

NAILAH K. BYRD
CUYAHOGA COUNTY CLERK OF COURTS
1200 Ontario Street
Cleveland, Ohio 44113

Court of Common Pleas

New Case Electronically Filed: COMPLAINT
November 12, 2025 10:19

By: MATTHEW A. MOONEY 0093332

Confirmation Nbr. 3671900

ESTATE OF ROGER BRUCE ANDREWS, DECEASED — CV 25 128011

vs.

Judge: CARL J. MAZZONE

AVENUE AT AURORA CARE & REHABILITATION, ET AL

Pages Filed: 28

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

ESTATE OF ROGER BRUCE ANDREWS, DECEASED Through Estate Representative Roger Bruce Andrews, Jr. c/o Michael Hill Trial Law 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. AVENUE AT AURORA CARE & REHABILITATION CENTER AKA PROGRESSIVE AURORA, LLC 425 S. Chillicothe Road Aurora, Ohio 44202 Also Serve c/o Registered Agent: 350 Corporate Circle, Inc. 31105 Bainbridge Road, Suite 3 Solon, Ohio 44139 and PROGRESSIVE QUALITY CARE, INC. c/o Registered Agent: DHP Landerbrook, Inc. 6105 Parkland Boulevard, Suite 100 Cleveland, Ohio 44124 and PROGRESSIVE AURORA REAL ESTATE, LLC c/o Registered Agent: DHP Landerbrook, Inc. 6105 Parkland Boulevard, Suite 100 Cleveland, Ohio 44124 Defendants.	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

Electronically Filed 11/12/2025 10:19 / / CV 25 128011 / Confirmation Nbr. 3671900 / CLAJB

Plaintiff, the Estate of Roger Andrews, Deceased, through Estate Representative Roger Bruce Andrews, Jr., for this Complaint against the above-named Defendants, states and avers upon information and belief:

INTRODUCTION

1. This action involves multiple claims (medical negligence, wrongful death, Resident's Rights Law violations, civil conspiracy, and fraud) involving Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC's ("Facility's") inadequate care of Roger Andrews and the corporate control of the facility leading to such inadequate care that led to Roger Andrews's untimely and wrongful death on January 19, 2025.

2. Roger Andrews lived independently in an apartment until December 30, 2024, when he lost his balance and fell at home. Mr. Andrews was admitted to Hillcrest Hospital for evaluation and discharged directly to the Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC, on January 3, 2025, for short-term rehabilitation to improve his strength with the intention that he would return to his independent lifestyle.

3. Upon his admission, Avenue at Aurora Care & Rehabilitation Center was aware that Roger Andrews was at high risk of falling. The sole reason he was admitted to the facility was to increase his strength to prevent a fall like the one he had at home days earlier.

Nursing: Fall Risk Assessment - V 1

Resident: Andrews, Roger (25006)	**Effective Date:** 01/03/2025 15:03	**Location:** North 118-B CAT1 1
Admission: 01/03/2025	**Score:** 20	**Category:** At risk
Physician: Zivic, Miodrag	**Type:** Admission	**Facility:** Avenue at Aurora

Upon his admission, Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC, performed a Fall Risk Assessment and identified Roger Andrews "at risk" of falls, with a fall risk score of 20.

Created Date: 01/03/2025 23:45

Effective Date: 01/03/2025 23:45 Type: Nursing

Note Text : Resident admitted to facility at 1915 to RM#118 from Hillcrest hospital via MMT Ambulance service. Admitting DX: S/p fall. Resident acclimated to room, call light, meal times and therapy services. Resident is alert and oriented x3 and able to make needs known. Resident is a status Full Code. Resident transfers with a two person assist and is on a heart healthy diet. Dr. zivic made aware and verified all meds.

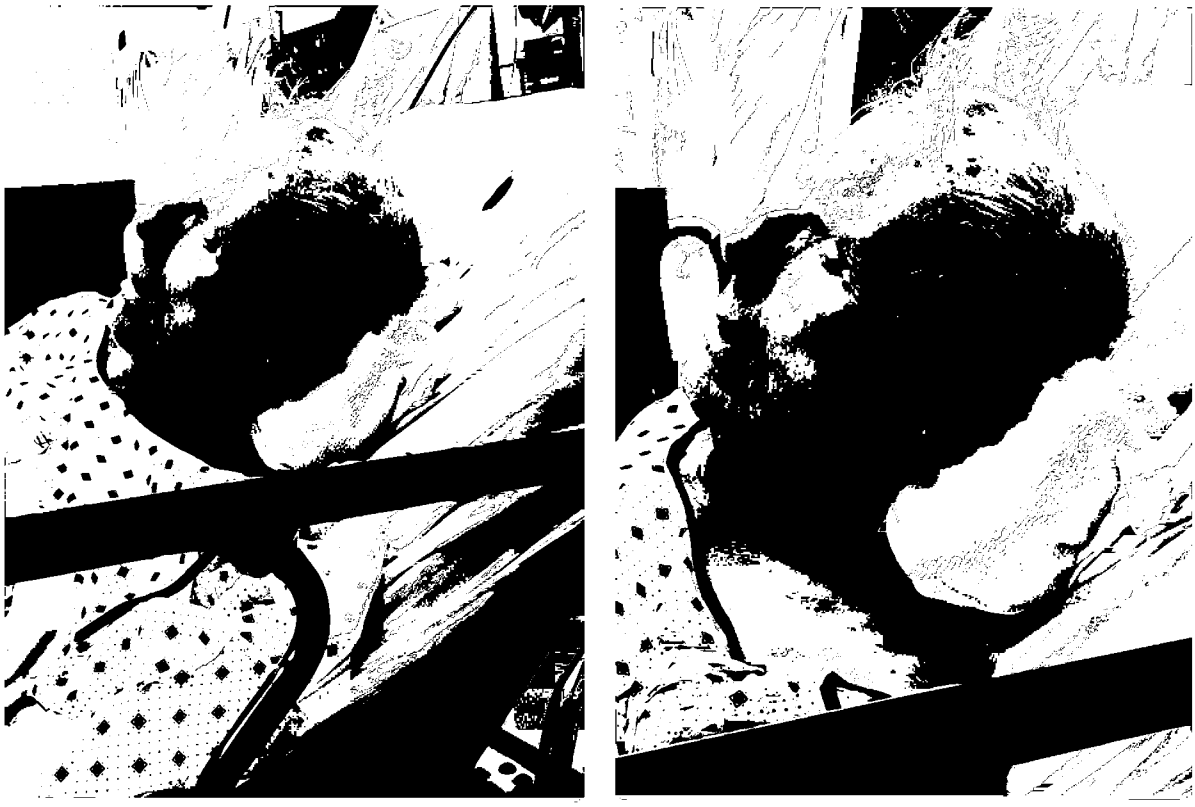
Author:Robbin Fletcher Nursing - LPN [e-SIGNED]

Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC, notes reflect that Rogers Andrews was admitted after a recent fall and required a two person assist when being transferred.

4. On January 6, 2025, just days after being admitted to the facility, Roger fell in his room suffering a 5.5 cm x 4.0 cm open wound to his upper back. Avenue at Aurora Care & Rehabilitation Center did not send Roger for medical treatment. Roger was unsupervised and not being monitored when he fell. A second fall risk assessment was completed, which reflected an increased fall risk score of 21.

5. On January 7, 2025, Roger fell again, this time striking his head. Mr. Andrews was sent to the emergency room where he was diagnosed with a hematoma on his head. Roger was unsupervised and not being monitored when he fell. Roger returned

to Avenue at Aurora Care & Rehabilitation Center with an order for ice packs every 15 minutes and a lidocaine patch for pain.



On January 7, 2025, Roger Andrews was sent to the emergency room where he was diagnosed with a hematoma on his head after falling a second time within days of being at the Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

6. On January 9, 2025, Avenue at Aurora Care & Rehabilitation Center's interdisciplinary team determined that Roger required 1:1 supervision to prevent falls, meaning that a nurse, aide, or other staff member needed to be with him at all times.

7. On January 11, 2025, an Avenue at Aurora aka Progressive Aurora, LLC nurse left Roger Andrews unattended in the common area of the facility. The Facility's staff left Roger Andrews sitting alone in his wheelchair longer than he anticipated after eating breakfast. Roger Andrews began to lean to his right, then fell for **the third time in five days**, falling face first out of the chair striking the front of his head, causing a large, bleeding laceration. The nurse was only alerted to the fall when she heard Roger screaming in pain. Roger was unsupervised and not being monitored when he fell.

Created Date: 01/11/2025 10:35

Effective Date: 01/11/2025 10:35 Type: Nursing

Note Text : at approximately 945 this nurse observed resident relaxing in common area. nurse stepped away for a few minutes, nurse heard resident shouting and came running to assess, upon return nurse observed resident lying on right side with right arm under head and actively bleeding from a laceration to right front on head/hairline. nurse called for help, applied pressure to the wound, completed an assessment on resident. directed an aide to contact 911. resident remained conscious and continued to talk and conversate with nurses and aides. when asked what he was trying to do, resident stated "I don't know" resident education provided. resident neuro checks started and WNL, full ROM, no other injuries observed. son bruce notified, manager on call notified, MD notified, resident sent to CC Twinsburg ER for evaluation. resident left facility at 948 AM via 911. report called to ER nurse. resident had on gripper socks. education provided. resident VS 94/60 62HR 17RR 3/10P 93O2

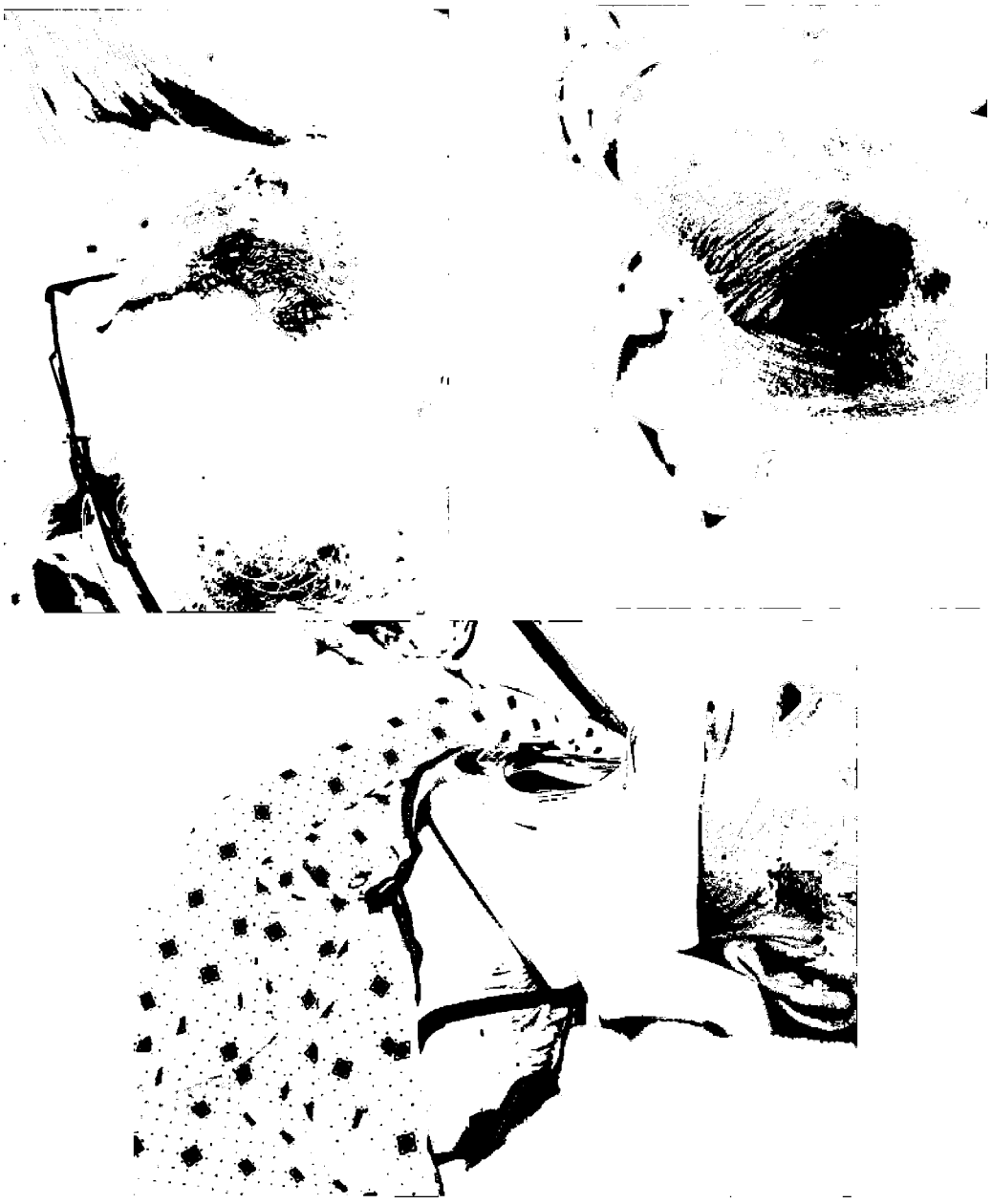
History

Patient presents with:
Fall
Head Injury
Shoulder Injury: Right

93-year-old male with history of hypertension, hyperlipidemia, diabetes, neurogenic bladder presents to the ER by EMS for evaluation of a fall. Patient recently transferred to Avenue over or skilled nursing facility for rehab after multiple falls in the last few weeks. Today he states that he was sitting in his wheelchair after breakfast. They removed his breakfast tray but had left him sitting there for longer than he anticipated so he was leaning in his chair to the right and began to fall forward. States he fell out of a chair and struck the right side of his head. No LOC. He was helped up immediately by staff though the fall was not directly witnessed. He is complaining primarily of right shoulder pain and right sided head pain. Patient is not anticoagulated. Daughter is at bedside.

On January 11, 2025, Roger Andrews fell for the third time in five days after being left unsupervised in the common area of the facility, striking the front of his head, causing a large, bleeding laceration. The Emergency Dept. notes reflect the facility left him unattended longer than expected – contrary to the claim of the facility that the nurse "stepped away for a few minutes."

8. Roger was taken to the Cleveland Clinic Twinsburg Hospital where he was diagnosed with head and elbow lacerations, a brain bleed, and a broken neck. Roger was then transferred to Cleveland Clinic Hillcrest Hospital, where he was under the care of the trauma service.



Roger Andrews suffered severe lacerations on his right elbow and the right side of his head, as well as a broken neck and brain bleeding as a result of his January 11, 2025 fall at Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

9. Roger suffered a continuous decline following the fall that occurred on January 11, 2025. His level of consciousness decreased; he was no longer communicative; he exhibited pain symptoms; and he stopped eating.

10. By January 18, 2025, Roger Andrews was almost unarousable. The decision was made to move Roger to hospice service.

11. On January 19, 2025, at 5:12 p.m., Roger Andrews died.

12. Given the traumatic nature of Roger's death, Hillcrest Hospital alerted the Cuyahoga County Medical Examiner's Office. The Cuyahoga County Medical Examiner's Office took jurisdiction over Roger Andrews' body. After examination, the Medical Examiner's Office determined that Roger died from "blunt impact of head and neck with subdural hemorrhage and cervical spine fracture." The manner of death was ruled accidental, meaning it was not the result of any natural disease process.

28. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent blue or black ink.		Approximate Interval: Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BLUNT IMPACT TO HEAD AND NECK WITH SUBDURAL HEMORRHAGE AND CERVICAL SPINE FRACTURE.	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause.	b. Due to (or as Consequence of)	
Enter Underlying Cause (Disease or injury that initiated events resulting in a death)	c. Due to (or as Consequence of)	
	d. Due to (or as Consequence of)	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	29a. Was An Autopsy Performed?	29b. Were Autopsy Findings Available Prior To Completion Of Cause of Death?
ISCHEMIC HEART DISEASE.	NO	NOT APPLICABLE

30. Did Tobacco Use Contribute to Death?	31. If Female, Pregnancy Status	32. Manner of Death
UNKNOWN	NOT APPLICABLE.	ACCIDENT

33a. Date of Injury (Mo/Day/Year)	33b. Time of Injury	33c. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)	33d. Injury at Work?
UNKNOWN		UNKNOWN	NO

33e. Location of Injury (Street and Number or Rural Route Number, City or Town, State)
UNKNOWN LOCATION(S), UNKNOWN, OHIO

33f. Describe How Injury Occurred:	33g. If Transportation Injury, Specify:
HISTORY OF FALLS.	

The official cause of death as determined by Cuyahoga County Medical Examiner's Office was blunt impact to head and neck with subdural hemorrhage and cervical spine fracture and the manner of death was accident.

13. Plaintiff requests a trial by jury.

14. An Affidavit of Merit is attached.

15. Plaintiff brings this action for compensation for the harms and losses sustained as the result of the negligence, 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

16. Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, 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 Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

17. Progressive Quality Care, Inc. 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 Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

18. Progressive Aurora Real Estate, 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 Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

19. The Defendants employ, manage, and direct the care and service providers who were responsible for Roger Andrews's care, treatment, and safety at Avenue at Aurora Care & Rehabilitation Center while he 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 Roger Andrews's injuries and untimely and wrongful death on January 19, 2025.

20. 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.

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

22. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Avenue at Aurora Care & Rehabilitation Center directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

23. The Defendants employ the care providers who were responsible for ensuring Roger Andrews' care and safety.

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

25. Roger Andrews and his 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 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.

28. Venue is proper in Cuyahoga 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; or (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, violations of federal and Ohio nursing home regulations regarding staffing levels and universal nursing home industry standards.

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

33. 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.

34. As a 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 Roger Andrews, meaning they are responsible for

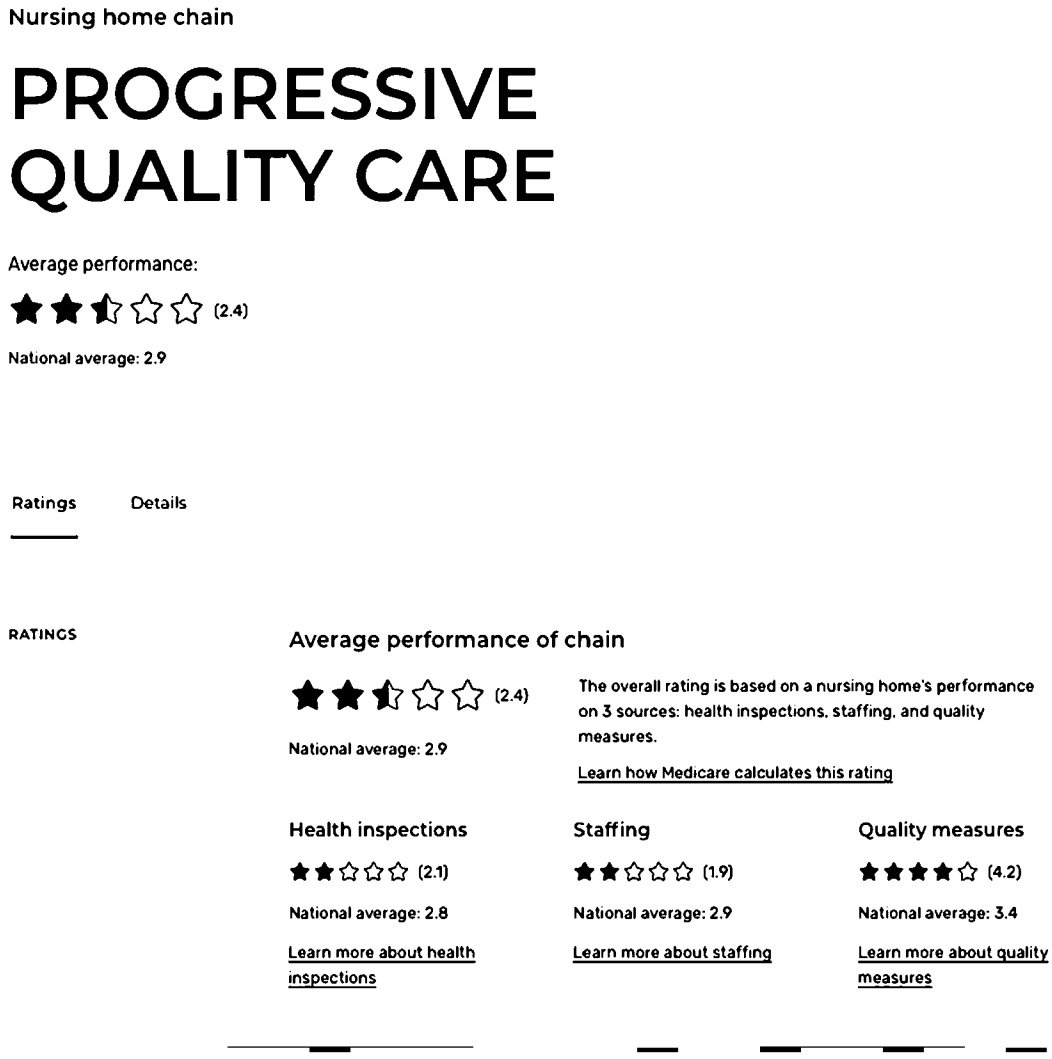
the foreseeable harm that results from careless decisions while voluntarily exercising that control.

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 Roger Andrews.

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

37. The lack of staffing resulted in delayed call light response, inadequate monitoring and supervision, deficient fall prevention measures, and no nurse present when Roger Andrews fell on January 11, 2025 and suffering fatal neck fractures and brain bleed—despite Defendants' knowledge that Roger needed someone with him at all times to prevent him from falling.

38. The Defendants' understaffing practices are practiced throughout their facilities across Northeast Ohio where they exercise operational and managerial control over, resulting in an average 2.4-star, or "below average," rating for all Defendants' facilities overall, and a 1.9-star, or "below average," rating for staffing.



According to the Centers for Medicare and Medicaid, Progress Quality Care earned a 2.4 -star, or "below average," overall rating, and a 1.9-star, or "below average," staffing rating. This data was taken directly from medicare.gov on October 23, 2025.

39. 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. Avenue at Broadview Heights Care & Rehabilitation Center
1201 Akins Road, Broadview Heights, Ohio 44147

b. Avenue at Brooklyn Care & Rehabilitation Center
4700 Idlewood Drive, Brooklyn, Ohio 44144

c. Avenue at Lyndhurst Care & Rehabilitation Center
5442 Rae Road, Lyndhurst, Ohio 44124
d. Avenue at North Ridgeville Care & Rehabilitation Center
6200 Lear Nagle Road, North Ridgeville, Ohio 44039

e. Avenue at Macedonia Care & Rehabilitation Center
9730 Valley View Road, Macedonia, Ohio 44056

f. Parma Care Center
5553 Broadview Road, Parma, Ohio 44134

g. Avenue at Strongsville Care & Rehabilitation Center
18936 Pearl Road, Strongsville, Ohio 44136

h. Avenue at Medina Care & Rehabilitation Center
699 East Smith Road, Medina, Ohio 44256

i. Avenue at Warrensville Care & Rehabilitation Center
4120 Interchange Corporate Center Road, Warrensville Heights, Ohio 44128

j. Avenue at Wooster Care & Rehabilitation Center
1700 E. Smithville Western Road, Wooster, Ohio 44691

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 PDPM Scores)

44. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Avenue at Aurora Care & Rehabilitation Center 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 Avenue at Aurora Care & Rehabilitation Center 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.

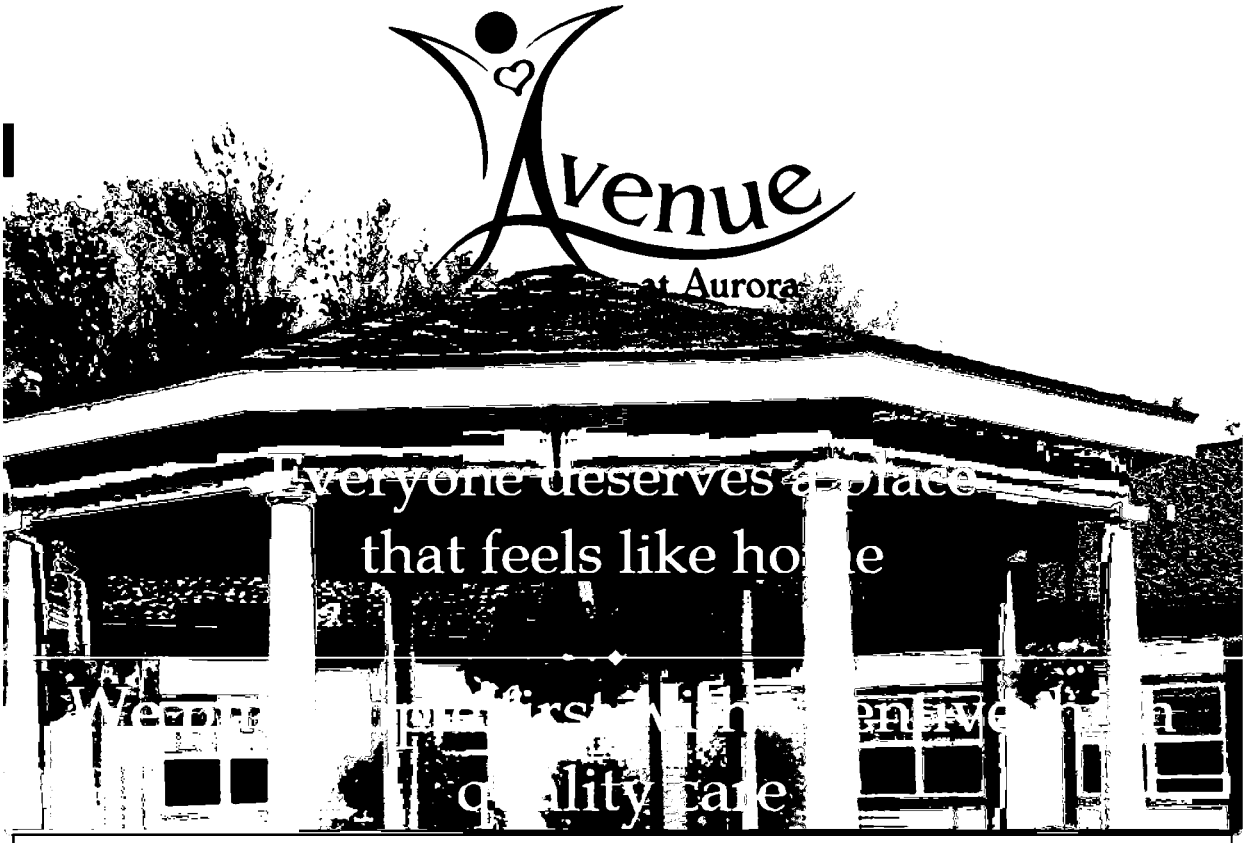
46. Based on this Minimum Data Set, each resident's individual care needs (called "acuity level") are assigned into a group signifying how much nursing or staff care the resident requires, called a Patient-Driven Payment Model score, or PDPM score. The PDPM score is calculated for physical therapy, occupational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

47. 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.

48. 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

49. 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.



The Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC, advertises that "Everyone deserves a place that feels like home," and that they "put people first with attentive, high quality care," to lead families and potential residents to believe that their loved one will be taken care of at a level that the facility cannot actually provide.

This data was taken directly from www.avenueataurora.com on October 27, 2025.

REDUCING RE-HOSPITALIZATIONS



Recovering from a recent hospital stay following an injury or illness can come with many challenges. Often times, a family member, based on their experiences caring for loved ones at home, believe that certain changes require hospitalization. However, while true for the elderly living at home, one of the advantages of having your loved one in our care is our ability to respond and manage virtually any need they have – now and in the future.

When hospitals discharge patients and recommend continuing the healing process at our facility, they do so with the trust that we can "take it from here". Our goal is to build off the progress our patients have made at the hospital and to get them back to their everyday lives as soon as possible. Thus, we have taken measures to improve our clinical capabilities and keep a watchful eye on your loved ones to avoid any unnecessary hospitalizations.

Additionally, our staff is uniquely trained to identify any changes in condition and to communicate that to the appropriate team member, ensuring your loved one receives the best quality care possible.

The Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC, advertises that it has a goal of reducing re-hospitalizations, directly targeting individuals like Roger Andrews and their families. The Facility claims that their "goal is to build off the progress our patients have made at the hospital to get them back to their everyday lives as soon as possible," and in doing so, "keep a watchful eye on your loved ones to avoid any unnecessary hospitalizations."

This data was taken directly from www.avenueataurora.com on October 27, 2025.

50. 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.

51. 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 Roger Andrews's Care

52. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Avenue at Aurora Care & Rehabilitation Center was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Roger Andrews during the period he was a resident at the facility.

53. Defendants engaged in a systemic practice to understaff Avenue at Aurora Care & Rehabilitation Center to maximize profits at the expense of its residents' care.

54. This lack of sufficient staff directly resulted in Roger Andrews not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to his injuries at Avenue at Aurora Care & Rehabilitation Center during the period he was a resident at the Facility.

Defendants' Negligence and Recklessness with Roger Andrews

55. Defendants accepted Roger Andrews as a nursing home resident for short-term rehabilitation on January 3, 2025.

56. Defendants agreed to accept Roger Andrews into their facility and provide care to him in exchange for monetary payment.

57. The Facility knew Roger Andrews had difficulty in walking and was a high fall risk as a result when it accepted him into their care upon admission.

58. Roger Andrews was admitted to Avenue at Aurora Care & Rehabilitation Center on January 3, 2025 for short term rehabilitation to improve his strength after a fall at home. Roger Andrews would fall three times in the next eight days.

59. On January 6, 2025, Roger Andrews was left was unsupervised when he fell in his room, suffering a 5.5 cm x 4.0 cm open wound to his upper back.

60. On January 7, 2025, Roger Andrews was left unsupervised and fell again, this time striking his head and developing a hematoma on his head.

61. On January 11, 2025, Roger Andrews fell a third time while unsupervised in the facility common area, striking the front of his head, causing a large, bleeding laceration. Roger Andrews was subsequently diagnosed with a brain bleed and a broken neck.

62. Roger Andrews suffered a continuous decline following his third fall on January 11, 2025.

63. Roger Andrews died on January 19, 2025. The cause of death listed on his death certificate is "blunt impact of head and neck with subdural hemorrhage and cervical spine fracture."

64. Roger Andrews 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)

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

66. Roger Andrews depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

67. The Defendants had a duty to provide proper care and treatment to Roger Andrews and to avoid causing injury to Roger Andrews.

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

69. 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 Roger Andrews;

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

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

g. Choosing to violate orders relating to care of Roger Andrews;

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

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

j. Choosing not to provide appropriate care to Roger Andrews while he was a resident of the Facility; and

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

70. These actions constituted a conscious disregard for Roger Andrews'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.

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

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

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

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

75. 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.

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

77. 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
(NURSING HOME RESIDENT RIGHTS VIOLATION R.C. 3721.13)

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

79. Defendants, directly or through their employees or agents, violated Roger Andrews'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 Roger Andrews's rights and safety, and give rise to a statutory cause of action.

81. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Roger Andrews's conscious pain, suffering, and disability, and other harms and losses including death.

82. WHEREFORE, Plaintiffs demand 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.

THIRD CAUSE OF ACTION
(WRONGFUL DEATH)

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

84. As a direct and proximate result of the negligence / recklessness described above, Roger Andrews sustained injuries that caused his untimely and wrongful death.

85. Roger Andrews'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.

86. 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.

FOURTH CAUSE OF ACTION
(CIVIL CONSPIRACY)

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

88. 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 PDPM 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.

89. This understanding constitutes a malicious combination to injure residents of the Facility, including Roger Andrews.

90. 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.

91. The conspiracy caused injury to Roger Andrews.

92. WHEREFORE, Plaintiffs demand 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)

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

94. Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Avenue at Aurora Care & Rehabilitation Center aka Progressive Aurora, LLC.

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

96. 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 Roger Andrews's family and other potential customers into placing their loved ones in the care and custody of Defendants.

97. Roger Andrews's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

98. The result of these inducements and concealments was that Roger Andrews's family, and the family of numerous other residents, allowed their loved one to be placed in Defendants' facility.

99. As a direct and proximate result of Defendants' actions, representations, and concealments, Roger Andrews suffered conscious pain and suffering and death.

100. As a direct and proximate result of Defendants' action, representations, and concealments, Roger Andrews's 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.*

101. 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

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 Roger Andrews while a resident of Avenue at Aurora Care and Rehabilitation Center aka Progressive Aurora, LLC, Progressive Quality Care, Inc., and Progressive Aurora Real Estate, LLC.

4. I have reviewed all medical records reasonably available to Plaintiff, Estate of Roger Andrews, Deceased concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Avenue at Aurora Care and Rehabilitation Center aka Progressive Aurora, LLC, Progressive Quality Care, Inc., and Progressive Aurora Real Estate, LLC, breached the standard of care and the breach caused Roger Andrew's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

Kapil Gulati
KAPIL GULATI, MD

SWORN TO BEFORE ME and subscribed in my presence this 7th day of ~~October~~ November 2025.

NOTARY PUBLIC
Beth Drost
My commission has no expiration date pursuant to RC§ 147.03

Electronically Filed 11/12/2025 10:19 / / CV 25 128011 / Confirmation Nbr. 3671900 / CLAJB