other things, all Defendants 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.

27. Venue is proper in Montgomery 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

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

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

30. 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 and Ohio nursing home regulations regarding staffing levels.

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

32. The Defendants exercise actual control over the Facility's 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.

33. As the result of this control, the Defendants make decisions that affect the day-to-day care of residents of the Facility, such as the resources available for providing nursing staff and care to residents like Edith Adkins, meaning they are responsible for the

foreseeable harm that results from careless decisions while voluntarily exercising that control.

34. 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 Edith Adkins.

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

36. The Defendants' systemic understaffing of the Facility resulted in a "2-star" ("below average") ranking for Staffing on the Medicare.gov Nursing Home Compare website and 2-star overall ranking.

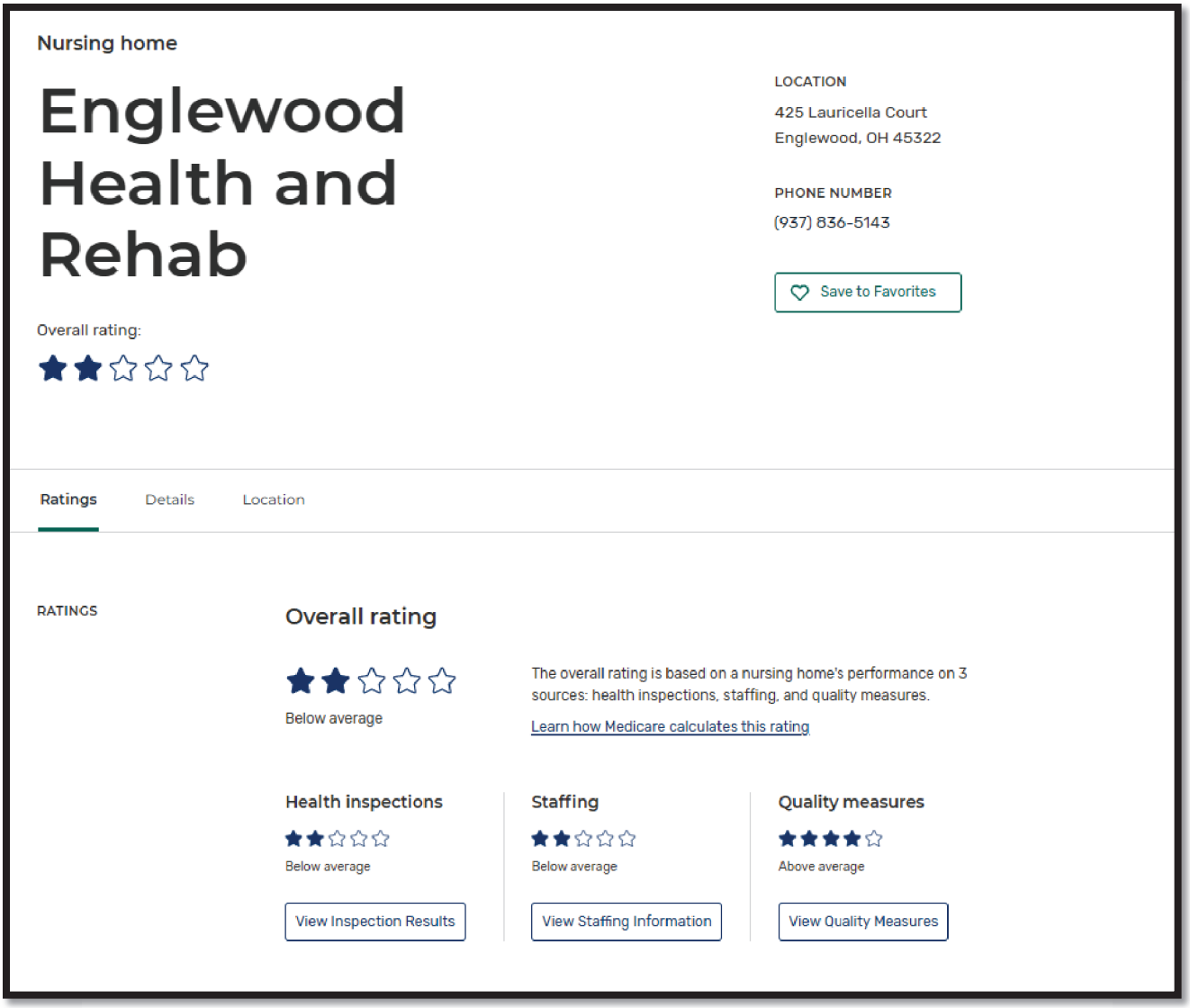



*Figure 1: Center for Medicare and Medicaid found that Englewood Health and Rehab aka CT Ohio Englewood, LLC earned a 2-star, or below average rating for health inspections, staffing, and quality measures. This data was taken directly from medicare.gov on November 13, 2024.*

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

**Reporting Data – Nursing Home**

38. 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."

39. 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.

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

41. 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 Scores)**

42. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Englewood Health and Rehab aka CT Ohio Englewood, LLC—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.

43. Nursing homes like Englewood Health and Rehab aka CT Ohio Englewood, LLC 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.

44. 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.

45. 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.

46. 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."

47. 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.

**Hyman and Zanziper Facilities**

48. Simcha Hyman and Naftali Zanziper is the affiliated entity and nursing home chain that operates CT Ohio Englewood LLC dba Englewood Health and Rehab.

49. The affiliated entity name is a unique name used to identify a group of nursing homes that share organizational ownership or entity with operational/managerial control.

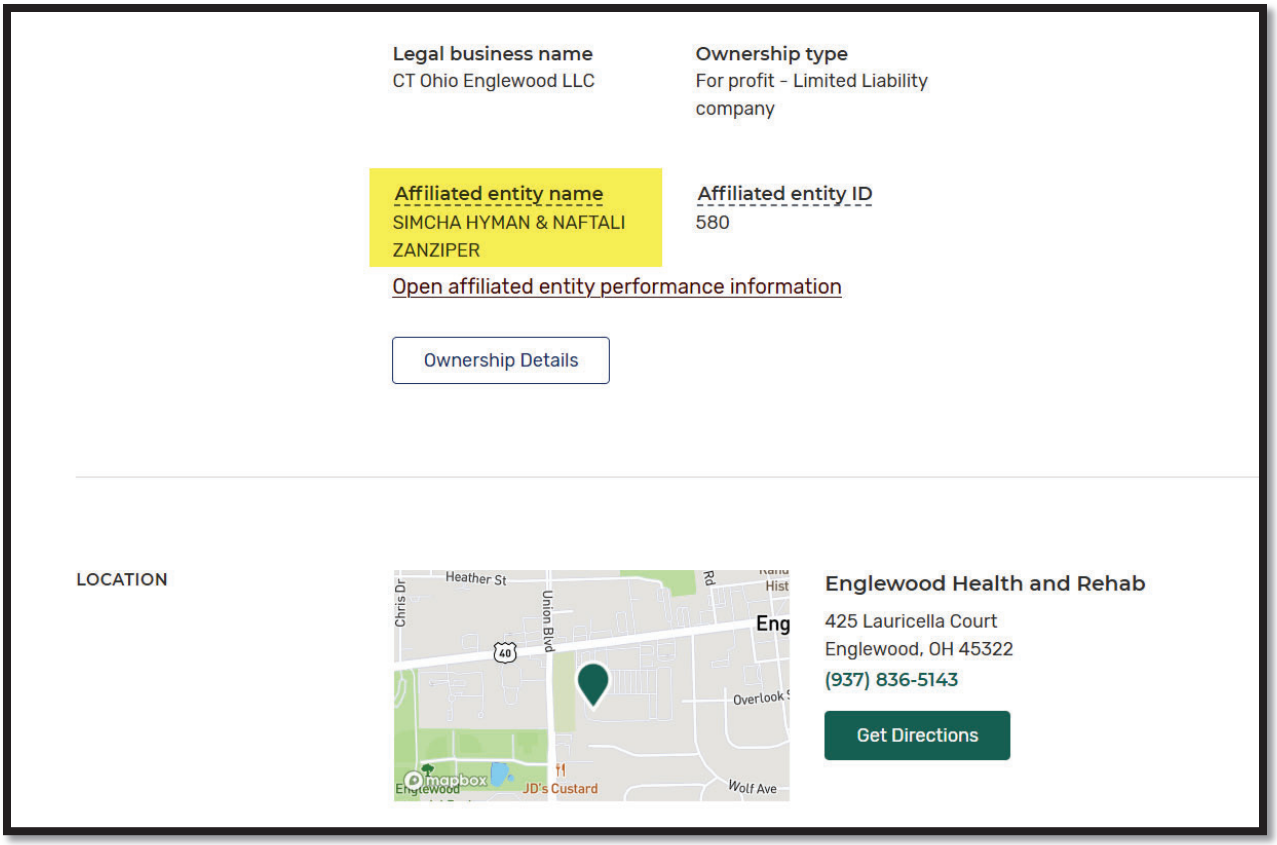



*Figure 2: https://www.medicare.gov/care-compare/details/nursing-home/365088?id=1669aff2-2c2b-4a31-8362-b3ee8c894409&city=Dayton&state=OH&zipcode=, last accessed December 18, 2024.*

50. Naftali Zanziper is a direct owner of CT Ohio Englewood, LLC.

51. Simcha Hyman & Naftali Zanziper ("Hyman & Zanziper") is a nursing home chain affiliated with 131 nursing facilities in 11 states.

52. Hyman & Zanziper are the primary owners and key decision-makers of The Portopiccolo Group, LLC, a financial investment and private equity firm located in New Jersey that invests heavily in nursing homes through a complex web of limited liability companies and related entities and assumed operations of numerous nursing homes during the Covid-19 pandemic.

53. Hyman & Zanziper and The Portopiccolo Group are estimated to control more than 15,000 nursing home beds in the United States.

54. Simcha Hyman, Naftali Zanziper, and The Portopiccolo Group are responsible for making key determinations at their affiliated facilities, including Englewood Health and Rehab. These decisions include: setting monetary budgets for supplies, staffing, equipment, and dietary (food), and imposing strict oversight to ensure that these budgets are followed; enacting and enforcing policies and procedures; and providing funds for training staff.

55. In an effort to cut corners in pursuit of profits, Hyman & Zanziper and the Portopiccolo Group lower their overhead and reduce nurse availability at their nursing homes.

56. Studies conducted by the public and private sector have repeatedly demonstrated that nurse availability is the most important determinant of quality of care and fewer nursing staff is associated with: decreased resident personal hygiene (including bathing, oral care, *i.e.*, brushing teeth, clothing and linens being changed and washed, and cleaned after toileting), less frequent turning and repositioning in bed, increased development of pressure wounds or pressure injuries (aka bedsores), fewer hands to help and fewer eyes to watch resulting in decreased supervision and monitoring; and increased incidences of dehydration, malnutrition, and infections.

57. Hyman & Zanziper facilities had nearly 3 times the number of serious deficiencies at their nursing facilities as the national average during the time that Edith Adkins was a resident of Englewood Health and Rehab.

58. Hyman & Zanziper facilities reported significantly lower nurse staffing hours per resident per day across all of their affiliated nursing homes during the time that Edith Adkins was a resident of Englewood Health and Rehab, which is consistent with the low staffing numbers at Englewood Health and Rehab while Edith Adkins was a resident.

59. Hyman & Zanziper facilities had a higher percentage of nurse turnover, which is defined as the percentage of nursing staff who stopped working at affiliated homes over a 12-month period, which is consistent with the high turnover at Englewood Health and Rehab while Edith Adkins was a resident.

60. In the last three years, Hyman & Zanziper facilities have been fined on average $86,696, more than two times the national average.

61. As of the time Edith Adkins was injured and died at Defendants' facility, Hyman & Zanziper was the most penalized nursing home chain in America by Centers for Medicare and Medicaid.

| Affiliated entity | # of facilities | # of states and territories | Total fines 2021-2023 |
|---|---|---|---|
| SIMCHA HYMAN & NAFTALI ZANZIPER | 131 | 11 | $11,838,984 |
| GENESIS HEALTHCARE | 236 | 22 | $9,901,096 |
| INFINITY HEALTHCARE MANAGEMENT | 58 | 5 | $9,788,322 |
| COMMUNICARE HEALTH | 103 | 7 | $6,557,001 |
| THE ENSIGN GROUP | 254 | 14 | $6,527,043 |
| LIFE CARE CENTERS OF AMERICA | 198 | 29 | $6,205,806 |
| PETERSEN HEALTH CARE | 62 | 2 | $6,194,895 |
| APERION CARE | 38 | 2 | $5,137,280 |
| MEDILODGE | 50 | 1 | $5,022,989 |
| CIENA HEALTHCARE/LAUREL HEALTH CARE | 79 | 5 | $5,013,223 |
| CREATIVE SOLUTIONS IN HEALTHCARE | 110 | 1 | $4,777,034 |
| ATHENA HEALTHCARE SYSTEMS | 41 | 3 | $4,447,717 |
| MISSION POINT HEALTHCARE SERVICES | 24 | 1 | $4,094,000 |
| LEGACY HEALTHCARE | 55 | 3 | $3,975,521 |
| FUNDAMENTAL HEALTHCARE | 72 | 7 | $3,874,572 |

Table: The Conversation, CC-BY-ND • Source: Centers for Medicare & Medicaid Services • Created with Datawrapper

*Figure 3: https://www.yahoo.com/news/profit-nursing-homes-cutting-corners-124659885.html?guccounter=1, last accessed December 18, 2024.*

62. Hyman & Zanziper and The Portopiccolo Group assumed operations of Englewood Health and Rehab in September 2022.

63. Hyman & Zanziper and The Portopiccolo Group had assumed operational control of Englewood Health and Rehab as of the date Edith Adkins became a resident and they remained in control during the entirety of her stay, which included 18 documented falls and a profound head injury causing her death.

64. Of the 18 documented times that Edith Adkins fell at Englewood Health and Rehab, on only 3 occasions staff actually witnessed the fall, meaning that during 15 of the 18 times that Edith Adkins fell she was unsupervised, unmonitored, and staff did not observe the fall—a clear indication of understaffing.

**Misleading Advertising**

65. 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.




*Figure 4: Englewood Health and Rehab advertises its services in a way to lead families and potential residents to believe that their services are specialized to each resident. This is done to make individuals believe that their loved one will be cared for at a level that the facility cannot provide. This data was taken directly from rehabatenglewood.com on November 13, 2024.*

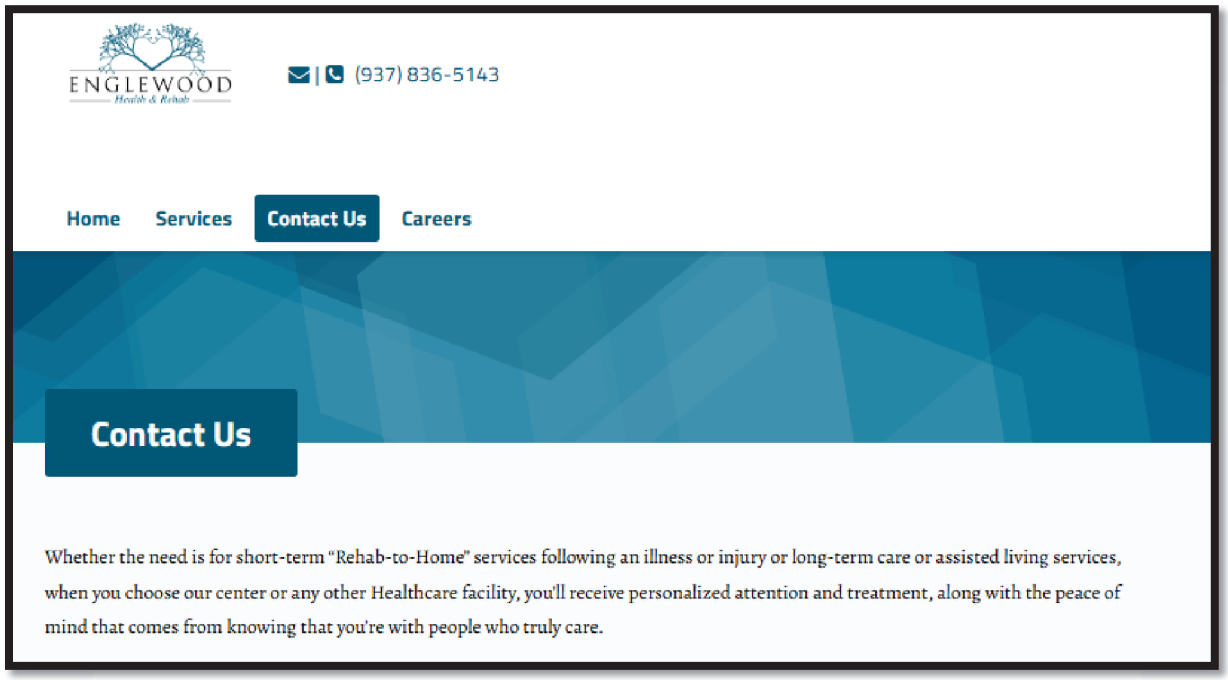



*Figure 5: Englewood Health and Rehab advertises its services in a way that leads people to believe that residents receive "personalized" treatment and promises "peace of mind" knowing that their residents are being care for by people who "truly care." This data was taken directly from rehabatenglewood.com on November 13, 2024.*

66. The above advertisements for Englewood Health and Rehab boast numerous promises, including claims of "personalized care", "personalized attention and treatment," and providing "peace of mind" with staff who "truly care." However, Englewood Health and Rehab knows it cannot meet these promises, as evidenced by its 2-star rating on the Medicare.gov Nursing Home Compare website, which reflects significant deficiencies in staffing and care. Despite this knowledge, the facility continues to mislead families, including Edith Adkins, into trusting it with their loved ones, ultimately exposing residents to serious harm and injury.

67. 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.

68. 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 Edith Adkins' Care**

69. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Englewood Health and Rehab aka CT Ohio Englewood, LLC was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Edith Adkins during the period she was a resident at the facility.

70. Defendants engaged in a systemic practice to understaff Englewood Health and Rehab aka CT Ohio Englewood, LLC to maximize profits at the expense of its residents' care.

71. This lack of sufficient staff directly resulted in Edith Adkins not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to her injuries at Englewood Health and Rehab aka CT Ohio Englewood, LLC during the period she was a resident at the Facility.

**Defendants' Negligence and Recklessness with Edith Adkins**

72. Defendants accepted Edith Adkins as a nursing home resident for long-term care on July 29, 2023.

73. Defendants agreed to accept Edith Adkins into their facility and provide care to her in exchange for monetary payment.

74. The Facility knew Edith Adkins was a risk when it accepted her into their care given her medical conditions, history of falls with injury, being in a new environment, and level of dependence with transfers, sit-to-stand, sit-to-lying, ambulation, and activities of daily living.

75. Within five days of being admitted to Englewood Health and Rehab, Edith Adkins sustained her first unwitnessed fall while under the facility's care. On or about August 3, 2023, Edith was found on her knees on the ground in front of her wheelchair, crying out in pain. Despite this, the facility failed to conduct a proper post-fall assessment and did not implement necessary interventions to prevent further falls, leaving Edith vulnerable to additional incidents and injury.

76. On or about August 6, 2023, Edith Adkins slid out of her wheelchair in front of one of Englewood Health and Rehab's employees. Once again, the facility failed to conduct a proper post-fall assessment and did not implement the necessary interventions to prevent further falls, leaving Edith at continued risk of harm.

77. On or about August 12, 2023, Edith Adkins sustained a third fall while under Englewood Health and Rehab's care when she became agitated and accused staff of throwing her onto the floor. Despite this, the facility failed to conduct a proper fall risk assessment and did not implement any new interventions to address her increased risk of falling, allowing her continued exposure to harm.

78. On or about August 16, 2023, Edith Adkins was found on her knees on the floor in front of the toilet in her bathroom. No proper post-fall assessment was conducted, and no new interventions were put in place to prevent further incidents. This was her fourth documented fall while under Englewood Health and Rehab's care.

79. On or about August 19, 2023, Edith Adkins was found lying on the floor near the bedroom door in her room. Upon assessment, a laceration to the back of her head was discovered, requiring staples to close the wound. Despite sustaining a serious injury to her head, Englewood Health and Rehab failed to do a proper fall risk assessment, and no new interventions were implemented to prevent Edith from sustaining additional falls.

80. On or about August 24, 2023, Edith Adkins was found lying on her right side on the floor near the foot of her bed. No proper post-fall assessment was performed, and no new interventions were put in place. This was her sixth documented fall in approximately three weeks since being admitted to the facility.

81. On or about September 7, 2023, Edith Adkins was found sitting on the floor in front of her toilet, complaining of left shoulder pain. No proper post-fall assessment was conducted, and no new interventions were implemented. This was her seventh documented fall while under Englewood Health and Rehab's care.

82. On or about September 10, 2023, Edith Adkins sustained yet another fall while under Englewood Health and Rehab's care, when she was found on her floor mat

next to her bed and reported needing to use the restroom. Again, Defendants did not perform a proper post-fall assessment, and no new interventions were implemented to prevent Edith Adkins from continuing to sustain falls.

83. On or about September 26, 2023, a loud noise was heard from Edith Adkins' room, and she was found on the ground next to her bed after attempting to ambulate to the restroom on her own. Ms. Adkins hit the back of her head again as a result of this fall. Defendants did not perform a proper post-fall assessment, and no new interventions were implemented to prevent Edith Adkins from continuing to sustain falls. This was her ninth documented fall within approximately two months of being under Englewood Health and Rehab's care.

84. Just a few days later, on or about September 29, 2023, Edith Adkins was found on her bathroom floor in front of her wheelchair again, marking her tenth documented fall while under Englewood Health and Rehab's care. Defendants did not perform a proper post-fall assessment, and no new interventions were implemented to prevent Edith Adkins from continuing to sustain falls.

85. On or about September 30, 2023, Edith Adkins fell again while attempting to ambulate to the restroom. Defendants did not perform a proper post-fall assessment, and no new interventions were implemented to prevent Edith Adkins from continuing to sustain falls. This was her eleventh documented fall while under Englewood Health and Rehab's care.

86. On or about October 5, 2023, screaming could be heard from Edith Adkins' room, and she was found once more on the floor in front of her wheelchair in the bathroom. This marked Edith Adkins' twelfth documented fall while under Englewood Health and Rehab's care. Despite her repeated falls while attempting to use the restroom

without assistance, Defendants again failed to conduct a proper post-fall assessment or implement new interventions to prevent further incidents.

87. On or about October 9, 2023, Edith Adkins was found lying on her back in front of the restroom. This was her thirteenth fall while under Englewood Health and Rehab's care. Defendants again failed to conduct a proper post-fall assessment or implement new interventions, despite a clear pattern of Ms. Adkins sustaining falls while attempting to use the restroom unassisted.

88. Just a couple of days later, on or about October 11, 2023, Edith Adkins was found on her back on the floor next to her bed after sliding out of her wheelchair. Defendants failed once again to conduct a proper post-fall assessment or take sufficient steps to prevent further incidents from occurring while under their care.

89. On or about October 20, 2023, Edith Adkins was found on the floor beside her bed after attempting to get into bed on her own. This marked her fifteenth fall while under Englewood Health and Rehab's care. Defendants again failed to conduct a proper post-fall assessment or implement new interventions.

90. On or about November 1, 2023, while in the common area, Edith Adkins became agitated and attempted to stand on her own but lost her balance. Despite knowing Ms. Adkins was distressed, staff walked away, leaving her unsupervised, which resulted in her sixteenth fall while under Englewood Health and Rehab's care. Defendants again neglected to conduct a proper post-fall assessment or implement any new interventions to address the ongoing fall risk.

91. On or about December 14, 2023, Edith Adkins fell to the floor, striking her leg on her roommate's bed and sustaining a skin tear to her right leg. This was her

seventeenth fall within approximately five months since her admission. Defendants again failed to conduct a proper post-fall assessment or implement new interventions.

92. On or about January 3, 2024, Edith Adkins sustained her eighteenth and final fall while under Englewood Health and Rehab's care. She was found on the floor with blood coming from the left side of her head.

93. Edith Adkins was transported to Miami Valley Hospital due to her head injury, where she remained until January 12, 2024.

94. Edith Adkins died on January 12, 2024. Her death certificate lists the cause of death as blunt force trauma to the head.

95. Edith Adkins endured significant mental and physical pain, suffering, and ultimately death as a direct and proximate result of Defendants' failure to provide adequate care, due to understaffing the facility, among other critical failures.

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

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

97. Edith Adkins depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

98. The Defendants had a duty to provide proper care and treatment to Edith Adkins and to avoid causing injury to Edith Adkins.

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

100. 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 Edith Adkins;

e. Choosing to not provide accurate, adequate, or timely information to Edith Adkins' family;

f. Choosing to provide inadequate supervision to prevent accidents and falls;

g. Choosing to violate orders relating to the care of Edith Adkins;

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

i. Failing to ensure the rights and safety of its residents, including Edith Adkins as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Edith Adkins while she was a resident of the Facility; and

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

101. These actions constituted a conscious disregard for Edith Adkins' 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 harm that could result from their willful, wanton, and/or reckless misconduct.

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

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

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

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

106. 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.

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

108. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, 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)**

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

110. Edith Adkins depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

111. The Defendants had a duty to provide proper care and treatment to Edith Adkins and to avoid causing injury to Edith Adkins.

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

113. 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 Edith Adkins;

e. Choosing to not provide accurate, adequate, or timely information to Edith Adkins' family;

f. Choosing to provide inadequate supervision to prevent accidents and falls;

g. Choosing to violate orders relating to the care of Edith Adkins;

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

i. Failing to ensure the rights and safety of its residents, including Edith Adkins, as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Edith Adkins while she was a resident of the Facility; and

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

114. Defendants, directly or through their employees or agents, violated Edith Adkins' 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; and

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

115. These violations are evidence of negligence and conscious disregard of Edith Adkins' rights and safety, and give rise to a statutory cause of action.

116. Edith Adkins 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.

117. These actions constituted a conscious disregard for Edith Adkins' 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.

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

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

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

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

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

123. 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.

124. As a direct and proximate result of the negligence / recklessness described above, Edith Adkins sustained injuries that caused her untimely and wrongful death.

125. Edith Adkins' 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.

126. 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)**

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

128. Defendants, directly or through their employees or agents Edith Adkins' 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; and

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

129. These violations are evidence of negligence and conscious disregard of Edith Adkins' rights and safety, and give rise to a statutory cause of action.

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

131. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, 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)**

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

133. Defendants 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 federal 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. inflate resident RUG levels to obtain excessive and unjustified payments from Medicare and Medicaid while not providing the care paid for with these taxpayer dollars;

e. not provide the level of care, by understaffing the facility, paid for by taxpayer dollars;

f. misrepresenting to Medicare the staffing level of the facility to increase their rating; and

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

134. This understanding constitutes a malicious combination to injure residents of the Facility, including Edith Adkins.

135. 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.

136. The conspiracy caused injury to Edith Adkins.

137. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, 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.

**FIFTH CAUSE OF ACTION**
**(FRAUD)**

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

139. Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Englewood Health and Rehab aka CT Ohio Englewood, LLC.

140. Not only did Defendants conceal this information, but they also publicly and privately represented that they provide exceptional services in an effort to induce the family of Edith Adkins and other potential customers to place their loved ones in their care and custody.

141. These inducements were made falsely, with knowledge of their falsity, or with such utter disregard and recklessness as to whether they were true or false that knowledge may be inferred with the intent of misleading Edith Adkins' family and other potential customers into placing their loved ones in the care and custody of Defendants.

142. Edith Adkins' family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide to residents.

143. The result of these inducements and concealments was that Edith Adkins' family, and the family of numerous other residents, allowed their loved one to be placed in Defendants' facility.

144. As a direct and proximate result of Defendants' actions, representations, and concealments, Edith Adkins suffered conscious pain and suffering and death.

145. As a direct and proximate result of Defendants' action, representations, and concealments, Edith Adkins' next-of-kin have experienced harms and losses as a result of their death, including those damages set forth in Ohio's wrongful death statute, Ohio Revised Code section 2125.02 *et seq*.

146. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($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.

**A TRIAL BY JURY IS HEREBY DEMANDED**

Respectfully Submitted,

*/s/ Michael A. Hill*

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***Counsel for Plaintiff***

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**AFFIDAVIT OF MERIT**

Affiant **Brianna M. de Oro, MSN, RN, WCC, CLCN** 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 received my Master of Science in Nursing (MSN) in Leadership and Management from Western Governor's University and am currently the owner of Lakeview Legal Nurse Consulting, LLC. As an RN, I have worked as a staff nurse at Valley Hospital and Providence Sacred Heart Hospital in Spokane, Washington. I have held the clinical positions of Charge Nurse, Resident Care Manager, Director of Nursing, and Regional Nurse Consultant for Avalon Healthcare. Currently, I continue my clinical application as a remote RN for Foundation Health Services and as Regional Director of Clinical Services for Life Care Centers of America where I oversee 5 skilled nursing facilities to ensure successful clinical systems and quality of care to the residents we serve. I have obtained certifications in Nursing Home Infection Prevention through the CDC, Wound Care (WCC), and as a Legal Nurse Consultant (CLNC). I hold an active RN License in all 41 states and 1 territory (Nursing Compact Act).

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 Edith Adkins while a resident of CT Ohio Englewood Health and Rehab in Englewood, Ohio between July 2023 and January 2024.

4. I have reviewed all medical records reasonably available to the Estate of Edith Adkins, Deceased, including the death certificate, concerning the allegations contained in the complaint.

***5.*** To a reasonable degree of nursing probability, the Defendants CT Ohio Englewood Health and Rehab, LLC dba Englewood Health and Rehab, Flyer 4 Operations Holdings, LLC, ACH Hashem Holdings, LLC, Flyer 4 Holdings, LLC, FTK Flyer OH, LLC, NPNH1, LLC, SHS Keren, LLC, Englewood Property Landlord, LLC aka Englewood Property LLC, Naftali Zanziper, Simcha Hyman, and The Portopiccolo Group, LLC breached the standard of care that applied to Edith Adkins while she was a resident causing violations of her residents rights, 18 documented falls including the final fall resulting in her a subdural hematoma (brain bleed), amongst other violations.

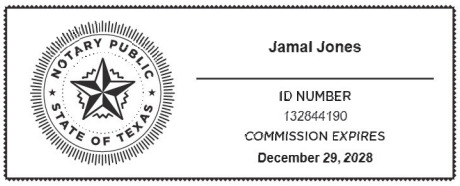
***FURTHER AFFIANT SAYETH NAUGHT.***

Brianna De Oro

Brianna M. de Oro, MSN, RN, WCC, CLCN

State of Texas; County of Harris

SWORN TO BEFORE ME and subscribed in my presence this 19th day of December, 2024.




Jamal Jones 12/29/2028

NOTARY PUBLIC

Electronically signed and notarized online using the Proof platform.