IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

THE ESTATE OF JOHN LEONARD, SR. Through Estate Representative Bernard Leonard, c/o Michael Hill Trial Law 815 Superior Ave., Ste. 623 Cleveland, OH 44113, Plaintiff, vs. CROWN POINTE CARE CENTER AKA SHCP FRANKLIN, INC., 1850 Crown Park Court Columbus, OH 43235 Also Serve c/o Registered Agent: Ohio Agent Solutions, Inc. 25000 Country Blvd., Suite 255 North Olmsted, OH 44070 and FOUNDATIONS HEALTH SOLUTIONS AKA FOUNDATIONS HEALTH SOLUTIONS, LLC, Ohio Agent Solutions, Inc. 25000 Country Blvd., Suite 255 North Olmsted, OH 44070 and FOUNDATIONS HEALTH, LLC Ohio Agent Solutions, Inc. 25000 Country Blvd., Suite 255 and	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND AND MOTION FOR EXTENSION OF TIME TO FILE AN AFFIDAVIT OF MERIT**

1850 CROWN PARK COURT, LLC)
Ohio Agent Solutions, Inc.)
25000 Country Blvd., Suite 255)
North Olmsted, OH 44070)
)
Defendants)
)

Plaintiff, The Estate of John Leonard, through Estate Representative Bernard Leonard (Franklin County Probate Court Estate Number 637141), for this Complaint against the above-named Defendants, states and avers upon information and belief:

INTRODUCTION

1. This action involves the wrongful death of John Leonard due to Defendant Crown Pointe Care Center aka SHCP Franklin, Inc. ("The Facility's") inadequate care of John Leonard and the corporate control of the facility leading to such inadequate care that led to John Leonard's untimely and wrongful death on May 18, 2023.

2. While a resident under the care of the Facility, the Defendants neglected John Leonard by failing to assess, plan, and properly implement a care plan to address John Leonard's risk for falls.

3. Defendants failed to conduct proper assessments of John Leonard to determine the extent of his risk for falls.

4. Even based on the limited assessment conducted by the Facility, Defendants knew that John Leonard required assistance to sit or stand. John Leonard depended on the Facility to provide assistance for transfers.

5. Even based on the limited assessment conducted by Defendants, Defendants knew that John Leonard required physical assistance for bathing. John Leonard did not have medical equipment for mobility to assist while bathing

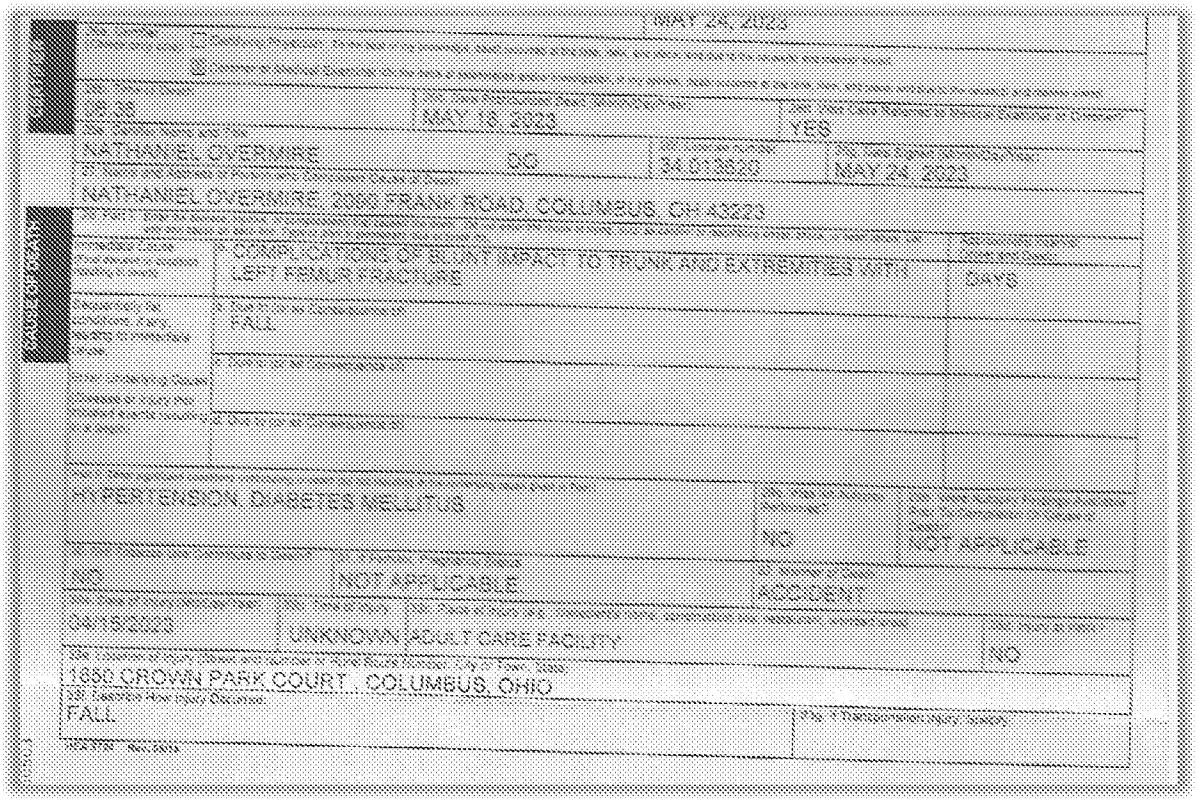
6. On April 15, 2023, Defendants, through their agents or employees, neglected John Leonard by leaving him alone in the bathroom to bathe.

7. Not only did Defendants leave John Leonard alone in the shower area, they left John in a chair without locking the wheels on the shower chair.

8. After leaving John Leonard alone in the bathing area, Defendants' agents or employees eventually returned and found John Leonard on the floor of the bathroom, flat on his back.

9. As a result of Defendants' neglect, John Leonard suffered a fall, which resulted in a left femur facture, which caused his wrongful death on May 18, 2023.

10. John Leonard's death certificate, certified by Nathaniel Overmire, D.O, lists John's death as accidental in nature. The death certificate further certifies that John Leonard died of complications of blunt impact to trunk and extremities with left femur fracture due to the fall at the Facility on April 15, 2023:



11. The facility failed to create and appropriately update a resident-centered plan of care, failed to effect safe bathing procedures, failed to provide appropriate supervision to prevent accidents, and failed to ensure Glenn received adequate care and attention. The facility's neglect resulted in John's fall on April 15, 2023, and his eventual death on May 18, 2023.

12. Plaintiff requests a trial by jury.

13. Plaintiff has concurrently filed a motion for extension to file an affidavit of merit.

14. Plaintiff brings this action for compensation for the harms and losses sustained as a result of the negligence, recklessness, conscious disregard, and other conduct by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that their conduct is likely to cause, at the time those services or that treatment was 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

15. Crown Pointe Care Center aka SHCP Franklin, Inc. ("Crown Pointe Care Center") 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.

16. Foundations Health Solutions aka Foundations Health Solutions, 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 Crown Point Care Center.

17. Foundations Health Solutions aka Foundations Health Solutions, LLC is a 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 Crown Pointe Care Center.

18. Foundations Health, 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 Crown Pointe Care Center.

19. 1850 Crown Park Court, 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 Crown Pointe Care Center

20. The Defendants employ, manage, and direct the care and service providers who were responsible for John Leonard's care, treatment, and safety at the Facility 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 John Leonard's injuries and death.

21. 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.

22. 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.

23. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of the Facility directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

24. The Defendants employ the care providers who were responsible for ensuring John Leonard's care and safety.

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

26. John Leonard and their family looked to the Defendants for care based upon their representations.

27. 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

28. 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.

29. Venue is proper in Franklin 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

30. Defendants hold themselves out to the public as medical and nursing providers at a skilled nursing facility, also known as a nursing home.

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

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

33. The Defendants manage, control, and / or employ the nursing staff, licensed aides, and unlicensed caregivers at the Facility.

34. 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

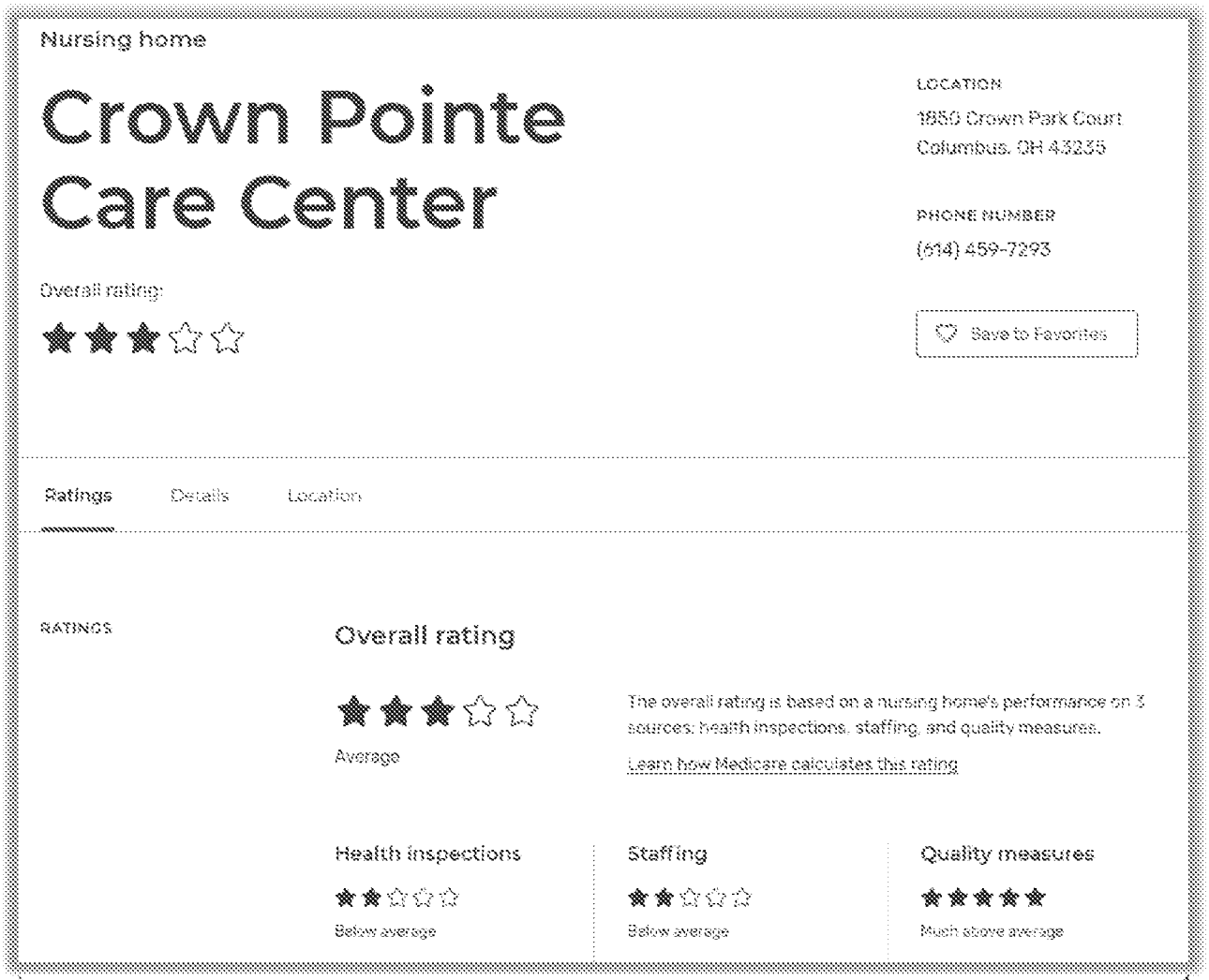
k. Reporting procedures, including reporting to Medicare as to individual resident care and facility-wide issues.

35. 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 John Leonard, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

36. 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 John Leonard.

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

38. The Defendants' systemic understaffing of the Facility resulted in a "2-star" ranking for Staffing on the Medicare.gov Nursing Home Compare website.



According to the Centers for Medicare and Medicaid, Crowne Pointe Care Center earned a 2-star, or "below average" rating for Staffing. This data was taken directly from medicare.gov on April 13, 2025.

39. This lack of sufficient staff directly resulted in John Leonard not receiving basic and necessary services to prevent, among other things, neglect leading to his injuries and death.

Reporting Data – Nursing Home

40. The Defendants are required to report significant amounts of data to the federal agency that oversees operations of nursing homes receiving federal or state funding, the Centers for Medicare and Medicaid Services, or "Medicare."

41. The data the Defendants submit to Medicare regarding its facility includes data on its residents (numbers, care needs, and bed days), its finances, and its nurse and nursing aide staffing levels as compared to resident care needs.

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

43. Medicare uses some of this data submitted by Defendants to produce its nursing home 5-star rating system, also known as "Nursing Home Compare."

Nursing Home Resident Care Needs and Staffing Levels (MDS and RUG Scores)

44. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including The Facility, and others operated and / or controlled by Defendants—is required to provide detailed information regarding the health status, care and treatment, and services provided to each resident in the facility using a questionnaire called the Minimum Data Set, or MDS. This evaluation is done for all nursing home residents regardless of whether their care is being paid for by Medicare.

45. Nursing homes like The Facility are required to evaluate every resident using the Minimum Data Set questionnaire shortly after the time of admission, every 90 days thereafter, when a resident has a significant improvement or decline in health (physical, mental, or psychosocial), and upon discharge.

46. Based on this Minimum Data Set, each resident's individual care needs (called "acuity level") are assigned into a group signifying how much nursing or staff care the resident requires, called a Resource Utilization Group score, or RUG score.

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

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

49. When these Resource Utilization Group scores are combined for all residents in a nursing home facility, the nursing home knows exactly how many minutes of nursing and nursing aide care should be provided, on average, to meet the expected care needs of their residents.

Misleading Advertising

50. In an effort to persuade the families of patients to become customers, Defendants make promises to the families of such potential residents that they will provide a level of care that they know they are incapable of providing.

51. The intent and outcome of this misleading practice is to cause residents, their families, and external care providers to believe the nursing facility is much better staffed to provide the promised care than what is actually the practice of the Defendants with regard to staffing the Facility.

52. The intent and outcome of this misleading practice is to drastically limit the budget and overhead needed to run a safe facility in order to maximize profits and syphon resources at the expense of patient safety.

Systemic Understaffing and John Leonard's Care

53. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that The Facility was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of John Leonard during the period he was a resident at the facility.

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

55. This lack of sufficient staff directly resulted in John Leonard not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at The Facility during the period they were a resident at the Facility.

Defendants' Negligence and Recklessness with John Leonard

56. While a resident under the care of the Facility, the Defendants neglected John Leonard by failing to assess, plan, and properly implement a care plan to address John Leonard's risk for falls.

57. Even based on the limited assessment conducted by the Facility, Defendants knew that John Leonard required assistance to sit or stand. John Leonard depended on the Facility to provide assistance for transfers.

58. Even based on the limited assessment conducted by Defendants, Defendants knew that John Leonard required physical assistance for bathing. John Leonard did not have medical equipment for mobility to assist while bathing

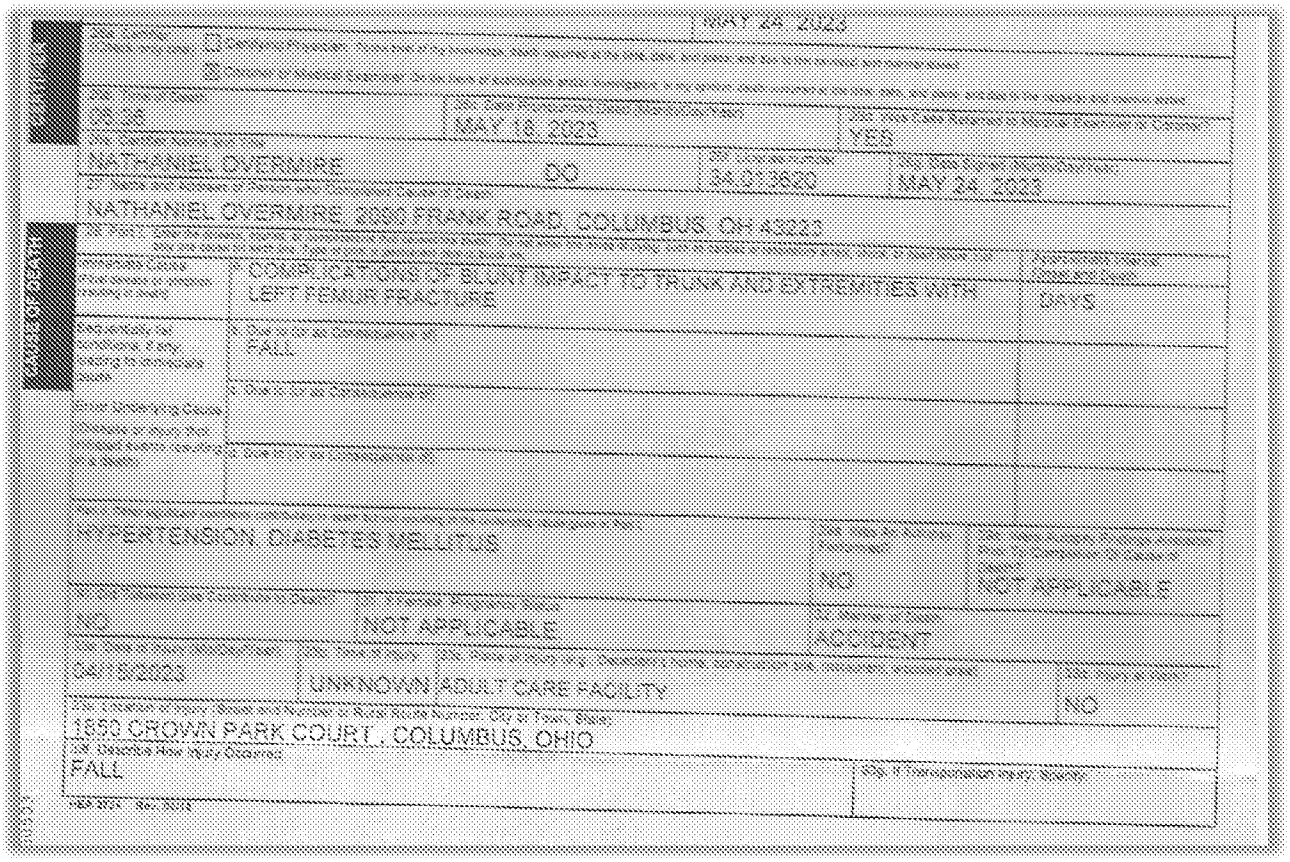
59. On April 15, 2023, Defendants, through their agents or employees, neglected John Leonard by leaving him alone in the bathroom to bathe.

60. Not only did Defendants leave John Leonard alone in the shower area, they left John in a chair without locking the wheels on the shower chair.

61. After leaving John Leonard alone in the bathing area, Defendants agents or employees eventually returned and found John Leonard on the floor of the bathroom, flat on his back.

62. As a result of Defendants' neglect, John Leonard suffered a fall, which resulted in a left femur facture, which caused his wrongful death on May 18, 2023.

63. John Leonard's death certificate, certified by Nathaniel Overmire, D.O, lists John's death as accidental in nature. The death certificate further certifies that John Leonard died of complications of blunt impact to trunk and extremities with left femur fracture due to the fall at the Facility on April 15, 2023:


MAY 24 2023
MAY 18 2023
YES
NATHANIEL OVERMIRE
DO
34 ST 3820
MAY 24 2023
NATHANIEL OVERMIRE 4560 FRANK ROAD, COLUMBUS, OH 43220
COMPLICATIONS OF SCOUT INPLOT TO TRUNK AND EXTREMITIES WITH
LEFT FEMUR FRACTURE
DAYS
FALL
HYPERTENSION, DIABETES MELLITUS
NO
NOT APPLICABLE
NO
NOT APPLICABLE
ACCIDENT
04/15/2023
UNKNOWN
ADULT CARE FACILITY
NO
1650 CROWN PARK COURT, COLUMBUS, OHIO
FALL

64. The facility failed to create and appropriately update a resident-centered plan of care, failed to effect safe bathing procedures, failed to provide appropriate supervision to prevent accidents, and failed to ensure Glenn received adequate care and attention. The facility's neglect resulted in John's fall on April 15, 2023, and his eventual death on May 18, 2023.

65. Defendants agreed to accept John Leonard into their facility and provide care to him in exchange for monetary payment.

66. Defendants knew John Leonard was a fall risk and suffered from dementia, meaning he would need consistent monitoring and supervision from staff to prevent him from trying to get up unassisted. Defendants also knew that he needed the assistance of

the Defendants' staff for transfers, including for bathing, when they accepted him into their Facility.

67. During his stay at the Facility, due to Defendants' neglect John Leonard suffered a fall on April 15, 2023, while left unattended in the bathing area.

68. John Leonard never recovered from his injuries from the fall at the facility on April 15, 2023, and passed away on May 18, 2023.

69. As a direct and proximate consequence of Defendants' negligence, John Leonard suffered conscious pain and suffering and death.

FIRST CAUSE OF ACTION
(WRONGFUL DEATH)

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

71. John Leonard depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

72. The Defendants had a duty to provide proper care and treatment to John Leonard and to avoid causing injury to John Leonard.

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

74. 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 John Leonard;

e. Choosing to violate orders relating to care of John Leonard;

f. Failing to ensure the rights and safety of its residents, including John Leonard, as required by Ohio and federal regulations;

g. Choosing not to provide appropriate care to John Leonard while he was a resident of the Facility; and

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

75. Defendants, directly or through their employees or agents, violated John Leonard'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 participate in decisions that affect the resident's life; and

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

76. These violations are evidence of negligence and conscious disregard of John Leonard's rights and safety, and give rise to a statutory cause of action.

77. John Leonard 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.

78. These actions constituted a conscious disregard for John Leonard'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 harm that could result from their willful, wanton, and/or reckless misconduct.

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

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

81. The Defendants and their medical and nursing staff provided care to John Leonard that fell below the standard of care expected of medical care and residential care facilities, under the same or similar circumstances.

82. 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.

83. As a direct and proximate result of the negligent and/or willful, wanton and/or reckless actions of the Defendants described above, John Leonard sustained

permanent injury and loss including, but not limited to, conscious pain and suffering, disability, and death.

84. Plaintiff brings this Cause of Action pursuant to Ohio's Wrongful Death Statute, Ohio Revised Code section 2125 *et seq.*, for the benefit of John Leonard's heirs and next of kin who have suffered loss and damage due to John Leonard's wrongful and untimely death.

85. John Leonard's next-of-kin suffered damages as set forth in the Ohio Wrongful Death statute, including mental anguish and grief, medical and funeral expenses, and loss of Decedent's support, services, society, and companionship.

86. WHEREFORE, Plaintiff demands judgment against Defendants, in an amount more than $25,000.00 to compensate the decedent's next of kin and heirs at law, together with costs of suit, attorneys' fees and expenses, exemplary damages, and any other relief the court finds is appropriate and / or equitable.

A TRIAL BY JURY IS HEREBY DEMANDED

Respectfully submitted,

/s/ C. Joseph McCoy
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