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IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO

ESTATE OF CRAIG LATCHAW, DECEASED Through Estate Representative James Latchaw c/o Michael Hill Trial Lawyers 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. INSPIRA HEALTH GROUP AKA JCTH HOLDINGS, INC. 48444 Bell School Road Calcutta, Ohio 43920 Also Serve c/o Registered Agent: Joseph Cilone, Jr. 48444 Bell School Road Calcutta, Ohio 43920 and CAPRICE HEALTH CARE CENTER AKA BLCC, INC. c/o Registered Agent: Joseph Cilone, Jr. 48444 Bell School Road Calcutta, Ohio 43920 and JCTH CAPRICE REAL ESTATE, LLC c/o Registered Agent: Joseph Cilone, Jr. 48444 Bell School Road Calcutta, Ohio 43920	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

Plaintiff, the Estate of Craig Latchaw, Deceased, through Estate Representative James Latchaw, for this Complaint against the above-named Defendant(s), states and avers upon information and belief:

2025 CV 03114

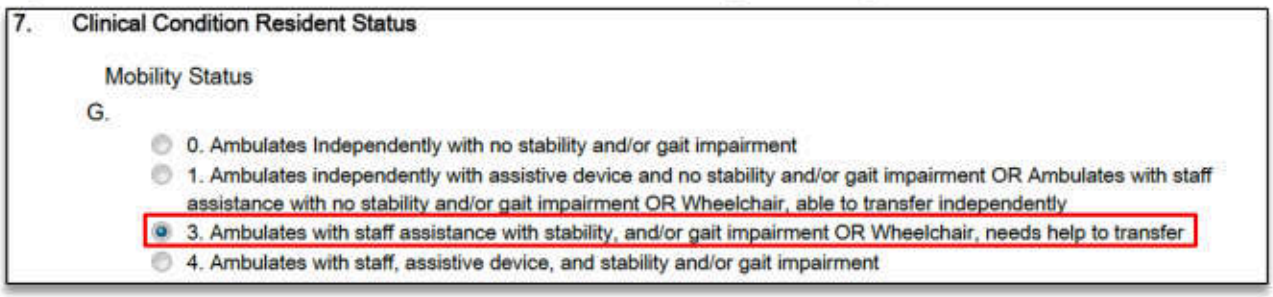
INTRODUCTION

1. This action involves multiple claims (medical negligence, recklessness, wrongful death, Resident's Rights Law violations, civil conspiracy, and fraud) involving Caprice Health Care Center aka BLCC, Inc.'s ("Facility's") inadequate care of Craig Latchaw and the corporate control of the facility leading to such inadequate care that led to Craig Latchaw's untimely and wrongful death on December 23, 2024.

2. Craig Latchaw was admitted to Caprice Health Care Center aka BLCC, Inc. on November 1, 2024 at 64 years old for short term care.

3. Upon his admission, Caprice Health Care Center conducted a fall risk evaluation of Craig Latchaw. This evaluation produces a score that ranges from 0 to 10 or higher. According to Caprice Health Care Center's own records, a score of 0 to 4 signifies that the resident is at a low risk for falls; a score of 5 to 9 signifies that the resident is at a moderate risk for falls; and a score of 10 or higher signifies the resident is at a high risk for falls. Should a resident be scored at a moderate or high risk for falls, his or her care plan must be marked as "potential for falls" with appropriate interventions to reduce the risk. Caprice Health Care Center found Craig Latchaw's fall risk score to be a 12 – meaning he was a high risk for falls.

4. In the fall risk evaluation, Caprice Health Care Center noted that Craig required staff assistance to ambulate, and that he required help to transfer.


7. Clinical Condition Resident Status

Mobility Status

G.

- 0. Ambulates Independently with no stability and/or gait impairment
- 1. Ambulates independently with assistive device and no stability and/or gait impairment OR Ambulates with staff assistance with no stability and/or gait impairment OR Wheelchair, able to transfer independently
- 3. Ambulates with staff assistance with stability, and/or gait impairment OR Wheelchair, needs help to transfer
- 4. Ambulates with staff, assistive device, and stability and/or gait impairment

Caprice Health Care Center noted Craig required staff assistance with ambulating.

5. On the same day, Caprice Health Care Center completed a physical therapy evaluation on Craig. During this evaluation, the therapist noted Craig felt unsteady when standing and walking, and had a fear of falling. The therapist also noted that Craig needed supervision or touching assistance with a majority of the most basic movements.

Fall Risk Assessment	
History of Falls	Has Patient fallen in past year? = No
Steadiness	Does Patient feel unsteady when standing? = Yes; Does Patient feel unsteady when walking? = Yes
Fear of Falling	Does Patient worry about falling? = Yes
Functional Mobility Assessment	
Bed Mobility	Roll left and right = Supervision or touching assistance
	Sit to lying = Supervision or touching assistance
	Lying to sitting on side of bed = Supervision or touching assistance
Dyspnea	Is patient Short of Breath when lying flat? = No
Transfers	Sit to stand = Supervision or touching assistance
	Chair/bed-to-chair transfer = Supervision or touching assistance
	Toilet transfer = Supervision or touching assistance
	Toilet Assessed = Standard Commode
	Car transfer = Not attempted due to environmental limitations
	Assistive Device During Transfers = FWW
Ambulation	Walk 10 feet = Supervision or touching assistance
	Walk 50 feet with Two Turns = Not attempted due to medical conditions or safety concerns
	Walk 150 feet = Not attempted due to medical conditions or safety concerns

On November 1, 2024, Caprice Health Care Center conducted a physical therapy evaluation and determined Craig feels unsteady when standing and walking, and he has a fear of falling.

6. On November 4, 2024, Craig's family met with the Caprice Health Care Center staff to discuss his care plan moving forward. Craig's family informed the staff that he was not the type of person to ask for help, emphasizing that he would need to be checked on regularly, regardless of whether he requested assistance.

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7. Caprice Health Care Center acknowledged this and agreed to intervene by anticipating and meeting his needs, amongst other efforts. At no point during this meeting did Caprice Health Care Center indicate it would not be able to properly take care of Craig Latchaw.

Focus	Goal	Interventions
• Craig has a communication problem related to tracheostomy in place. Date Initiated: 11/04/2024 Revision on: 11/04/2024	• Needs will be met in a timely manner through staff intervention through next review date Date Initiated: 11/04/2024 Revision on: 11/14/2024 Target Date: 02/19/2025	• anticipate and meet needs Date Initiated: 11/04/2024 • attempt to have resident imitate the activity you want them to perform Date Initiated: 11/04/2024 • Ensure/provide a safe environment, call light with in reach. Date Initiated: 11/04/2024 • explain all procedures prior to implementation Date Initiated: 11/04/2024 • monitor/document for physical/non-verbal indicators of discomfort or distress. Date Initiated: 11/04/2024 • observe for signs of frustration and anxiety. change activity if observed. Date Initiated: 11/04/2024 • OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, or use of computer as alternate communication for speech as needed Date Initiated: 11/04/2024 • refer to audiology for hearing consult as ordered Date Initiated: 11/04/2024 • Refer to speech therapy as indicated with MD order Date Initiated: 11/04/2024 • use simple commands, one word commands if possible Date Initiated: 11/04/2024

Craig Latchaw's care plan indicated he had issues with communicating. Caprice Health Care Center agreed to intervene by anticipating and meeting his needs, and monitoring for indicators of discomfort, distress, frustration and anxiety.

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8. During this meeting, Caprice Health Care Center also acknowledged Craig's tracheostomy tube and the need for staff to ensure it is suctioned and cleared so Craig may breathe properly.

Focus	Goal	Interventions	F
• Respiratory failure, tracheostomy in place, oxygen dependent. At risk for self-decannulation and/or disconnection from oxygen tubing; at risk for infection due to indwelling tracheostomy. Craig has been observed removing his oxygen via trach mask and stating he "does not need oxygen." 1:1 from nursing staff ineffective. Date Initiated: 11/04/2024 Revision on: 11/13/2024	• Will be at reduced risk for infection through the next review date related to tracheostomy. Date Initiated: 11/04/2024 Revision on: 11/14/2024 Target Date: 02/19/2025 • Will have adequate oxygenation, a patent airway and remain free of pulmonary infection and other complications through next review date. Date Initiated: 11/04/2024 Revision on: 11/14/2024 Target Date: 02/19/2025	• 35% ATM CONTINUOUSLY Date Initiated: 11/04/2024 • Administer medication as per MD orders. Date Initiated: 11/04/2024 • ALL RELATED TRACH,O2 SET UP WILL BE CHANGED PER RT. FYI Date Initiated: 11/21/2024 • Assess the need and suction as per MD order and PRN Date Initiated: 11/04/2024 • Avoid administering respiratory depression medications Date Initiated: 11/04/2024 • Change closed suction system per MD orders. Date Initiated: 11/04/2024 • Change trach ties per MD orders Date Initiated: 11/04/2024 • Elevate HOB as tolerated. Date Initiated: 11/04/2024 • Ensure that trach ties are secured at all times. Date Initiated: 11/04/2024 • Environmental cleaning and disinfecting as per infection control policy. Date Initiated: 11/04/2024 • Gloves and gown are to be utilized for residents whom Enhanced Barrier Precautions are indicated when performing any of the following high-contact resident care activities: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing Linens, Changing Briefs or assisting with toileting. Device care or use: tracheostomy. Date Initiated: 11/04/2024 • Maintain proper hand hygiene before and after contact with resident per policy. Date Initiated: 11/04/2024 • Monitor for cough, increased sputum production, dyspnea, and use of accessory muscles for respiratory effort. Date Initiated: 11/04/2024	

Craig Latchaw's care plan indicated Caprice Health Care Center would assess the need for Craig's tracheostomy tube to be suctioned.

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9. Most significantly, Caprice Health Care Center, once again, recognized that Craig was at a high-risk for falling. The Facility recognized multiple interventions necessary to reduce Craig's risk of falling.

Focus	Goal	Interventions
• Craig has potential risk for falls related to decreased physical mobility, oxygen/trach dependent, pain management use, and psychotropic medication use. Has been educated regarding wearing proper footwear during transfers & ambulation & utilize call light for assistance. Date Initiated: 11/04/2024 Revision on: 11/04/2024	• resident will be at reduced risk for injury r/t potential for falls through next review date Date Initiated: 11/04/2024 Revision on: 11/14/2024 Target Date: 02/19/2025	• NONSKID SOCKS ON AT ALL TIMES (WHEN SHOES ARE NOT ON) Date Initiated: 12/13/2024 • Remind resident to wear proper footwear during transfers and/or ambulation. Date Initiated: 11/04/2024 • bed in lowest position at all times except for personal care Date Initiated: 11/04/2024 • do not leave unattended in shower room Date Initiated: 11/04/2024 • encourage use of call light to ask for assistance, and respond promptly to call light Date Initiated: 11/04/2024 • explain use of call light and assess ability to use as needed Date Initiated: 11/04/2024 • Fall risk assessment quarterly and prn Date Initiated: 11/04/2024 • if fall occurs, neuro checks to be done per facility policy Date Initiated: 11/04/2024 • keep call light within reach at all times when in room Date Initiated: 11/04/2024 • monitor for pattern of risk or tendency to fall Date Initiated: 11/04/2024 • notify MD with changes in condition Date Initiated: 11/04/2024 • place frequently used items in reach at all times Date Initiated: 11/04/2024 • therapy screens and evals PRN with MD orders Date Initiated: 11/04/2024

Craig Latchaw's care plan indicated he was at risk of falling and Caprice Health Care Center would intervene in multiple ways to reduce his risk of falling.

10. Between the time of his admission and his discharge on December 13, 2024, Craig's family noticed multiple issues regarding his care at the Caprice Health Care Center.

11. During visits, Craig's family noticed that Caprice Health Care Center had not bathed Craig; he was visibly unclean. Craig's family often had to bathe him themself.

12. Craig's family also recognized that his tracheostomy tube was consistently clogged, making it difficult for Craig to properly breath.

13. During visits, Craig's family found that Caprice Health Care Center's staff had left his bed's wheel locks disengaged, causing the bed to move anytime he got into or out of bed.

14. When Craig needed to go to the bathroom, he or his family would put on the call light to get help from Caprice Health Care Center's staff, however the call light often rang unanswered for extended periods of time before facility staff came into the room. On occasion, nobody would answer the call light at all, and Craig's family would have to go search for a staff member to help their father get to the bathroom. These long waits led to Craig soiling or urinating himself in front of his family, causing him shame and embarrassment.

15. On December 12, 2024, around 3:00 p.m., Craig Latchaw suffered an unwitnessed fall when attempting to use the restroom. Two of Caprice Health Care Center's STNAs located Craig, barefoot, on the floor at the foot of his bed and contacted a nurse for assistance. A nurse working for Caprice Health Care Center reported to Craig's room while he was still on the floor – Craig reported to her he was trying to get to the bathroom.

16. This nurse checked Craig's vitals and completed an inadequate and incompetent head-to-toe assessment, failing to notice that Craig had struck his head and/or neck in the fall. Caprice Health Care Center's staff then picked Craig up from the floor and put him back in his bed.

17. Following Craig's fall, Caprice Health Care Center staff failed to recognize Craig's declining state until approximately ***17 hours later***.

18. On December 13, 2024, at 7:58 a.m., a nurse entered Craig's room and found him to be lethargic and unable to verbalize or respond to any verbal stimuli.

19. As a result of his condition, EMS was called to transport Craig to Mercy St. Elizabeth Boardman Hospital Emergency Department.

20. After its arrival, EMS indicated that Craig sounded very congested and was coughing up yellow mucus.

21. Mercy St. Elizabeth Boardman Hospital Emergency Department determined that Craig had a fever of 100.4 degrees Fahrenheit, a heartrate of 90 beats per minute, which made him borderline tachycardic, and pneumonia.

Medical Decision Making/Differential Diagnosis:

CC/HPI Summary, DDx, ED Course, Reassessment, Tests Considered, Patient expectation:

64 y.o. male who presents to the emergency department with chief complaint of fall and cough, fevers, and altered mental status for the past day. On initial examination patient presents covered in yellow appearing sputum all over his gown. Initial vital signs he is febrile at 100.4 °F and borderline tachycardic at 90 bpm. Vital signs otherwise stable. Initial concerns include intracranial abnormalities, pneumonia, COVID, influenza, among others. Patient CBC with leukocytosis of 18.5. He is COVID-negative. Influenza negative. Chest x-ray as interpreted by myself concerning for a left lower lobe pneumonia. Patient was ordered Zosyn. Upon chart review patient had received Unasyn in the past without any difficulty. CT head without any acute evidence of intracranial abnormalities or fractures. CT C-spine however does demonstrate an acute fracture of the tip of the dens. There is also C1-C2 malalignment that is concerning for an unstable fracture as read by radiology. Neurosurgical consultation was recommended. Spoke with Dr. Taha, neurosurgery, who recommends that patient be transferred to Cleveland clinic for higher level of care. Spoke with Mercy health access center who had spoke with the Cleveland clinic access center and stated that Cleveland Clinic is not a trauma center and noted due to the mechanism of the patient's injury he will need to be transferred to MetroHealth if it will be proceeded with as a trauma transfer. Patient has been ordered a dose of fentanyl at this time for pain control. He is also ordered Tylenol solution for fever control. Patient placed into a Aspen c-collar at the morning advice of Dr. Kelly, MetroHealth neurosurgery. He is excepted by Dr. Kreiner, trauma surgery, who does accept the patient for transfer. CTA C-spine ordered and results at the time of transfer demonstrating a occlusion of the right vertebral artery with reconstitution. Patient transferred to MetroHealth, CCF, and stable condition.

Mercy St. Elizabeth Boardman Hospital Emergency Department received Craig and determined he had a fever of 100.4 degrees Fahrenheit; had a high heartrate; had pneumonia in his chest; and had a fracture and misalignment in his spine following his fall at Caprice Health Care Center.

22. A CT scan revealed a new fracture of Craig's spine, and a misalignment of the C1 and C2 bones of his spine. In response to these concerns, Craig was placed into a cervical collar, or stiff neck brace, to assist with supporting his neck.



Craig was placed into a cervical collar to assist with supporting his spine before being transferred to the MetroHealth Medical Center, Trauma Division.

23. Craig's injuries were severe and required care that was beyond the means of Mercy St. Elizabeth Boardman Hospital Emergency Department, so he was transferred to MetroHealth Medical Center Trauma Division.

24. After arriving at MetroHealth Medical Center Trauma Division, orthopedic spine surgeons and neurosurgeons were consulted.

25. On the evening of December 16, 2024, and into the following morning, Craig developed trouble breathing and became tachycardic. In response, he was moved to the intensive care unit for respiratory distress.

26. On December 17, 2024, Craig's family met with an orthopedic spine surgery team. They were informed that attempting surgery on Craig's spine would be very high-risk and he was unlikely to have a good outcome from surgery, with a high possibility he would not survive the procedure.

27. Craig's family decided to pursue comfort care and the palliative care team was consulted to assist with symptom management.

28. On December 20, 2024, Craig was transferred from MetroHealth Medical Center to Hospice of the Valley for inpatient hospice care.

29. On December 23, 2024, at 3:12 a.m., Craig Latchaw died a premature death at 64 years old.

30. After his death, the Mahoning County Coroner's Office took jurisdiction over Craig's body. The coroner determined that Craig died from "complications of cervical fracture" and "fall."

31. The date of injury was "December 12, 2024," the date of Craig's fall, and the location of the injury was "9184 Market Street, North Lima, Ohio," the address of Caprice Health Care Center.

32. The description of how the injury occurred was "unwitnessed fall."

33. 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. COMPLICATIONS OF CERVICAL FRACTURE	DAYS
Sequentially list conditions, if any, leading to immediate cause.	b. Due to (or as Consequence of): FALL	DAYS
	c. Due to (or as Consequence of):	
Enter Underlying Cause (Disease or injury that initiated events resulting in a death)	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?
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, TONSILLAR CANCER	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?
12/12/2024 PM HOURS		NURSING HOME	NO

33e. Location of Injury (Street and Number or Rural Route Number; City or Town; State)
9184 MARKET STREET , NORTH LIMA, OHIO

33f. Describe How Injury Occurred:	33g. If Transportation Injury, Specify:
UNWITNESSED FALL	

The Mahoning County Coroner's ruled that Craig Latchaw died from "complications of cervical fracture" and "fall."

34. When Craig Latchaw's family called Caprice Health Care Center to find out why their father fell while under Caprice Health Care Center's watch, the Director of Nursing told them Craig "Had a right to fall."

ARE NO LONGER ALLOWED TO BE USING IN FACILITIES AND THAT EVERY RESIDENT HAS THE RIGHT TO FALL. WE CAN NOT IMPLEMENT INTERVENTIONS WITHOUT A CAUSE. I EXPLAINED TO HER THAT POST FALL INVESTIGATION WAS DONE AND THE INTERVENTIONS OF CALL LIGHT EDUCATION AND NON-SKID SOCKS ON AAT WERE IMPLEMENTED BUT SHE WAS NOT HAPPY WITH THIS EXPLANATION. SHE STATED THAT THEY REQUESTED MEDICAL RECORDS AND I TOLD HER THAT SHE WOULD RECEIVE A CALL WHEN THEY WERE READY AND SHE ENDED THE CALL.

Author:Jessica Carson Nursing - RN [e-SIGNED]

Created Date: 12/13/2024 15:02

Documentation of Charter Health Care Center's Director of Nursing of the phone call with Craig Latchaw's family on December 18, 2024, where her response to the family's questions about what interventions were in place at the time of Craig's fall was to say, "every resident has the right to fall." This is not a right recognized anywhere in the Ohio Nursing Home Residents' Bill of Rights.

35. Plaintiff requests a trial by jury.

36. An Affidavit of Merit is attached.

37. 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

38. Caprice Health Care Center aka BLCC, 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 Caprice Health Care Center aka BLCC, Inc.

39. Inspira Health Group aka JCTH Holdings, 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 Caprice Health Care Center aka BLCC, Inc.

40. JCTH Caprice Real Estate, LLC is an Ohio limited liability 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 Caprice Health Care Center aka BLCC, Inc.

41. The Defendants employ, manage, and direct the care and service providers who were responsible for Craig Latchaw's care, treatment, and safety Caprice Health Care Center aka BLCC, Inc. while they were a resident there, and / or are responsible for

creating unsafe conditions at the Facility through their control of the Facility management that directly led to Craig Latchaw's injuries and untimely and wrongful death on December 23, 2024.

42. 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.

43. 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.

44. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Caprice Health Care Center aka BLCC, Inc. directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

45. The Defendants employ the care providers who were responsible for ensuring Craig Latchaw's care and safety.

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

47. Craig Latchaw and his family looked to the Defendants for care based upon their representations.

48. 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

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

50. Venue is proper in Mahoning 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

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

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

53. 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.

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

55. 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; and

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

56. 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 Craig Latchaw, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

57. 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 Craig Latchaw.

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

59. This lack of sufficient resources directly resulted in Craig Latchaw not receiving basic and necessary services to prevent, among other things, neglect leading to his injuries and death.

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. Canterbury Senior Care Facility
9928 Vail Drive
Twinsburg, Ohio 44087

b. Carroll Health Care Center
648 Longhorn Street NW
Carrollton, Ohio 44615

c. Calcutta Health Care Center
48444 Bell School Road
Calcutta, Ohio 43920

d. Elmwood Assisted Living Center
871 Elmwood Drive
Hubbard, Ohio 44425

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 Caprice Health Care Center aka BLCC, Inc. 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 Caprice Health Care Center aka BLCC, Inc. 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

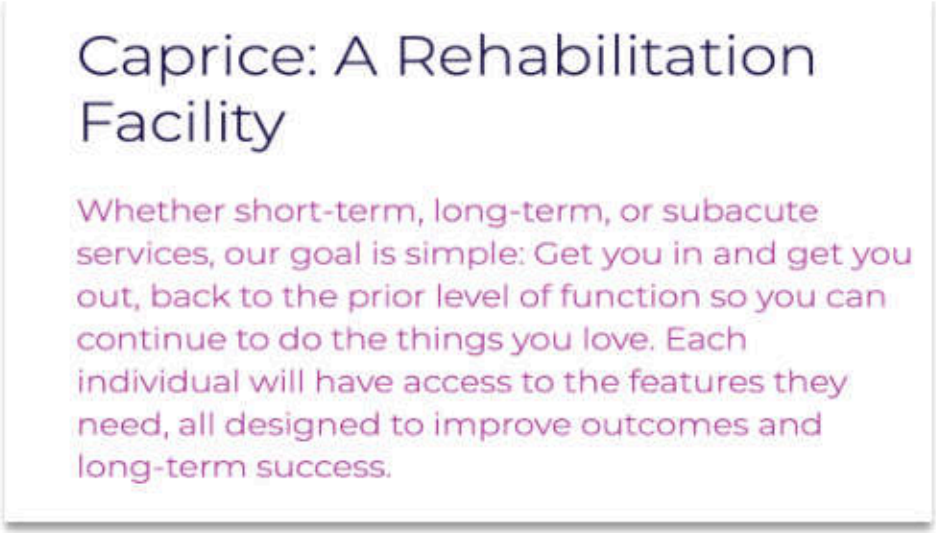
PDPM score is calculated for physical therapy, occupational therapy, speech-language pathology, non-therapy ancillary services, and nursing services.

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.



Caprice Health Care Center's website promises to return residents to their prior level of function.

This information was taken directly from www.inspirahealthgroup.com/senior-care-services/rehabilitation/ on December 2, 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 Craig Latchaw's Care

73. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Caprice Health Care Center aka BLCC, Inc. was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Craig Latchaw during the period he was a resident at the facility.

74. Defendants engaged in a systemic practice to understaff Caprice Health Care Center aka BLCC, Inc. to maximize profits at the expense of its residents' care.

75. This lack of sufficient staff directly resulted in Craig Latchaw not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at Caprice Health Care Center aka BLCC, Inc. during the period they were a resident at the Facility.

Defendants' Negligence and Recklessness with Craig Latchaw

76. Defendants agreed to accept Craig Latchaw into their facility for short-term care to provide care to him in exchange for monetary payment.

77. Defendants were fully aware that Craig Latchaw was at high risk of falling.

78. Defendants failed to properly monitor Craig Latchaw while he was in his room, allowing him to fall.

79. Defendants failed to implement appropriate fall interventions, including a toileting schedule so that their staff were ensuring Craig Latchaw did not suffer prolonged periods of urgency to urinate or have a bowel movement – increasing the likelihood he would attempt to get up to the restroom without assistance.

80. Defendants failed to conduct a thorough physical evaluation of Craig Latchaw after he fell, returning him to his bed after suffering a cervical fracture.

81. Defendants failed to regularly check in on Craig Latchaw after his fall to monitor his condition with competent neurologic assessments by qualified and well-trained staff, allowing 17 hours to pass before recognizing his declining mental and neurologic status.

82. Craig Latchaw 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(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

84. Craig Latchaw 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 Craig Latchaw and to avoid causing injury to Craig Latchaw.

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

e. choosing to not provide accurate, adequate, or timely information to Craig Latchaw's family;

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

g. choosing to violate orders relating to care of Craig Latchaw;

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

i. failing to ensure the rights and safety of its residents, including Craig Latchaw, as required by Ohio and federal regulations;

j. choosing not to provide appropriate care to Craig Latchaw 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 Craig Latchaw'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 Craig Latchaw 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 Craig Latchaw 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, Craig Latchaw 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(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

97. Craig Latchaw 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 Craig Latchaw and to avoid causing injury to Craig Latchaw.

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

e. choosing to not provide accurate, adequate, or timely information to Craig Latchaw's family;

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

g. choosing to violate orders relating to care of Craig Latchaw;

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

j. choosing not to provide appropriate care to Craig Latchaw while he 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 Craig Latchaw'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 Craig Latchaw's rights and safety, and give rise to a statutory cause of action.

103. Craig Latchaw 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 Craig Latchaw'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 Craig Latchaw 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 Craig Latchaw 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, Craig Latchaw sustained injuries that caused his untimely and wrongful death.

112. Craig Latchaw'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(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

115. Defendants, directly or through their employees or agents, violated Craig Latchaw'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 Craig Latchaw'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, Craig Latchaw 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(s) incorporate 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 scores 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 Craig Latchaw.

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 Craig Latchaw

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(s) incorporate 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 Caprice Health Care Center aka BLCC, Inc.

127. Not only did Defendants conceal this information, but they also publicly and privately represented that they provide exceptional services in an effort to induce the family of Craig Latchaw 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 Craig Latchaw's family and other potential customers into placing their loved ones in the care and custody of Defendants.

129. Craig Latchaw'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 Craig Latchaw'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, Craig Latchaw suffered conscious pain and suffering and death.

132. As a direct and proximate result of Defendants' action, representations, and concealments, Craig Latchaw'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/ Matthew Mooney
MATTHEW MOONEY (0093332)
C. JOSEPH MCCOY (0092669)
LINA GIRGIS (0106469)
MICHAEL HILL TRIAL LAW
815 Superior Ave., Suite 623
Cleveland, Ohio 44114
(800)659-2712 (o) | (216)304-6630 (f)
matthew.mooney@protectseniors.com
joe.mccoy@protectseniors.com
lina.girgis@protectseniors.com
protectseniors.com
Counsel for Plaintiff