IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

ESTATE OF DOLORES L. NIEDERHELMAN Through Estate Representative Dave Niederhelman c/o Michael Hill Trial Law 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. THREE RIVERS HEALTHCARE CENTER AKA 3R OPERATING CO LLC 7800 Jandaracres Dr Cincinnati, OH 45248 Also Serve c/o Registered Agent: ACFB 127 Public Square, Suite 4900 Cleveland OH 44114 and COMMUNICARE FAMILY OF COMPANIES DBA HEALTH CARE FACILITY MANAGEMENT, LLC c/o Registered Agent: Health Care Facility Management, LLC 4700 Ashwood Drive, Suite 200 Cincinnati, Ohio 45241 and COMMUNICARE HEALTH SERVICES, INC. c/o Registered Agent: ACFB 127 Public Square, Suite 4900 Cleveland, Ohio 44114 and COMMUNICARE, INC. c/o Registered Agent: ACFB	CASE NO. A 2400404 JUDGE MELBA D. MARSH **FIRST AMENDED COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

127 Public Square, Suite 4900)
Cleveland, Ohio 44114)
)
and)
)
PARKWAY MGT. CO., LLC)
c/o Registered Agent:)
CFD SERVICE COMPANY, INC.)
1300 East Ninth Street,)
20TH Floor,)
Cleveland, Ohio 44114)
)
and)
)
CT OPERATIONS HOLDCO, LLC)
c/o Registered Agent:)
ACFB)
127 Public Square, Suite 4900)
Cleveland OH 44114)
)
and)
)
3R RE HOLDINGS, LLC)
c/o Registered Agent:)
ACFB)
127 Public Square, Suite 4900)
Cleveland OH 44114)
)
and)
)
LINDA BRODBECK, NP)
7800 Jandaracres Dr)
Cincinnati, OH 45248)
)
and)
)
TAWNY CROSS, RN)
7800 Jandaracres Dr)
Cincinnati, OH 45248)
)
and)
)
ROBIN SPOONAMORE, LPN)
7800 Jandaracres Dr)
Cincinnati, OH 45248)
)
and)
)
AMANDA FIELDS, LPN)

7800 Jandaracres Dr)
Cincinnati, OH 45248)
)
and)
)
UNIDENTIFIED TEMO/AGENCY NURSES)
7800 Jandaracres Dr)
Cincinnati, OH 45248)
_____)

Pursuant to Ohio Civ. R. 15(A) and Ohio Revised Code Section 2323.451(D)(1)-(2), , Plaintiff, Estate of Dolores L. Niederhelman, through Estate Representative Dave Niederhelman (Butler County Probate Court Estate Number PE23-05-0434), for this Complaint against the above-named Defendants, states and avers upon information and belief:

INTRODUCTION

1. This action involves multiple claims (negligence, recklessness, wrongful death, Resident's Rights Law violations, civil conspiracy, fraud) involving Three Rivers Healthcare Center aka 3r Operating CO LLC's ("Facility's") inadequate care of Dolores Niederhelman and the corporate control of the facility leading to such inadequate care that led to Dolores Niederhelman's untimely and wrongful death on January 30, 2023.

2. This is a wrongful death case against Three Rivers Healthcare Center, a Communicare facility, for allowing Dolores Niederhelman to be assaulted and suffer multiple fractures. Her family was not informed of her injuries. The following day, she was rushed to the hospital, unresponsive. Only then was the family informed she had had a fall. Upon arrival, she was septic from pneumonia. She passed within a few days of the attack.

3. Plaintiff requests a trial by jury.

4. An Affidavit of Merit is attached.

5. 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.

6. Plaintiff seeks punitive damages in an amount necessary to punish the above-named Defendants and deter the Defendants from engaging in similar conduct in the future, attorneys' fees, and the costs of this litigation.

DEFENDANTS

7. Three Rivers Healthcare Center aka 3r Operating CO 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

8. Communicare Family of Companies dba Health Care Facility Management, 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

9. Communicare Health Services, 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

10. Communicare, 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

11. Parkway Mgt. Co., 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

12. CT Operations Holdco, 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

13. 3R RE Holdings, 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 Three Rivers Healthcare Center aka 3r Operating CO LLC.

14. Defendant, Linda Brodbeck Nurse Practitioner, licensed to practice nursing in the State of Ohio, who provided clinical oversight at Three Rivers and was responsible for providing nursing and nursing related services in accordance with the standard of care and who provided care to Dolores Niederhelman during the time frame that the

allegations in this Complaint arose.

15. Defendant, Tawny Cross was a registered nurse licensed to practice nursing in the State of Ohio, who served as the Director of Nursing of Three Rivers and provided clinical oversight at Three Rivers and was responsible for providing nursing and nursing related services in accordance with the standard of care and who provided care to Dolores Niederhelman during the time frame that the allegations in this Complaint arose.

16. Defendant, Robin Spoonamore, was a licensed practical nurse, licensed to practice nursing in the State of Ohio, who provided clinical oversight and direct care to patients at Three Rivers, including Dolores Niederhelman, and was responsible for providing nursing and nursing related services in accordance with the standard of care.

17. Defendant, Amanda Fields, was a licensed practical nurse, licensed to practice nursing in the State of Ohio, who provided clinical oversight and direct care to patients at Three Rivers, including Dolores Niederhelman, and was responsible for providing nursing and nursing related services in accordance with the standard of care.

18. Several unknown nurses identified only as "Temp" or "Agency" nurses in Dolores Niederhelman's records from Three Rivers provided clinical oversight and direct care to patients at Three Rivers, including Dolores Niederhelman, and was responsible for providing nursing and nursing related services in accordance with the standard of care. Plaintiff reserves the right to amend the Complaint to add them as Defendants pursuant to Ohio Revised Code Section 2323.451(D)(1)-(2).

19. Three Rivers Healthcare Center aka 3r Operating CO LLC, Communicare Family of Companies dba Health Care Facility Management, LLC, Communicare Health Services, Inc., Communicare, Inc., Parkway Mgt. Co., LLC, and 3R RE Holdings, LLC (collectively, "Communicare Defendants") employ, manage, and direct the care and service

providers who were responsible for Dolores Niederhelman's care, treatment, and safety at Three Rivers Healthcare Center aka 3r Operating CO LLC 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 Dolores Niederhelman's injuries and untimely and wrongful death on January 30, 2023.

20. The Communicare Defendants direct and control operations at the Facility and are therefore directly liable for mismanagement of the Facility without regard to piercing the corporate veil.

21. The Communicare Defendants control 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 Communicare Defendants should be held directly liable for such harms and losses.

22. The Communicare Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Three Rivers Healthcare Center aka 3r Operating CO LLC directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

23. The Communicare Defendants employ the care providers who were responsible for ensuring Dolores Niederhelman's care and safety.

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

25. Dolores Niederhelman and their family looked to the Defendants for care based upon their representations.

26. The Communicare Defendants are vicariously liable for the negligent actions of their employees and agents (respondeat superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including visiting physicians and nurse practitioners contracted with any of the Defendants and / or provided to residents as default or house care providers.

JURISDICTION AND VENUE

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

28. Venue is proper in Hamilton 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

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

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

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

federal nursing home regulations regarding staffing levels.

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

33. The Communicare Defendants exercise actual control over the Facility's management and operations to maximize profits, including control over facility-level:

a. Policies and procedures, including regarding resident care;

b. Finances, including obtaining credit and loans, guaranteeing loans (both at the corporate and individual facility level), maintaining funds and banking, obtaining, owning, and leasing facility land and buildings, and capital expenditures.

c. Budgeting, including controlling the amount of funds available for staffing facilities;

d. Personnel management, including hiring and firing, or having authority to hire and fire, the supervisory and management personnel in each facility;

e. Supervision of management, care providers, and staff in each facility, including compliance with federal and state regulations;

f. Employment, such as setting pay scales, shifts, and time and vacation policies;

g. Systems for training, monitoring, and supervising staff;

h. Medical record systems and management;

i. Financial control systems, including budgeting and payment processing;

j. Marketing, including setting the image and expectations residents and their family should expect at the facility, and even the name of the facility;

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

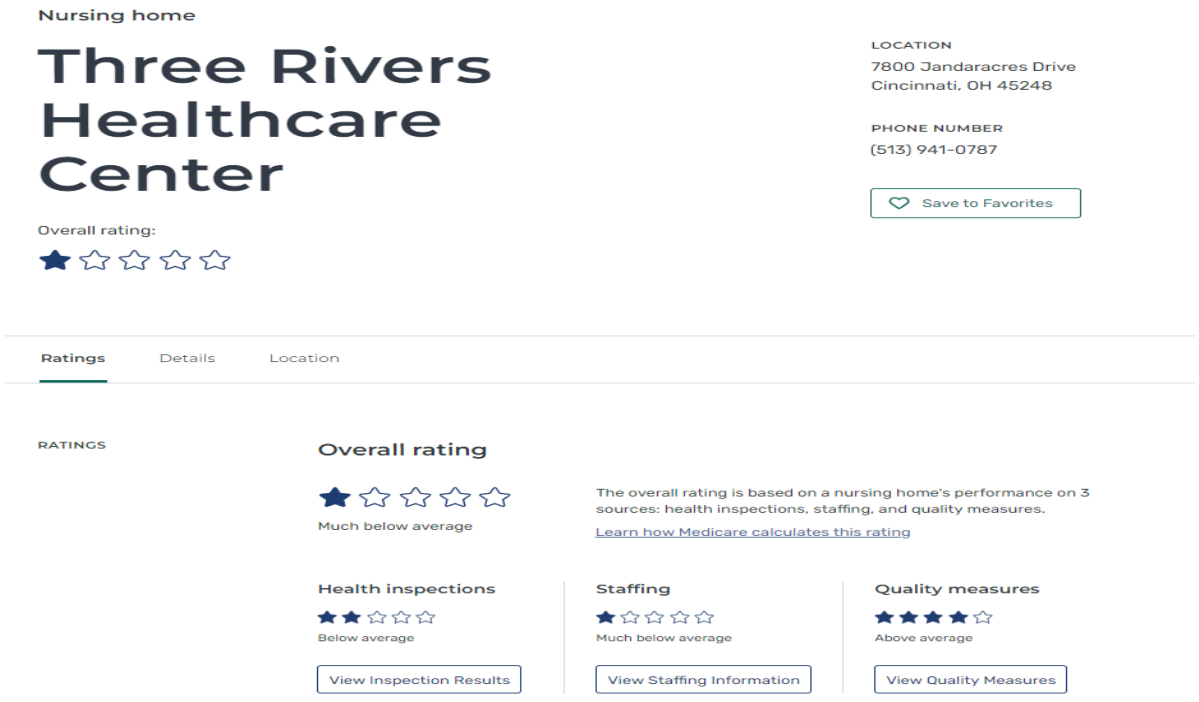
34. As the result of this control, the Communicare Defendants make decisions that affect the day-to-day care of residents of the Facility, such as the resources available for providing nursing staff and care to residents like Dolores Niederhelman, meaning they

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

35. The Communicare 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 Dolores Niederhelman.

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

37. The Communicare Defendants' systemic understaffing of the Facility resulted in a "1-star" ("much below average") ranking for Staffing on the Medicare.gov Nursing Home Compare website and 1-star overall ranking.



Centers for Medicare and Medicaid determined that, Three Rivers Healthcare Center aka 3r Operating CO LLC earned a 1-star, or "much below average" rating for Staffing and a 2-star, or "below average" rating for Health Inspections. This data was taken directly from medicare.gov on January 18, 2024.

38. The Medicare Compare ratings are statements and records of a public office based on factual findings carried out under while acting under their official duties.

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

40. The Communicare Defendants also exercise operational and managerial control, and apply this profits-over-safety model, at the following facilities in the State of Ohio:

1. Addison Healthcare Center
   8055 Addison Rd SE
   Masury, OH 44438
   Phone:330.448.2547
   Fax:877.259.5073

2. Advanced Healthcare Center
   955 Garden Lake Pkwy
   Toledo, OH 43614
   Phone: 419.382.2200
   Fax:419.381.8508

3. Advanced Specialty Hospitals Of Toledo
   1015 Garden Lake Pkwy
   Toledo, OH 43614
   Phone:419.381.3963
   Fax: 419.381.3990

4. Allen View Healthcare Center
   2615 Derr Rd
   Springfield, OH 45503
   Phone: 937.390.0005
   Fax:877.366.5844

5. Austintown Healthcare Center
   650 S Meridian Rd
   Youngstown, OH 44509
   Phone:330.792.7799
   Fax:877.403.1690

6. Berea Alzheimer's Care Center

49 Sheldon Rd
Berea, OH 44017
Phone:440.234.0454
Fax:440.234.0494

7. BridgePort Healthcare Center
   2125 Royce St
   Portsmouth, OH 45662
   Phone:740.354.6635
   Fax:740.354.1443

8. Brookside Healthcare Center
   315 Lilienthal St
   Cincinnati, OH 45204
   Phone:513.471.8667
   Fax:513.557.3629

9. Burlington House Healthcare Center
   2222 Springdale Rd
   Cincinnati, OH 45231
   Phone:513.851.7888
   Fax:513.589.3444

10. Canfield Healthcare Center
    2958 Canfield Rd,
    Youngstown, OH 44511
    Phone:330.792.5511
    Fax:877.301.3266

11. Chamberlin Healthcare Center
    3889 East Galbraith Rd
    Cincinnati, OH 45236
    Phone:513.793.5222
    Fax:513.791.2538

12. Chardon Healthcare Center
    620 Water St
    Chardon, OH 44024
    Phone:440.285.9400
    Fax:440.285.9378

13. Clifton Healthcare Center
    625 Probasco St
    Cincinnati, OH 45220
    Phone:513.281.2464
    Fax:513.281.2559

14. Columbus Healthcare Center
    4301 Clime Rd N

Columbus, OH 43228
Phone:614.276.4400
Fax:614.276.5509

15. Copley Health Center
155 Heritage Woods Dr
Copley, OH 44321
Phone:330.666.0980
Fax:330.666.5585

16. Crestwood Care Center
225 W Main St
Shelby, OH 44875
Phone:419.347.1266
Fax:419.342.7035

17. Dixon Healthcare Center
135 Reichart Ave
Wintersville, OH 43952
Phone:740.264.1155
Fax:877.292.0653

18. Evergreen Healthcare Center
924 Charlies Way
Montpelier, OH 43543
Phone:419.485.8307
Fax:877.301.3452

19. Falling Water Healthcare Center
18840 Falling Water Rd,
Strongsville, OH 44136
Phone:440.238.1100
Fax:440.238.9575

20. Forest Hills Healthcare Center
8700 Moran Rd
Cincinnati, OH 45244
Phone:513.578.6200
Fax:513.578.6333

21. Grande Lake Healthcare Center
1209 Indiana Ave
St Marys, OH 45885
Phone:419.394.7611
Fax:877.396.5260

22. Grande Pointe Healthcare Center
3 Merit Dr
Richmond Heights, OH 44143

Phone:216.261.9600
Fax:216.261.9662

23. Greenbriar Healthcare Center
8064 South Ave #1
Boardman, OH 44512
Phone:330.726.3700
Fax:330.726.2194

24. Greenbrier Health Center
6455 Pearl Rd
Parma Heights, OH 44130
Phone:440.888.5900
Fax:440.888.0976

25. Hanover Healthcare Center
435 Avis Ave NW
Massillon, OH 44646
Phone:330.837.1741
Fax:330.837.1747

26. Ivy Woods Healthcare Center
2025 Wyoming Ave
Cincinnati, OH 45205
Phone:513.251.2557
Fax:513.251.2648

27. Kenwood Healthcare Center
7450 Keller Rd
Cincinnati, OH 45243
Phone:513.793.2255
Fax:513.745.8743

28. Lake Pointe Health Center
3364 Kolbe Rd
Lorain, OH 44053
Phone:440.282.2244
Fax: 440.282.2280

29. Madeira Healthcare Center
7885 Camargo Rd
Madeira, OH 45243
Phone:513.561.6400
Fax:513.561.2450

30. Northwestern Healthcare Center
570 N Rocky River Dr
Berea, OH 44017
Phone:440.243.2122

Fax:440.243.8588

31. Parkview Healthcare Center
    3875 East Galbraith Rd
    Cincinnati, Ohio 45236
    Phone:513.793.5222
    Fax:513.791.2538

32. Pebble Creek Healthcare Center
    670 Jarvis Rd
    Akron, OH 44319
    Phone:330.645.0200
    Fax:330.645.0316

33. Pleasant Ridge Healthcare Center
    5501 Verulam Ave
    Cincinnati OH 45213
    Phone:513.631.1310
    Fax:513.631.1328

34. Riverside Healthcare Center
    1390 King Tree Dr
    Dayton, OH 45405
    Phone:937.278.0723
    Fax:937.276.8675

35. Salem North Healthcare Center
    250 Continental Dr
    Salem, OH 44460
    Phone:330.337.9503
    Fax:877.290.6786

36. Salem West Healthcare Center
    2511 Bentley Dr
    Salem, OH 44460
    Phone:330.337.9503
    Fax:877.290.6786

37. Southbrook Healthcare Center
    2299 S. Yellow Springs St
    Springfield, OH 45506
    Phone:937.322.3436
    Fax:937.322.2470

38. The Colony Healthcare Center
    563 Colony Park Dr
    Tallmadge, OH 44278
    Phone:330.630.9780
    Fax:330.630.0928

39. The Pines Healthcare Center
    3015 17th St NW
    Canton, OH 44708
    Phone:330.454.6508
    Fax:877.403.4580

40. Wood Glen Alzheimer's Community
    3800 Summit Glen Rd
    Dayton, OH 45449
    Phone:937.436.2273
    Fax:937.433.2017

41. Wyant Woods Healthcare Center
    200 Wyant Rd
    Akron, OH 44313
    Phone:330.836.7953
    Fax:330.836.6806

Reporting Data – Nursing Home

41. The Communicare 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."

42. The data the Communicare 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.

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

44. Medicare uses some of this data submitted by the Communicare 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)

45. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Three Rivers Healthcare Center aka 3r Operating CO LLC and others operated and / or controlled by the Communicare 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.

46. Nursing homes like Three Rivers Healthcare Center aka 3r Operating CO 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.

47. 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.

48. 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.

49. 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."

50. 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

51. 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.

52. 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.

53. 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 Dolores Niederhelman's Care

54. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Three Rivers Healthcare Center aka 3r Operating CO LLC was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Dolores Niederhelman during the period she was a resident at the facility.

55. Defendants engaged in a systemic practice to understaff Three Rivers Healthcare Center aka 3r Operating CO LLC to maximize profits at the expense of its residents' care.

56. This lack of sufficient staff directly resulted in Dolores Niederhelman not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at Three Rivers Healthcare Center aka 3r Operating CO LLC during the period they were a resident at the Facility.

Defendants' Negligence and Recklessness with Dolores Niederhelman

57. Defendants accepted Dolores Niederhelman as a nursing home resident for long-term care for dementia.

58. Defendants agreed to accept Dolores Niederhelman into their facility and provide care to them in exchange for monetary payment.

Three Rivers Healthcare Center

59. Ms. Niederhelman was an 88-year-old woman with a past medical history of Alzheimer's dementia, hypertension, hyperlipidemia, and hypothyroidism.

60. On March 5, 2021, Ms. Niederhelman was admitted to Three Rivers Healthcare Center (Three Rivers). She was admitted to the skilled nursing facility.

61. On September 16, 2021, Ms. Niederhelman was placed in a secured unit for behaviors.

62. Ms. Niederhelman was a vulnerable adult. She had a cognitive impairment that prevented her from being independent. Ms. Niederhelman required placement in the secured unit at Three Rivers for protection and monitoring.

63. The residents who reside in a secured unit have a cognitive disability (i.e., dementia). Patients with cognitive disability are likely to exhibit behaviors that pose harm to themselves and others. These behaviors include wandering, falling, assaulting other residents, and being assaulted by other residents.

64. The potential for harmful behaviors and protecting residents from these harmful behaviors are the reasons for placing residents in a secured and monitored unit.

65. The potential for harmful behaviors and protecting residents from harmful behaviors are the reasons for implementing the Safely You video monitoring system.

66. On December 5, 2022, Mr. David Niederhelman (son) agreed to and signed the Resident Consent to Fall Detection Program. The consent form explained and asked permission to use the Safely You video monitoring system. The purpose of the video monitoring system was fall detection and prevention for cognitively impaired residents. The consent form included the following:

- If evidence of abuse is discovered, it will be reported following all legal and statutory requirements.

67. Mr. Niederhelman agreed to use Safely You to monitor his mother.

68. The Safely You video monitoring system belonged to Three Rivers. Three Rivers had access to the recordings.

69. On August 7, 2022, a Brief Interview for Mental Status (BIMS) was completed. Ms. Niederhelman had memory problems, severely impaired ability to make decisions regarding tasks of life, repeated herself constantly, did not appear to remember things, and replied to questions non- sensical.

70. Ms. Niederhelman's BIMS evaluation was consistent with her known diagnosis of dementia.

71. On December 20, 2022, Ms. Niederhelman had normal renal function (BUN 23 and Creatinine 0.8) and a normal platelet count of 160K.

72. On December 30, 2022, the care plan included a fall mat to the right side of the bed.

73. On January 5, 2023, the MDS Section J1400 documented that Ms. Niederhelman had no life expectancy of fewer than six months.

74. On the evening of January 26, 2023, shortly before midnight, the Safely You video monitoring system recorded the following:

75. At 23:23:16, Ms. Niederhelman was asleep in the bed with the light off.

76. At 23:23:17, a female resident carrying a purse enters the room, turns the light on, and walks toward Ms. Niederhelman. The woman was fully dressed.

77. At 23:23:26, the woman pulls the covers off Ms. Niederhelman.

78. At 23:23:33, the woman grabs Ms. Niederhelman's right lateral leg below the knee and pulls the legs off the bed.

79. At 23:23:48, the woman appears to yell at Ms. Niederhelman and points her finger at her. Ms. Niederhelman was awake and holding onto the bedrail with her left hand. The individual walked toward Ms. Niederhelman while speaking and pointing her finger.

80. At 23:23:50, the woman grabs Ms. Niederhelman by the left hand. Ms. Niederhelman was awake and appeared frightened as the individual leaned over her, yelling.

81. 23:23:55, the woman forcefully grabs Ms. Niederhelman's mouth to stop her from speaking and leans over, speaking at Ms. Niederhelman.

82. At 23:24:07, the woman violently grabs Ms. Niederhelman by the right hand and wrist and repeatedly pulls her off the bed. Ms. Niederhelman held tightly to the bedrail with her left hand to prevent being pulled to the floor.

83. At 23:24:22, the woman finally stops pulling Ms. Niederhelman's right arm violently. Ms. Niederhelman was pulled to the floor with her head wedged between the bed rail and the bed.

84. At 23:24:36, after attempting to make the bed and throwing a book, the woman stands over Ms. Niederhelman (who is still on the floor) and appears to yell at her.

85. At 23:24:43, the woman again vigorously grabbed Ms. Niederhelman's right arm and pulled using all of her weight. Ms. Niederhelman was trying to resist.

86. At 23:24:48, the woman continued to pull Ms. Niederhelman by her right arm. She forcefully pulled her to the floor and then across the floor.

87. At 12:24:55, Ms. Niederhelman was left on the floor with her head up against the side of the bed. Ms. Niederhelman was rolling back and forth on the floor, distressed. The woman proceeded to gather the bed sheets.

88. At 23:25:50, the woman finally left the room. The lights were left on. Ms. Niederhelman was on the floor with her head under the bed and her pajama pants half

off. She rolled side to side on the floor.

89. At 23:26:08, the woman walks back into Ms. Niederhelman's room. Ms. Niederhelman was still lying on the floor. The woman again tried to make the bed.

90. At 23:27:15, finally, Three Rivers staff enter the room. Ms. Niederhelman was still on the floor, and the woman was gathering the bed sheets.

91. At 23:27:33, the Three Rivers staff left the room, leaving Ms. Niederhelman alone with the assailant and putting her at additional risk for significant harm. Ms. Niederhelman was left on the floor.

92. At 23:27:43, two Three Rivers staff walked into the room.

93. At 23:28:00. the two staff members grabbed Ms. Niederhelman by the arms, pulling her off the floor and onto the bed. The lifting of Ms. Niederhelman was an abusive violation of the standard of care and most likely worsened her shoulder fractures. Other than rubbing the back of Ms. Niederhelman's head and looking down at the back of the shirt, there was no cervical spine, musculoskeletal, or neurologic assessment.

94. At 23:28:25, one staff member grabbed Ms. Niederhelman under the right axilla and hoisted her back onto the bed. The staff covered Ms. Niederhelman with sheets. The staff did not pull her pajama pants back up to the waist. The bed was lowered. The nurse's post-fall assessment was negligent and abusive. The standard of care required a thorough evaluation for trauma and fracture by 911 and transport to the ED. The aggressive lifting of Ms. Niederhelman under the left shoulder and by the right arm, more likely than not worsened the bilateral shoulder fractures and caused further pain and suffering. At 23:29: 31, the two staff members left Ms. Niederhelman in the

room.

95. Three Rivers failed to provide appropriate supervision of Ms. Niederhelman and other residents.

96. Three Rivers failed to identify a patient with dementia who was fully dressed at midnight, wandering the halls and walking into another resident's room. Their failure represented inadequate supervision of the patients and caused significant harm to Ms. Niederhelman.

97. On January 26, 2023, at 23:35, Nurse Robin Spoonamore, LPN, documented a call was received that the resident was on the floor and another resident was straightening her covers. The resident was checked on with no complaints of pain and put back into bed.

98. The call most likely came from the Safely You video monitoring system. It is not reasonable to conclude that Nurse Spoonamore did not review the video or as the caller did not know what the video recorded.

99. On January 26, 2023, at 23:39, Nurse Spoonamore documented a post-fall evaluation/notification note. She documented that no injuries occurred, the physician and family were notified at 11:30 pm, and no complaints of pain were reported.

100. Nurse Spoonamore most likely did not inform the physician of the assault. A reasonable physician would have sent Ms. Niederhelman to the hospital if notified of physical abuse.

101. Mr. David Niederhelman was not notified on January 26, 2023, at 23:30. The DON called and left a voicemail twelve hours later.

102. Three Rivers had access to the Safely You video monitoring system that recorded the assault. Nurse Spoonamore failed to document a review of the Safely You video, accurately describe the events, and inform the physician and son.

103. An assault is a significant change in condition and poses a great risk of harm to the person assaulted and to the assailant. The standard of care requires the following:

1. Emergently call EMS via 911 for transport to the emergency department (ED) for a thorough trauma evaluation.
2. Do not move the victim so as to avoid further harm.
3. Review the video monitor and document the review.
4. Immediately notify the provider of the assault.
5. Immediately notify the family of the assault; including the families of the one assaulted and the assailant.
6. Immediately notify the Director of Nursing (DON) and Administration.

104. Had Mr. David Niederhelman been notified that his mother was physically assaulted, he would have demanded his mother be evaluated at the hospital. Ms. Niederhelman would not have suffered sepsis and death had she been sent to the hospital.

105. Three Rivers violated the standard of care by failing to do the following:

1. Failed to review the Safely You recorded events.
2. Failed to report abuse according to all legal and statutory requirements.
3. Failed to call 911 for emergency evaluation.
4. Failed to call the son.
5. Failed to inform the physician of the assault.
6. Moved Ms. Niederhelman by her shoulders and without cervical protection.

106. Had Three Rivers comported with the standard of care, Ms. Niederhelman would not have suffered hypoxic respiratory failure, coma, sepsis, and death.

107. On January 27, 2023, NP Linda Brodbeck ordered a stat bilateral shoulder x-ray.[1]

108. On January 27, 2023, at 11:23, a three-view x-ray of the right and left shoulder was obtained. NP Brodbeck ordered the x-rays. The clinical indication for the shoulder x-rays was trauma and pain. The radiologist's interpretation of the x-rays was reported on January 27, 2023, at 11:49. The radiologist's interpretation was the following:

- Right shoulder: Prominent deformity of the humeral head consistent with trauma. Fracture of the proximal humerus age indeterminate suboptimally evaluated.
- Left shoulder: Deformity of the humeral head consistent with fracture, age indeterminate. Bone fragment inferior to the glenoid surface consistent with fracture fragment, not thought to be acute. Evidence of fractures, probably not acute, on the limited two-view exam.

109. The assault caused bilateral acute shoulder fractures and bone deformities.

110. On January 27, 2023, at 11:57, the DON, Tawny Cross, RN, called and left a voicemail for Mr. Dave Niederhelman. Nurse Tawny's voicemail stated that there was a non-urgent "incident" regarding Ms. Deloros and asked for a callback.

111. Twelve hours after Ms Niederhelman was assaulted, Nurse Cross finally notified Mr. Niederhelman. She failed to describe the events accurately and failed to inform the son of the bilateral shoulder fractures. Nurse Cross' actions were negligent and caused harm to Ms. Niederhelman. Had Nurse Cross notified Ms. Niederhelman that his mother had been assaulted it is reasonable to conclude that he would have sent his mother to the hospital. Had Ms. Niederhelman been sent to the hospital on January 27, 2023, at 11:57, she would have survived.

112. The standard of care required Nurse Cross to send Ms. Niederhelman to the hospital.

113. On January 27, 2023, at 12:14, NP Brodbeck evaluated Ms. Niederhelman for "[F]ollowup after being found on the floor last night." The staff were concerned about Ms. Niederhelman's right arm due to guarding it. Ms. Niederhelman's guarding of the right arm was consistent with pain. [2] Ms. Niederhelman had normal vital signs and her oxygenation was normal (98% on room air).

114. NP Brodbeck did not complete a review of systems due to dementia. Despite Ms. Niederhelman guarding her arm, NP Brodbeck failed to ask about arm pain.

115. NP Brodbeck's examination showed that Ms. Niederhelman was in no acute distress; she had decreased breath sounds in the bases and was oriented to person.

116. NP Broadbeck failed to examine the shoulders and the arms.

117. NP Brodbeck's diagnosis was a fall. The plan included that Ms. Niederhelman remain in the secured unit until X-rays are obtained.

118. NP Brodbeck failed to review the shoulder x-rays. The bilateral shoulder x-rays had been obtained at 11:23 and were interpreted by the radiologist at 11:49, approximately 30 minutes before the NP Brodbeck's evaluation.

119. NP Brodbeck and Three Rivers had access to the videotape. NP Brodbeck either failed to review the video or failed to act appropriately after reviewing the videotape. She either knew or should have known of the assault.

120. The standard of care required NP Brodbeck to examine the shoulders and arms, to review the results of the x-rays, document the assault, report the assault to the family, report the assault to the legal authorities, and send Ms. Niederhelman to the

hospital for a trauma evaluation following the assault.

121. NP Brodbeck failed to comply with the standard of care. Her failures were grossly negligent and reckless. NP Brodbeck's violations of the standard of care caused Ms. Niederhelman's sepsis, air hunger, respiratory failure, multiorgan failure, and death.

122. Had NP Brodbeck comported with the standard of care, Ms. Niederhelman's pneumonia would have been treated, the sepsis would have been prevented, the multiorgan failure would not have occurred, and she would have survived.

123. NP Brodbeck billed Medicare using the CPT 99309 or moderate-level visit for 30 minutes. Components of a 99309 include a detailed history and exam, moderate decision-making, and a significant new problem. She did not perform a detailed history and examination of the new problem (i.e., assault and bilateral shoulder fractures). NP Brodbeck did not examine the shoulders, review the x-rays that she ordered stat, or review the videotape, and did not implement moderate decision-making.

124. On January 27, 2023, at 12:48 (effective date), the Clinical Manager, Nurse Amanda Fields, LPN, documented that a report was made to the Hamilton County Sheriff's Department regarding the "fall."

125. Nurse Fields wrongly described the event as a fall. Ms. Niederhelman did not fall. She was physically assaulted for nearly 4 minutes by another resident.

126. On January 27, 2023, at 12:53, approximately 13 hours after the assault, the Three Rivers staff called the Hamilton County Sheriff's Office. Three Rivers reported that on January 26, 2023, at 23:30, another resident pulled Ms. Niederhelman out of

her bed. Both patients had dementia, and there was no criminal act. Three Rivers stated they "[W]ished to have it [assault] documented by police per their corporate policy." In addition, the staff reported they were made aware after the fall alarm went off when the patient left the bed and a video started recording.

127. Three Rivers did not contact the sheriff for Ms. Niederhelman's well-being. Three Rivers contacted the sheriff "per corporate policy" to cover themselves.

128. According to Three Rivers's report to the Sheriff, they knew Ms. Niederhelman had come off the bed due to the bed alarm. Three Rivers took nearly 4 minutes (23:23:33 to 23:27:15) to evaluate Ms. Niederhelman after being pulled off the bed.

129. The report that Three Rivers was made aware of the "fall" by the bed alarm is consistent with inadequate supervision of the residents, including Ms. Niederhelman. Had it not been for the bed alarm, Three Rivers would not have known that Ms. Niederhelman was off the bed and assaulted.

130. The Sherriff report confirms that Three Rivers provided inadequate supervision based on the following:

- Three Rivers only knew of the "fall" because of the alarm.
- Three Rivers failed to hear the woman speaking to Ms. Niederhelman.
- Three Rivers failed to hear the assault.
- Three Rivers failed to respond timely to the assault. It took four minutes to respond.

131. On January 27, 2023, at 19:51, the Temp/Agency Nurse documented a Fall Follow-Up evaluation form. Ms. Niederhelman's vital signs were a blood pressure of 134/77 mmHg, a temperature of

132. 97.2 F, pulse of 85 beats per minute, respiratory rate of 16 breaths per minute, and an oxygen saturation of 95%.

133. The Fall Follow-Up evaluation reported the following:

- The "fall" occurred on January 27, 2023.
- No complaints of pain.
- All extremities with full range of motion.
- No change in baseline mental status.
- Neuro checks are being completed per facility protocol.
- No interventions in place to prevent future falls.

134. The Fall Follow-Up form was negligently completed for the following reasons:

- Ms. Niederhelman did not have a fall.
- The assault occurred on January 26, 2023, not January 27, 2023.
- Most likely, Ms. Niederhelman had pain from the two humerus fractures. She exhibited pain early in the day with guarding.
- Three Rivers failed to consider and implement preventive measures such as providing appropriate supervision of its residents.
- The evaluation failed to document the assault.

135. Less than 2 hours later, on January 27, 2023, at 21:41, Ms. Niederhelman had hypoxic respiratory failure with labored respirations, breathing at 32 breaths per minute, and was comatose.[3]

136. On January 27, 2023, at 21:30, Nurse Cross documented that she received a call from staff regarding a change in condition. NP Brodbeck and Dr. Pisati were informed and ordered to be sent to the hospital.

137. The Three Rivers medical record failed to document when the change in condition started and exactly what the change in condition represented.

138. On January 27, 2023, at 21:41, Three Rivers called the Miami Township Fire Department (EMS). The chief complaint was shortness of breath. The duration of the symptoms was 2 hours.

139. The EMS assessment at 21:55 revealed that Ms. Niederhelman had rapid, labored respirations, coarse bilateral pulmonary rhonchi, hot skin temperature, and was unresponsive. The vital signs were a blood pressure of 160/90 mmHg, a pulse of 98 beats per minute, a respiratory rate of 32 breaths per minute, an oxygen saturation of 82% on room air, and a Glasgow Coma Score (GCS) of 5. The EKG showed atrial fibrillation.

140. A GCS measures eye opening, verbal response, and motor response. The GCS is scored between 3 and 15. A GCS of 3 to 8 is consistent with a comatose state. A score of 3 to 5 has a high mortality rate.

141. Ms. Niederhelman was hypoxic. Hypoxia causes central nervous system (CNS) ischemia. CNS ischemia causes coma (i.e., GCS < 8).

142. The Three Rivers medical record has no documentation that Ms. Niederhelman had a loss of consciousness and no documentation that she had shortness of breath before EMS was called. The most recent nurse note before 21:41 was the Fall Follow-Up evaluation at 19:51, which did not report loss of consciousness or shortness of breath.

143. The following is a summary of the EMS Narrative History:[1]

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[1] See Miami Township Fire Department Prehospital Care Report Summary.

- Ms. Niederhelman was found lying supine with labored respirations. She was unresponsive with audible rhonchi.
- The nurses on the scene had no information about the patient besides low oxygen saturation.
- Medical treatment was not being provided. The patient was not on oxygen.
- Nurses could not report Ms. Niederhelman's medical condition, as they said because nobody had reported it to them during shift change.
- Breathing labored. Respiratory rate: 32 breaths per minute.
- Circulation appeared poor as skin tone and color [e.g., cyanosis] reflected patient oxygen saturation on room air of 82% [Pa02/FiO2 - 219 mmHg].
- Temperature was 98.8, and pulse was 104 beats per minute.
- EKG showed atrial fibrillation with premature ventricular contractions (PVC).
- Auscultation of lungs confirmed rhonchi.
- Capillary refill delayed by greater than two seconds.
- Nonrebreather face mask oxygen at 15 liters was placed.
- GCS 5.
- Patient showed improvement upon arrival to the hospital with a GCS of 8 [with supplemental oxygen].

144. Three Rivers's nurses failed to provide any medical treatment to Ms. Niederhelman and knew nothing about her health. The previous shift nurses failed to communicate Ms. Niederhelman's relevant healthcare information (i.e., recent assault and bilateral shoulder fractures) to the oncoming shift nurses. The lack of communication was negligent and represented a disregard for Ms. Niederhelman's well-being.

145. The EMS narrative does *not* document the assault, nor does it document the bilateral shoulder fractures; consistent with the Three Rivers provider's poor communication and lack of knowledge regarding their patient.

146. Ms. Niederhelman had acute hypoxic respiratory failure and suffered from air hunger manifested by severe tachypnea and audible rhonchi (without a stethoscope). Despite the visible suffering and audible rhonchi, the Three Rivers nurses failed to provide any medical treatment, such as supplemental oxygen.

147. Three Rivers staff did *nothing* to correct the hypoxia. They did not apply supplemental oxygen. Three Rivers's lack of treatment was egregious and caused unnecessary prolongation of hypoxia, tissue ischemia, cerebral ischemia, and coma, and significantly contributed to her death.

148. Three Rivers' failure to provide supplemental oxygen or any other medical treatment while Ms. Niederhelman suffered from air hunger was reckless and grossly negligent. Their lack of medical care showed a conscious disregard for Ms. Niederhelman's well-being. It resulted in prolonged suffering and tissue ischemia, including encephalopathy. When EMS provided appropriate supportive care by applying oxygen to Ms. Niederhelman, her GCS improved from 5 to 8, consistent with an improvement in the comatose state due to oxygenation.

149. On January 27, 2023, 21:59 (effective date), Nurse Spoonamore documented that Ms. Niederhelman had a change in condition. Her blood pressure was 90/63 mmHg, and her oxygen saturation was 82%. Mr. Dave Niederhelman had been called. An order was received to send her to the hospital.

150. Nurse Spoonamore documented the note after EMS had been called. Nurse Spoonamore did not report any complaints of shortness of breath, labored respirations, or loss of consciousness.

Mercy Health West Hospital

151. On January 27, 2023, at 22:19, Ms. Niederhelman arrived at the Mercy Health West Hospital (Mercy) ED. She was not responsive. The GCS was 7 (opened eyes to pain, no verbal response), and withdrew from pain). (Mercy Health West Hospital 103)

152. The ED nurse documented the chief complaint was the following: (Mercy Health West Hospital 103)

153. Altered mental status (found by SNF staff unresponsive; when EMS arrived pt, was in 70's on RA)

154. Ms. Niederhelman's family reported to the ED nurse that she had a fall at the nursing home last night, and her normal baseline was wheeling herself in the wheelchair and speaking.

155. Neither the ED nurse nor the family reported the physical assault or the bilateral shoulder fractures, consistent with not being informed of the events by Three Rivers.

156. On January 27, 2023, at 23:00, Ms. Niederhelman's vital signs in the ED were a temperature of

157. 100.3 F, pulse of 79 beats per minute, respiratory rate of 22 breaths per minute, a blood pressure of 118/37 mmHg, mean arterial pressure (MAP) of 61 mmHg, and an oxygen saturation of 100% on 5 liters supplemental oxygen.

158. The chest x-ray revealed ground glass opacification involving both lungs. The impression included mild pulmonary edema or early bronchopneumonia.

159. Ms. Niederhelman's shoulder fractures were not x-rayed in the ED, consistent with Three Rivers's failure to inform EMS, the family, or the hospital of the fractures and the assault.

160. Ms. Niederhelman's laboratory in the ED revealed the following:

- Lactic acid 2.1 (reference range: 0.4-2.0)
- Troponin 0.22 (reference range: < 0.01)
- White blood cell (WBC) of 3.2 (reference range: 4.0-11.0)
- Hemoglobin 9.5 (reference range: 12.0-16.0)
- Platelet count 98K (reference range: 135-450)
- BUN 58 (reference range: 7-20)
- Creatinine 1.3 (reference range: 0.6-1.2)
- Total bilirubin 1.8 (reference range: 0.0-1.0)
- Brain natriuretic peptide (BNP) 30,981 (reference range: 0-449)
- Negative influenza and negative COVID-19.
- Procalcitonin 3.13 (reference range: 0.00-0.15)
- High risk of sepsis/shock > 2.00

161. In 2016, The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) updated the definition of sepsis. Sepsis-3 defined sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection.[2] The

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[2] Singer M. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis- 3). *JAMA*. 2016; 315(8): 801-810.

sequential organ failure assessment (SOFA) score objectively measures organ dysfunction.[3] (*see figure below)* Organ dysfunction is defined as a SOFA score ≥ 2. Even a modest degree of organ dysfunction in the setting of early infection is associated with an in-hospital mortality of over 10%. The higher the SOFA score, the worse the mortality.

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score[a]

	Score				
System	0	1	2	3	4
Respiration					
PaO_2/FIO_2, mm Hg (kPa)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, $\times 10^3/\mu L$	≥150	<150	<100	<50	<20
Liver					
Bilirubin, mg/dL (μmol/L)	<1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose)[b]	Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1[b]	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1[b]
Central nervous system					
Glasgow Coma Scale score[c]	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol/L)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
Urine output, mL/d				<500	<200

Abbreviations: FIO_2, fraction of inspired oxygen; MAP, mean arterial pressure; PaO_2, partial pressure of oxygen.

[a] Adapted from Vincent et al.[27]

[b] Catecholamine doses are given as μg/kg/min for at least 1 hour.

[c] Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

162. Ms. Niederhelman had an infection with organ dysfunction consistent with sepsis. The manifestations of infection included elevated procalcitonin (3.13), fever (temperature of 100.3 F), abnormal chest x-ray consistent with pneumonia, tachycardia, tachypnea, and neutropenia (WBC of 3.2). The manifestations of organ dysfunction

[3] Id.

included hypoxic respiratory failure, acute kidney injury, altered mental status/coma, and hypotension.

163. A SOFA can objectively measure Ms. Niederhelman's organ dysfunction. Her SOFA score was the following:

- Respiration – 2 points (Pa02/FiO2 - 219 mmHg)
- Coagulation – 2 points (platelet count 98K)
- Liver – 1 point (bilirubin 1.8)
- Cardiovascular – 1 point (MAP 61mmHg)
- CNS – 4 points (GCS 5)
- Renal – 1 point (Creatine 1.3)

164. Ms. Niederhelman had a SOFA score of 11, which is consistent with multiorgan failure and high mortality. In addition, she had lactic acidosis secondary to tissue ischemia, demand myocardial ischemia, and prerenal azotemia (elevated BUN/Cr ratio) due to dehydration.

165. On January 27, 2023, the ED provider evaluated Ms. Niederhelman. The history of present illness reported that "per the family, she had rolled out of bed yesterday and hit the right side of her face last night," and she was unresponsive with respiratory distress.

166. The family reported that Three Rivers notified them today that Ms. Niederhelman was whispering and taking shallow respirations. EMS found her at 82% on room air. It was unclear how long she had been short of breath.

167. The history was consistent with the family being told false information regarding the mother's assault and bilateral shoulder fractures.

168. The Three Rivers medical records do not document the abnormal whispered speaking or the shallow respirations consistent with their poor medical care and supervision.

169. The review of the system revealed fever, cough, shortness of breath, weakness, and confusion.

170. The ED provider's examination showed a GCS of 7 and a temperature of 100.3F. Ms. Niederhelman appeared ill, had wheezes and rhonchi, was lethargic, and noncommunicative. The ED provider did not perform a musculoskeletal examination of the shoulders.

171. The ED provider started Ms. Niederhelman on broad-spectrum antibiotics and admitted her to the hospital. The diagnoses included altered mental status, acute hypoxic respiratory failure, pleural effusion, acute kidney injury, and elevated troponin.

172. The ED provider's history and physical was consistent with a lack of knowledge regarding Ms. Niederhelman's assault and bilateral shoulder fractures.

173. Three Rivers failed to inform the family and failed to notify the treating providers at Mercy regarding the assault and fractures. Their failure significantly interfered with Ms. Niederhelman's medical evaluation and care and caused harm.

174. On January 28, 2023, the hospitalist evaluated Ms. Niederhelman. The history of present illness again reported a "fall" the previous night and did not comment on an assault or bilateral shoulder fractures. The physician reported that Ms. Niederhelman had become more somnolent throughout the day at Three Rivers. The family reported that they were concerned that Ms. Niederhelman had been ignored. (Mercy Health West Hospital 160-164).

175. The admitting physician's history was consistent with a lack of knowledge of the physical assault or the bilateral shoulder fractures.

176. The Three Rivers medical records failed to indicate that Ms. Niederhelman had become more somnolent throughout the day.

177. Three River's acts and omission supported the family's concern that Ms. Niederhelman was ignored.

178. The admitting physician's examination revealed lethargy, dry mucous membranes, and bilateral pulmonary crackles.

179. The admitting physician's assessment included the following:

- Sepsis
- Pneumonia
- UTI [urinary tract infection]
- Pulmonary edema
- NSTEMI [no ST-segment elevation myocardial ischemia]
- Anemia

180. The admitting physician opined that Ms. Niederhelman had an infectious process and was dry (i.e., dehydrated). The NSTEMI was likely due to an infectious process (i.e., demand myocardial ischemia). The physician continued the broad-spectrum antibiotics, started heparin for the NSTEMI, and provided intravenous fluids.

181. On January 29, 2023, the family requested that Ms. Niederhelman be admitted to Hospice of Cincinnati.

182. On January 30, 2023, at 18:00, Ms. Niederhelman died. The Ohio Department of Health Certificate of Death documented the following:

1. Immediate cause: Acute respiratory failure with hypoxia

2. Conditions leading to the immediate cause of death: Sepsis and pneumonia.

183. On January 30, 2023, at 17:30, the physician's discharge summary documented that Ms. Niederhelman had suffered an assault by another resident on the previous Thursday; the details surrounding this were unclear. The discharge diagnoses included the following: (Mercy Health West Hospital 144-145)

- Sepsis secondary to suspected pneumonia. Present on admission: leukopenia, febrile, tachypnea.[6]
- Pancytopenia secondary to sepsis.
- Acute hypoxic respiratory failure and respiratory acidosis.
- Acute metabolic encephalopathy secondary to sepsis.
- Elevated troponin.
- Acute on chronic diastolic congestive heart failure.

FIRST CAUSE OF ACTION
(MEDICAL NEGLIGENCE / RECKLESSNESS)

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

185. Dolores Niederhelman depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

186. The Defendants had a duty to provide proper care and treatment to Dolores Niederhelman and to avoid causing injury to Dolores Niederhelman.

187. The Defendants, including their medical and nursing staff, failed to provide proper care and treatment to Dolores Niederhelman, which they knew or should

have known they required, and their negligence was the direct and proximate cause of the injuries that Dolores Niederhelman suffered.

188. These actions constituted a conscious disregard for Dolores Niederhelman'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.

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

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

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

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

193. 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.

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

195. 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)

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

197. As a direct and proximate result of the negligence / recklessness described above, Dolores Niederhelman sustained injuries that caused their untimely and wrongful death.

198. Dolores Niederhelman'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.

199. 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)

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

201. Defendants, directly or through their employees or agents, violated Dolores Niederhelman'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.

202. These violations are evidence of negligence and conscious disregard of Dolores Niederhelman's rights and safety and give rise to a statutory cause of action.

203. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Dolores Niederhelman conscious pain, suffering, and disability, and other harms and lossesincluding death.

204. 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)

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

206. Defendants had an express agreement, mutual understanding, or tacit agreement to, and/or their agents maliciously combined efforts to:

a. defraud residents and their families by delivering wholly inadequate care, contrary to their promises;

b. systemically understaff their facilities in violation of federal regulations, and for the purposes of their own profit, at the expense of resident health and safety;

c. under-capitalize the facilities and syphon money to themselves and related entities for the purposes of their own profit at the expense of resident health and safety;

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

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

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

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

207. This understanding constitutes a malicious combination to injure residents of the Facility, including Dolores Niederhelman.

208. 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.

209. The conspiracy caused injury to Dolores Niederhelman.

210. 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)

211. Plaintiffincorporates all other paragraphs of this Complaint as if fully rewritten herein.

212. Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Three Rivers Healthcare Center aka 3r Operating CO LLC.

213. 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 Dolores Niederhelman and other potential customers to place their loved ones in their care and custody.

214. 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 Dolores Niederhelman's family and other potential customers into placing their loved ones in the care and custody of

Defendants.

215. Dolores Niederhelman's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

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

217. As a direct and proximate result of Defendants' actions, representations, and concealments, Dolores Niederhelman suffered conscious pain and suffering and death.

218. As a direct and proximate result of Defendants' action, representations, and concealments, Dolores Niederhelman'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*.

219. 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)

MOLLY B. MORRIS (0102510)
MICHAEL HILL TRIAL LAW
815 Superior Avenue, Suite 623
Cleveland, Ohio 44114
(800) 659-2712
michael.hill@protectseniors.com
molly.morris@protectseniors.com
Counsel for Plaintiff

STATE OF CONNECTICUT)
)
HARTFORD COUNTY)
)
)

AFFIDAVIT OF MERIT

Affiant LORRAINE DOONAN, RN, BSN, MS, CSA, BCPA, CDP, 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 Director of Clinical Services and Certified Dementia Practitioner, licensed in the state of Connecticut, board-certified in Patient Advocacy, and a prior nursing supervisor to multiple skilled care nursing facilities. I have administrative and clinical experience in rehabilitation, skilled nursing facility, home healthcare and assisted living settings. Clinical point of contact for care teams with external referral sources. Collaborator with case management departments to facilitate safe and effective transitions of care across settings in the healthcare continuum. Facilitator for clinical review meetings with staff and providers. Responsible for staff recruitment and development. Educator for clinical staff on care management and quality improvement. Chairperson of statewide initiative pertaining to depression screening and intervention. Contributor to published articles pertaining to evidence-based best practice guidelines for depression screening. Operational knowledge of federal and state standards for acute care, rehabilitation, skilled nursing, assisted living and homecare. Responsible for risk management and compliance activities.

3. Through my specialized knowledge, skill, training, experience, and education, I am familiar with the standard of care applicable to the nursing care and treatment that was provided to Dolores Niederhelman while a resident of Three Rivers Healthcare Center aka 3r Operating CO LLC.

4. I have reviewed all medical records reasonably available to Estate of Dolores L. Niederhelman concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Three Rivers Healthcare Center aka 3r Operating CO LLC, Communicare Family of Companies dba Health Care Facility Management, LLC, Communicare Health Services, Inc., Communicare, Inc., Parkway Mgt. Co., LLC, CT Operations Holdco, LLC, 3R RE Holdings, LLC, Tawny Cross, RN, Robin Spoonamore, LPN, Amanda Fields, LPN, Unidentified TEMO/Agency Nurses breached the standard of care and the breach caused Dolores Niederhelman's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

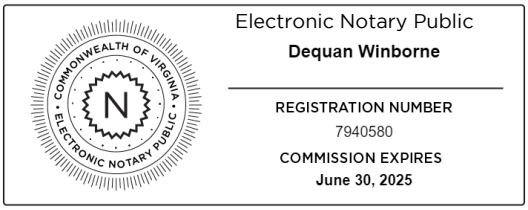
Lorraine Marie Doonan

LORRAINE DOONAN, RN, BSN, MS, CSA, BCPA, CDP

County of Henrico, Commonwealth of Virginia

SWORN TO BEFORE ME and subscribed in my presence this 26th day of January, 2024.

NOTARY PUBLIC



Notarized online using audio-video communication

STATE OF MISSOURI)
)
JASPER COUNTY)
)
)

AFFIDAVIT OF MERIT

Affiant JOHN J. CASCONE, 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 fields of Infectious Disease and Long-term Care, licensed in the state of Missouri, board certified in Infectious Disease, and a medical director of Joplin Gardens, Westgate Nursing Home, Wildwood Nursing Home, Sarcoxie Nursing home, and Kindred Hospital Northland, 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 Dolores Niederhelman while a resident of Three Rivers Healthcare Center aka 3r Operating CO LLC.

4. I have reviewed all medical records reasonably available to Estate of Dolores L. Niederhelman concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Three Rivers Healthcare Center aka 3r Operating CO LLC, Communicare Family of Companies dba Health Care Facility Management, LLC, Communicare Health Services, Inc., Communicare, Inc., Parkway Mgt. Co., LLC, CT Operations Holdco, LLC, 3R RE Holdings, LLC, Linda Brodbeck, NP, Tawny Cross, RN, Robin Spoonamore, LPN, Amanda Fields, LPN, Unidentified TEMO/Agency Nurses breached the standard of care and the breach caused Dolores Niederhelman's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.



JOHN J. CASCONE, MD

SWORN TO BEFORE ME and subscribed in my presence this _____ day of January, 2024.

certificate attached

NOTARY PUBLIC

VIRGINIA JURAT

State of Virginia)
)
County of Newport News)

On 01/25/2024 (*Date*), before me, Rushane E Smith (*Notary Name*),
the foregoing instrument was subscribed and sworn to before me by:

John J Cascone
Name of Affiant(s)

❑ Personally known to me **-- OR --**

❑ Proved to me on the basis of the oath of _____ (*Name of Credible Witness*) **-- OR --**

❑ Proved to me on the basis of satisfactory evidence: _____ (*Type of ID Presented*)

COMMONWEALTH OF VIRGINIA · ELECTRONIC NOTARY PUBLIC ·

Rushane E Smith

REGISTRATION NUMBER
7857590
COMMISSION EXPIRES
July 31, 2024

WITNESS my hand and official seal.

Notary Public Signature: _____

Notary Commission Number: 7857590

Notary Commission Expires: 07/31/2024

Notarized online using audio-video communication

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: court affidavit

Document Date: 01/25/2024

Number of Pages (including notarial certificate): 3

STATE OF OHIO)
) **AFFIDAVIT OF MERIT**
CUYAHOGA COUNTY)
)
)

Affiant MARK SHOAG, 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 fields of Geriatric and Internal Medicine, licensed in the state of Ohio, board certified in Internal Medicine, and a medical director of a long-term acute care hospital, 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 Dolores Niederhelman while a resident of Three Rivers Healthcare Center aka 3r Operating CO LLC.

4. I have reviewed all medical records reasonably available to Estate of Dolores L. Niederhelman concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Three Rivers Healthcare Center aka 3r Operating CO LLC, Communicare Family of Companies dba Health Care Facility Management, LLC, Communicare Health Services, Inc., Communicare, Inc., Parkway Mgt. Co., LLC, CT Operations Holdco, LLC, 3R RE Holdings, LLC, breached the standard of care and the breach caused Dolores Niederhelman's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

Mark Shoag MD

MARK SHOAG, MD

SWORN TO BEFORE ME and subscribed in my presence this 24th day of January, 2024.

Becki Dvorak
Notary Public my commission has no expiration date pursuant to RC 147.03