

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

Court of Common Pleas

New Case Electronically Filed: COMPLAINT
December 31, 2025 11:03

By: MATTHEW A. MOONEY 0093332

Confirmation Nbr. 3715343

ESTATE OF CHARLES BRUSH, DECEASED

CV 25 130431

vs.

Judge: KEVIN J. KELLEY

AVENUE AT BROADVIEW HEIGHTS CARE & REHABILI, ET AL

Pages Filed: 33

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

ESTATE OF CHARLES BRUSH, DECEASED Through Estate Representative Nicholas D. Laudato c/o Michael Hill Trial Law 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. AVENUE AT BROADVIEW HEIGHTS CARE & REHABILITATION CENTER AKA PROGRESSIVE BROADVIEW HEIGHTS, LLC 1201 Akins Road Broadview Heights, Ohio 44147 Also Serve c/o Registered Agent: DHP Landerbrook, Inc. 6105 Parkland Boulevard, Suite 100 Cleveland, Ohio 44124 and PROGRESSIVE QUALITY CARE, INC. c/o Registered Agent: DHP Landerbrook, Inc. 6105 Parkland Boulevard, Suite 100 Cleveland, Ohio 44124 and PROGRESSIVE BROADVIEW HEIGHTS REAL ESTATE, LLC c/o Registered Agent: Eitan Flank 5553 Broadview Road Parma, Ohio 44134 Defendants.	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

Electronically Filed 12/31/2025 11:03 / / CV 25 130431 / Confirmation Nbr. 3715343 / CLAJB

Plaintiff, the Estate of Charles Brush, Deceased, through Estate Representative Nicholas D. Laudato, 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 Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC's ("Facility's") inadequate care of Charles Brush and the corporate control of the facility leading to such inadequate care that led to Charles Brush's untimely and wrongful death on March 26, 2025.

2. Charles Brush became a resident of the Avenue at Broadview Heights Care & Rehabilitation Center on January 29, 2024.

3. On February 13, 2025, at approximately 9:26 a.m., Charles Brush left a voicemail for his daughter, Jennifer Brush, who lives in Colorado. In this voicemail, Charles Brush expressed he had been confined to his room with his door sealed off without explanation since the previous day. Mr. Brush reported that he had not received any food on February 12, 2025, and had still not eaten as of the time of his voicemail message.

4. In response to her father's voicemail, Jennifer Brush called the Avenue at Broadview Heights Care & Rehabilitation Center to inquire why her father was being confined to his room. A nurse informed Jennifer Brush that Charles Brush had a staph infection, that his room was filthy, and that he was being isolated to prevent the spread of the infection. Jennifer Brush requested a call from the Director of Nursing.

5. Later that day, Ms. Brush spoke with the Director of Nursing. The Director of Nursing stated that the prior nurse was mistaken when she stated Charles had a staph infection. The Director of Nursing stated that it was actually a contagious candida auris infection (a fungal infection caused by an overgrowth of yeast) that she had found documented in his chart from a year prior in March 2024.

6. Jennifer Brush raised several questions to the Director of Nursing, including: Why was she never told about an infection a year earlier when it was discovered? Why would an infection from a year earlier now be showing symptoms? Where on the body was the infection? Was he treated for the infection in the last year? Had he been retested for this infection? Was he getting treatment now and, if so, what treatment was he receiving and how long would the treatment last? When was he going to be retested? Why was he being isolated now when he had been in the library, used group computers, spent time in common areas, and participated in numerous activities throughout the last year? Rather than answer Jennifer Brush's questions, the Director of Nursing hung up on Jennifer.

Created Date: 04/02/2024 18:16

Effective Date: 04/02/2024 18:08 Type: Nursing

Note Text : resident arrived by stretcher, 3 staff members transferred resident in bed. some clothing items with resident, shirt and pants. BP 120/70 HR 88 RR 18 OX 99 RA temp 98.3. 0/10 pain, resident refused weight and partial skin assessment. Picc line removed, inreport from hospital, nurse stated resident has candida and MD stated to monitor for fever. Bandages are not to be removed just reinforce if need. DON, supervisor, NP notified. meds verified.

Author:TiarriaMc Nursing - LPN [e-SIGNED]

Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC progress notes indicate staff was aware of Mr. Brush's Candida auris infection when he was transported back to the facility from University Hospitals on April 2, 2024.

7. Jennifer Brush received a call back that same day from a nurse, who informed her that Charles Brush had undefined mental and social issues. She also stated that Charles Brush was "dirty" and picked at his skin. Confused at the offering of this information, Jennifer Brush asked how this correlated to her father being confined to his room without food. In response to the "dirty" remark, Jennifer Brush also asked why her father was not bathed. Rather than answering her questions, the Avenue at Broadview's nurse abruptly ended the phone call by hanging up on Jennifer.

8. On February 14, 2025, the following day, Jennifer called the Avenue at Broadview Heights and attempted to speak with the Director of Nursing, who was unavailable. Jennifer left a message requesting a return call. The Director of Nursing, however, did not return her call. Jennifer called and left a message for the Ohio Ombudsman.

9. On February 15, 2025, Jennifer Brush received a call from a nurse at the Avenue at Broadview Heights Care & Rehabilitation Center informing her that Charles Brush had fallen while attempting to use the restroom. The nurses stated that Charles was attempting to use the restroom but the Avenue at Broadview had sealed the bathroom. Charles fell while waiting for the Avenue at Broadview's staff to open the door and allow him to use the restroom.

10. While on this call, Jennifer asked if her father had been tested for either staph or candida and insisted that he be tested for both. The nurse informed her that he had not been tested at that point. Jennifer reminded the nurse that as her father's healthcare power of attorney, she was requesting a Zoom call with Charles Brush's doctors to discuss the plan for his treatment moving forward.

11. On February 16, 2025, Jennifer Brush purchased a Netflix account for her father to help occupy him while he was confined in his room.

12. On February 17, 2025, Jennifer Brush received a call from her father and noticed that he was beginning to cognitively decline. One significant indicator was Charles Brush's inability to write down the Netflix username and password after trying to do so for hours. This type of behavior was very unlike him and was a significant departure from his baseline mental status.

13. During this same phone call, Charles Brush informed his daughter that the staff had finally tested him for the Candida auris infection, and that he would receive his results later in the day. He also indicated that there was blood in his urine. After the call with her father, Jennifer Brush called the Avenue at Broadview Heights Care & Rehabilitation Center to request a urine test.

14. On February 18, 2025, Charles Brush's other daughter, Heather Brush, stopped by the facility to conduct a welfare check on him. Charles' room was still sealed off from the rest of the facility. Mr. Brush's family requested a psychology evaluation as well as a call back from the director of nursing to discuss their concerns.

15. On February 19, 2025, Jennifer Brush received a call from her father informing her that he saw blood in his urine again. Jennifer Brush called the staff at the Avenue at Broadview Heights Care & Rehabilitation Center and requested that his urine be tested again.

16. Later that day, Jennifer Brush was informed by the Avenue at Broadview Heights Care & Rehabilitation Center that her father tested negative for any wound infections and was released from isolation. His condition, however, was not improving indicating that some other infectious process was at work.

17. On February 21, 2025, Jennifer Brush called Charles Brush multiple times in order to wish him a happy birthday. Each time she called, there was no answer. Jennifer Brush called and left a message with the nurse's station.

18. On the morning of February 22, 2025, Jennifer Brush received a call from a nurse informing her that she believed Charles Brush had a seizure as he was lethargic, his heart rate was low, and he was slurring his words. Jennifer Brush urgently requested the nurse to call 9-1-1. The nurse told Jennifer Brush that Charles Brush had a Do-Not-Resuscitate Comfort Care order on file. Still, Jennifer Brush demanded that the nurse call 9-1-1.

19. On February 22, 2025, the nurse called Jennifer Brush and informed her that paramedics arrived and were putting an IV in to attempt to restore Charles' blood sugar levels. Once the paramedics were able to regulate his levels, the Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, asked if Jennifer wanted her father to be sent to the emergency room, to which she insisted.

20. On February 22, 2025, Charles Brush was transferred to MetroHealth Brecksville Health Center by emergency medical services.

21. After Mr. Brush arrived at MetroHealth Brecksville Health Center, a nurse attempted to call the Avenue at Broadview Heights Care & Rehabilitation Center to get more information regarding Charles' condition, and was repeatedly hung up on.

ED Notes by Plas, Kevin, RN at 2/22/2025 1253

Attempted to call The Avenue Broadview Heights SNF for report, was hung up on multiple times and put on hold without speaking to any nursing staff.

Electronically signed by Plas, Kevin, RN at 2/22/2025 1:04 PM

Emergency Department notes from MetroHealth Brecksville Health Center show that a nurse attempted to contact the Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC to obtain information on Charles Brush, but was repeatedly hung up on.

22. Shortly thereafter, this same nurse contacted Jennifer Brush and informed her that Charles Brush arrived in a "severely neglected" condition. When paramedics arrived to aid Mr. Brush, his bedroom temperature was 52 degrees Fahrenheit, and his body temperature was a dangerously low temperature of 86.4 degrees Fahrenheit. In turn, his heart rate was also very low. The MetroHealth staff had Charles Brush covered with heated blankets in order to regulate his body temperature. The nurse confirmed Charles Brush would be transferred to the Intensive Care Unit of the MetroHealth Main Campus Medical Center.

23. Later that day, Jennifer Brush received a call from a social worker at MetroHealth Main Campus Medical Center. This social worker expressed concerns about the poor physical condition Charles arrived in from the Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC. The social worker pointed to several unsettling factors, including Charles Brush's low body temperature, his "dirty" appearance, his low blood sugar levels, and that he was septic upon admission.

The social worker advised Jennifer Brush against sending Charles Brush back to the Avenue at Broadview Heights Care & Rehabilitation Center.

24. At the hospital, Charles Brush was in septic shock, which is multiple organ failure due to a prolonged, untreated infection. Charles was hypoglycemic (low blood sugar), hypotensive (low blood pressure), bradycardia (low heart rate), hypothermic (low body temperature), in acute hypoxic respiratory failure (a life-threatening medical condition where the body does not receive enough oxygen due to an sudden impairment of lung function), in acute kidney injury (a sudden decline in kidney function), and suffering from metabolic encephalopathy (lack of brain functioning). Charles was diagnosed with septic shock secondary with evidence of a urinary tract infection and and multifocal pneumonia. Charles was admitted to the Medical Intensive Care Unit (ICU) for life saving medical treatment.

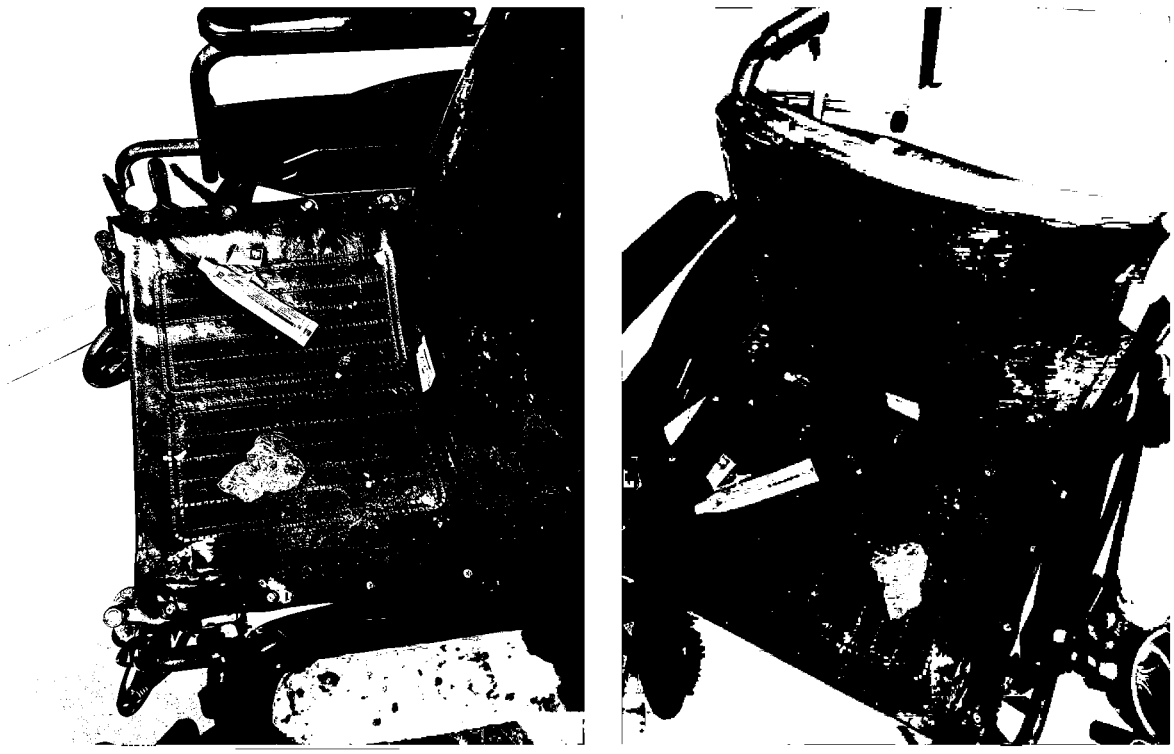
25. Charles remained hospitalized at MetroHealth Medical Center until March 7, 2025. Due to heroic interventions, MetroHealth's medical staff was able to stabilize Charles, but he never returned to his baseline status from prior to his isolation at the Avenue at Broadview Heights Care and Rehabilitation Center.

26. Charles was suffering from a condition called Post-Sepsis Syndrome (PSS), a condition that affects up to 50% of sepsis survivors that causes long-term physical and cognitive impairment, rehospitalizations, infections, and death. The mortality rate for an elderly person following hospital discharge after septic shock is estimated to be 60%.

27. On March 7, 2025, Charles Brush was transferred from MetroHealth Main Campus Medical Center to O'Neill Healthcare Fairview Park. At this point in time, Charles Brush was placed on a feeding tube and told that he would never eat solid foods again.

28. On March 10, 2025, Heather Brush returned to the Avenue at Broadview Heights Care & Rehabilitation Center to retrieve her father's belongings. Ms. Brush noted that the room was left exactly as it was when Charles Brush was taken to the hospital on February 22, 2025; the only difference now was that the room temperature had been regulated.

29. Once she entered the room, Heather Brush noted that there was a strong smell of urine in the air. There was urine on the bedroom and bathroom floors; feces on the seat of the wheelchair and chair; feces dripping along the legs of the wheelchair; feces on the side of the bed; urine on the blankets on the bed; blood and feces on a pair of prosthetic shoes; stale food in the drawers; soda spilled in the nightstand drawers; urine and blood in a urine container on the nightstand; and a filthy toothbrush (see photographs).



Sixteen days after Charles Brush was discharged from Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, Heather Brush returned to retrieve his belongings and found his wheelchair covered in feces.

Electronically Filed 12/31/2025 11:03 / / CV 25 130431 / Confirmation Nbr. 3715343 / CLAJB



Sixteen days after Charles Brush was discharged from Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, Heather Brush returned to retrieve his belongings and found his toothbrush in filthy condition and covered in blood.

30. On March 16, 2025, Charles Brush was transferred and admitted to Southwest General Health Center for urinary tract infection, sepsis, and pneumonia.

31. On March 21, 2025, Charles Brush was transferred to the Southwest General Health Center Hospice Department.

32. Charles Brush died on March 26, 2025. Charles Brush's official cause of death is listed as heart disease that was caused by pneumonia. Charles' decline and death is consistent with the expected outcome following his severe sepsis and multiple organ failure he developed at the Avenue at Broadview Heights Care and Rehabilitation Center. Post-Sepsis Syndrome patients like Charles Brush are at high risk of dying from cardiovascular complications because (1) the respiratory failure caused by septic shock places severe strain on the heart because the lungs are not able to provide sufficient oxygen causing long-term damage; (2) septic shock itself can directly cause injury to the heart as one of the organs primarily affected by sepsis; and (3) the reoccurrence of infection, like pneumonia, places further strain on an already damaged heart.

33. Plaintiff requests a trial by jury.

34. An Affidavit of Merit is attached.

35. 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

36. Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, 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 Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC.

37. 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 Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC.

38. Progressive Broadview Heights 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 Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC.

39. The Defendants employ, manage, and direct the care and service providers who were responsible for Charles Brush's care, treatment, and safety at Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC 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 Charles Brush's injuries and untimely and wrongful death on March 26, 2025.

40. 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.

41. 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.

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

VICARIOUS LIABILITY

43. The Defendants employ the care providers who were responsible for ensuring Charles Brush's care and safety.

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

45. Charles Brush and his family looked to the Defendants for care based upon their representations.

46. 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

47. 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.

48. 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; and (b) part of the claim for relief arose in that county.

COMMON FACTS

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

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

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

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

53. 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.

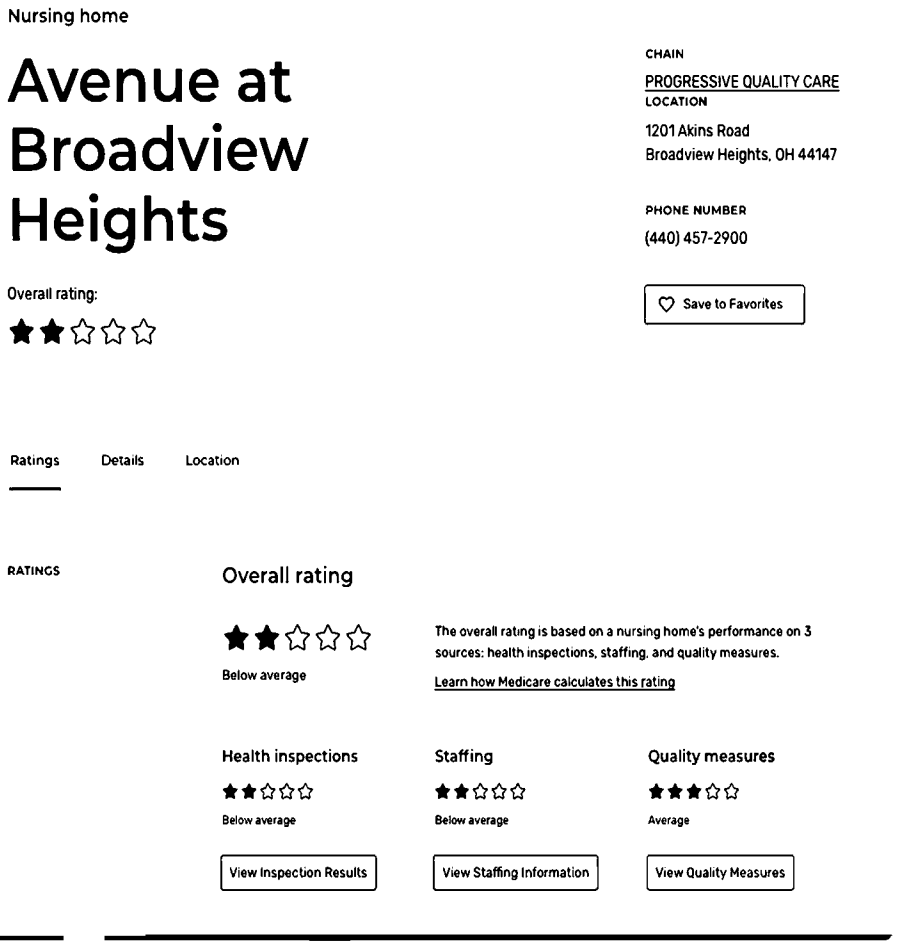
54. As the result of this control, the Defendants make decisions that affect the day-to-day care of residents of the Facility, such as the resources available for providing nursing staff and care to residents like Charles Brush, meaning they are responsible for the foreseeable harm that results from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

55. 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 Charles Brush.

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

57. 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.

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



According to the Centers for Medicare and Medicaid, Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, earned a 2-star, or "below average" overall and Staffing rating. This data was taken from medicare.gov on October 21, 2025.

59. The Defendants' understaffing practices are practiced throughout the facilities 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, Progressive 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 21, 2025.

60. 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 Aurora Care & Rehabilitation Center
425 South Chillicothe Road, Aurora, Ohio 44202

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

61. 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."

62. 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.

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

64. 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)

65. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC 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.

66. Nursing homes like Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, 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.

67. 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.

68. 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.

69. 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

70. 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 Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, 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.avenueatbroadviewheights.com on October 26, 2025.

71. 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.

72. 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 Charles Brush's Care

73. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Charles Brush during the period he was a resident at the facility.

74. Defendants engaged in a systemic practice to understaff Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, to maximize profits at the expense of its residents' care.

75. This lack of sufficient staff directly resulted in Charles Brush not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, during the period they were a resident at the Facility.

Defendants' Negligence and Recklessness with Charles Brush

76. Defendants accepted Charles Brush as a nursing home resident for long-term care on January 29, 2024.

77. Defendants agreed to accept Charles Brush into their facility and provide care to him in exchange for monetary payment.

78. The Facility knew Charles Brush suffered from difficulty in walking, muscle weakness, altered mental status and cognitive communication deficit, and obstructive and reflux uropathy when it accepted him into its care upon admission.

79. In March 2024, Charles Brush contracted Candida auris infection. Charles Brush's family was never informed or contacted in any capacity relative to this infection.

80. In February 2025, Charles Brush was isolated and sealed off in his room from the rest of the Facility due to the Candida auris infection that occurred a year prior, without explanation to him or his family.

81. Defendants neglected Charles Brush's basic needs by, amongst other things, failing to feed him, assisting him with using the restroom, monitoring the temperature of his room, and providing basic personal hygiene. Defendants' failures ultimately led to Mr. Brush being admitted to the hospital, where he was diagnosed with urosepsis and pneumonia and continued to decline over the course of several weeks until his eventual death.

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

FIRST CAUSE OF ACTION
(MEDICAL NEGLIGENCE / RECKLESSNESS)

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

84. Charles Brush depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

85. The Defendants had a duty to provide proper care and treatment to Charles Brush and to avoid causing injury to Charles Brush.

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

87. 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 Charles Brush;

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

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

g. Choosing to violate orders relating to care of Charles Brush;

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

j. Choosing not to provide appropriate care to Charles Brush while they were a resident of the Facility; and

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

88. These actions constituted a conscious disregard for Charles Brush'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.

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

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

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

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

93. 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.

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

95. 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)

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

97. Charles Brush 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 Charles Brush and to avoid causing injury to Charles Brush.

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

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

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

g. Choosing to violate orders relating to care of Charles Brush;

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

j. Choosing not to provide appropriate care to Charles Brush while they were a resident of the Facility; and

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

101. Defendants, directly or through their employees or agents, violated Charles Brush'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.

102. These violations are evidence of negligence and conscious disregard of Charles Brush's rights and safety, and give rise to a statutory cause of action.

103. Charles Brush 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.

104. These actions constituted a conscious disregard for Charles Brush'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.

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

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

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

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

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

110. 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.

111. As a direct and proximate result of the negligence / recklessness described above, Charles Brush sustained injuries that caused their untimely and wrongful death.

112. Charles Brush'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.

113. 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)

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

115. Defendants, directly or through their employees or agents, violated Charles Brush'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.

116. These violations are evidence of negligence and conscious disregard of Charles Brush's rights and safety, and give rise to a statutory cause of action.

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

118. 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.

FOURTH CAUSE OF ACTION
(CIVIL CONSPIRACY)

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

120. 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.

121. This understanding constitutes a malicious combination to injure residents of the Facility, including Charles Brush.

122. 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.

123. The conspiracy caused injury to Charles Brush.

124. 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)

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

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

127. 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 Charles Brush and other potential customers to place their loved ones in their care and custody.

128. 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 Charles Brush's family and other potential customers into placing their loved ones in the care and custody of Defendants.

129. Charles Brush's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

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

131. As a direct and proximate result of Defendants' actions, representations, and concealments, Charles Brush suffered conscious pain and suffering and death.

132. As a direct and proximate result of Defendants' action, representations, and concealments, Charles Brush'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*.

133. 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

MICHAEL A. HILL (0088130)
MATTHEW A. MOONEY (009332)
MOLLY B. MORRIS (0102510)
MICHAEL HILL TRIAL LAW
815 Superior Ave., Suite 623
Cleveland, Ohio 44114
(800) 659-2712 (o) | (216) 304-6630 (f)
michael.hill@protectseniors.com
matthew.mooney@protectseniors.com
molly.morris@protectseniors.com
www.protectseniors.com

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 Charles Brush while a resident of Avenue at Broadview Heights Care & Rehabilitation Center aka Progressive Broadview Heights, LLC, Progressive Quality Care, Inc., and Progressive Broadview Heights Real Estate, LLC.

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

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

FURTHER AFFIANT SAYETH NAUGHT.

KAPIL GULATI, MD

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

NOTARY PUBLIC
Brian DeWald
My commission has no expiration date pursuant to RC § 147.03

Electronically Filed 12/31/2025 11:03 / / CV 25 130431 / Confirmation Nbr. 3715343 / CLAJE