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COMMON PLEAS DIVISION

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July 14, 2026 11:41 AM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1852661

ESTATE OF BARBARA K RALEIGH

vs.

CARECORE AT MARGARET HALL LLC

A 2603761

FILING TYPE: INITIAL FILING (OUT OF COUNTY) WITH JURY DEMAND

PAGES FILED: 25

EFR200

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

ESTATE OF BARBARA K. RALEIGH, DECEASED, Through Estate Representative, James M. Raleigh, c/o Michael Hill Trial Law 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. CARECORE AT MARGARET HALL, LLC 1960 Madison Road Cincinnati, Ohio 45206 Also Serve c/o Registered Agent: Taft Service Solutions Corp. 425 Walnut Street Suite 1800 Cincinnati, Ohio 45202 and CARECORE HEALTH, LLC c/o Registered Agent: Eric M. Simon 200 Public Square Suite 3500 Cleveland, Ohio 44114 and MARGARET HALL REALTY, LLC 1 Executive Boulevard Suite 203 Suffern, NY 10901 Also Serve c/o Registered Agent: Taft Service Solutions Corp. 425 Walnut Street Suite 1800 Cincinnati, Ohio 45202	CASE NO.: JUDGE PATRICK T. DINKELACKER **COMPLAINT (REFILED)** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED** Previously filed Case No.: A 2500540 (Previously assigned to: Judge Patrick T. Dinkelacker)

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and

CHAIM HERTANU
46 Briarcliff Dr.
Monsey, NY 10952

Defendants.

Plaintiff, the Estate of Barbara K. Raleigh, Deceased, through Estate Representative James M. Raleigh, for this refiled Complaint (previously filed Case No. A 2500540 assigned to Judge Patrick T. Dinkelacker) against the above-named Defendant(s), states and avers upon information and belief:

INTRODUCTION

1. This action involves multiple claims (medical negligence, recklessness, wrongful death, and Resident's Rights Law violations) involving CareCore at Margaret Hall, LLC ("Facility's") inadequate care of Barbara Raleigh and the corporate control of the facility leading to such inadequate care that led to Barbara Raleigh's untimely and wrongful death on February 10, 2024.

2. CareCore at Margaret Hall, LLC ("CareCore at Margaret Hall"), and their corporate owners, injured and caused the death of 70-year-old Barbara Raleigh.

3. On December 7, 2022, St. Margaret Hall – the facility that would eventually be purchased by Defendants and become CareCore at Margaret Hall – tested nineteen (19) faucets, taps, and showerheads in the patient care areas of the facility for bacteria including *Legionella* strains.

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4. On December 15, 2022, the test results of 42% of the faucets, taps, and showerheads showed contamination with *Legionella* bacteria. This was proof of a systemic contamination of the facility's water supply with *Legionella* bacteria.

5. Industry standards dictate that if any greater 30% of tested potable water delivery points are positive for *Legionella*, that the entire water supply system must be flushed with hot water and shock disinfectant.

6. Adam Roberts, the Maintenance Director of St. Margaret Hall, decided not flush the water system with disinfectant but instead replaced several supply lines, hoses, and showerheads at the delivery points that tested positive. Mr. Roberts re-tested some of the contaminated delivery points in January 2023 – however these samples were lost in the mail.

7. Mr. Roberts then re-tested just three contaminated water delivery points in March 2023, which were negative for *Legionella*. The water supply was not tested again until after February 5, 2024.

8. On November 1, 2023, Defendants acquired St. Margaret Hall and assumed control of operations.

9. At the time Defendants acquired St. Margaret Hall, they retained Adam Roberts as the Maintenance Director, even though Mr. Roberts had no knowledge of ***any*** industry standards for maintaining a safe water supply system and the prevention of *Legionella* contamination in a nursing home.

10. Prior to acquiring St. Margaret Hall, Chaim Hertanu, the owner of the Defendants and an owner/operator of numerous other nursing homes throughout the State of Ohio and across the United States, personally visited and inspected the facility – including the facility's water supply and hot water circulation systems.

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11. Chaim Hertanu was personally responsible for conducting a due diligence inspection of the facility including its water supply and hot water circulation systems, and spoke directly with Adam Roberts during his tours and inspections of the facility.

12. As the individual conducting the inspections and due-diligence investigation of the facility on behalf of Defendants, Chaim Hertanu had a duty to ask questions about any testing results for the water supply, to review any of the testing results for the water supply at the facility, ask to review the facility's water management plan, and ask about any past remediation or disinfection of the facility's water system during his tours, inspection, or due-diligence efforts.

13. Chaim Hertanu never asked Adam Roberts about any testing results for the water supply, never reviewed any of the testing results for the water supply which Mr. Roberts kept in a binder in his office at the facility, never asked to review the facility's water management plan, and never asked about any past remediation or disinfection of the facility's water system during his tours, inspection, or due-diligence efforts during or after the acquisition of St. Margaret Hall by Defendants.

14. If Chaim Hertanu had asked about testing results for the water supply, reviewed any of the testing results for the water supply which Mr. Roberts kept in a binder in his office at the facility, asked to review the facility's water management plan, or asked about any past remediation or disinfection of the facility's water system, he and the Defendants would have learned that 42% of tested water delivery points in patient care areas tested positive for *Legionella*, that industry-standard flushing with disinfectant had never been performed, that only three of the contaminated delivery points were re-tested after Adam Roberts changed supply lines, hoses, and showerheads, and that the facility

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did not have a comprehensive water management plan that conformed to industry standards and regulations for the prevention of *Legionella* contamination.

15. Chaim Hertanu's above failures constituted a conscious disregard for the rights and safety of the existing and future residents of CareCore at Margaret Hall with a great probability of causing substantial harm, by which—through heedless indifference to the consequences—Chaim Hertanu and the Defendants disregarded a substantial and unjustifiable risk of injury, death for those residents, including but not limited to from exposure to *Legionella* bacteria.

16. Barbara Raleigh was admitted to CareCore at Margaret Hall on or about December 7, 2023 for rehabilitation following a fall at home.

17. On or about February 5, 2024, Ms. Raleigh began experiencing difficulty breathing, and she was transported to The Christ Hospital for evaluation and treatment.

18. On or about February 7, 2024 Ms. Raleigh was moved to the intensive care unit at The Christ Hospital, where she was diagnosed with Legionnaires Disease.

19. While in the care of CareCore at Margaret Hall, Ms. Raleigh utilized the Defendants' facilities and services on the premises, including the Facility's water supply, and did so until her last day at the Facility.

20. According to the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Legionnaires Disease is a very severe type of pneumonia that is caused by inhalation of *Legionella* bacteria from a water source. *Legionella* is found in improperly maintained hot tubs, water cookers, water systems, air conditioning cooling towers, stagnant water, spas, and potable water sources that are not adequately cleaned and disinfected.

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21. According to the Centers for Disease Control and Prevention, the incubation period for the *Legionella* bacteria to become symptomatic in a person is from two to fourteen days after the exposure to the contaminated water source. Ms. Raleigh became symptomatic within the time frame of her exposure to the Facility's water supply. It is more probable than not that Ms. Raleigh contracted *Legionella* pneumonia from the Facility's water supply.

22. Legionnaires Disease is not a communicable disease and cannot be transmitted person-to-person.

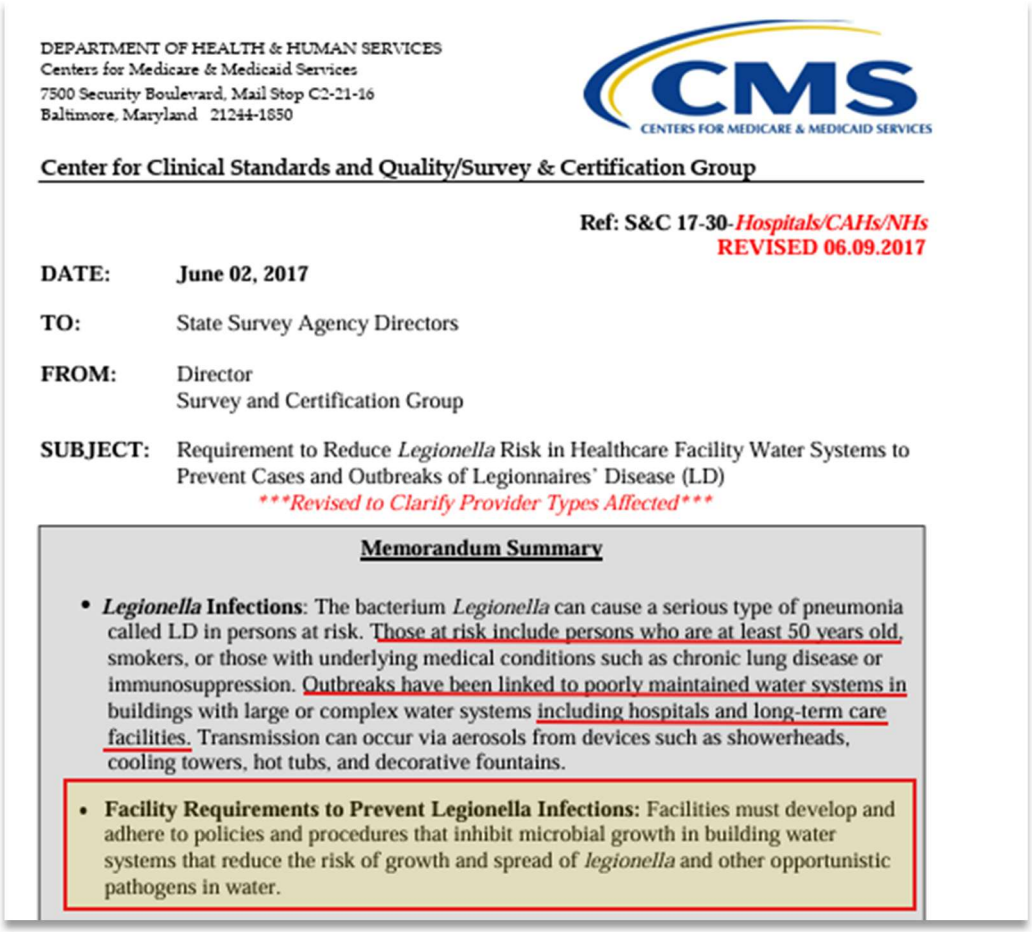
23. The Defendants were responsible for implementing specific control measures to monitor the water supply at the Facility for contamination.

24. The water supply provided to Ms. Raleigh was neither safe nor clean as it was contaminated with *Legionella* bacteria.

25. Defendants knew, or should have known, that the water supply in the Facility was at risk for contamination with *Legionella* bacteria, that the elderly and medically compromised residents of the Facility were at risk of serious harm and death due to exposure to *Legionella* bacteria, and that they had a duty to develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. Defendants knew this since at least June 2, 2017, when the Centers for Medicare

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and Medicaid Services issued requirements to nursing facilities regarding protection of water supplies against *Legionella* and other opportunistic bacteria:



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-30-*Hospitals/CAHs/NHs*
REVISED 06.09.2017

DATE: **June 02, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)
******Revised to Clarify Provider Types Affected******

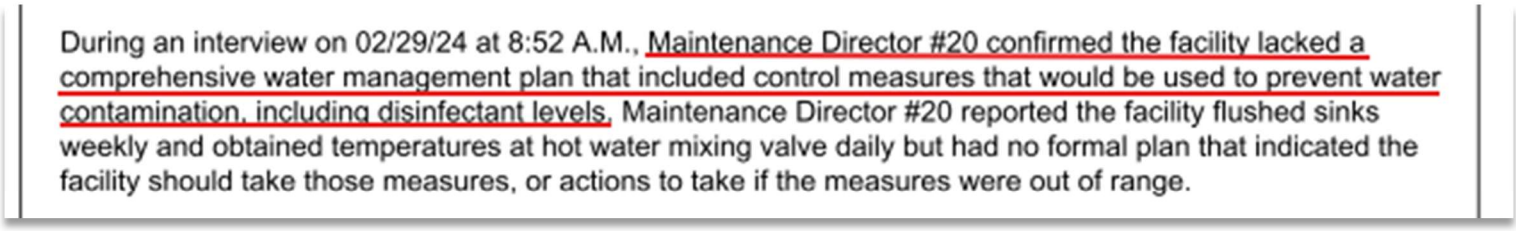
Memorandum Summary

- ***Legionella* Infections**: The bacterium *Legionella* can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains.
- **Facility Requirements to Prevent Legionella Infections:** Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of *legionella* and other opportunistic pathogens in water.

26. The Facility failed to have a comprehensive water management plan that included specific control measures to monitor the water supply for contamination. As a direct result, Barbara Raleigh passed away on February 10, 2024, from the *Legionella* pneumonia caused by the Defendants' failures and violations of her rights.

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27. A subsequent investigation by the Ohio Department of Health and Human Services revealed that the Facility lacked a comprehensive water management plan to prevent water contamination:



During an interview on 02/29/24 at 8:52 A.M., Maintenance Director #20 confirmed the facility lacked a comprehensive water management plan that included control measures that would be used to prevent water contamination, including disinfectant levels. Maintenance Director #20 reported the facility flushed sinks weekly and obtained temperatures at hot water mixing valve daily but had no formal plan that indicated the facility should take those measures, or actions to take if the measures were out of range.

Excerpt from February 29, 2024, Survey by the Ohio Dept. of Health wherein the Facility's Maintenance Director confirms there was no comprehensive water management plan.

28. The Facility tested water samples and hired a remediation consultant to address the *Legionella* bacteria presence in the water supply following Barbara Raleigh's death, which confirmed that 43% of water delivery points in patient care areas that Barbara was likely to come in contact with were contaminated with *Legionella* bacteria.

29. Plaintiff requests a trial by jury.

30. 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.

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DEFENDANTS

31. CareCore at Margaret Hall, 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 CareCore at Margaret Hall, Incorporated.

32. CareCore 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 CareCore at Margaret Hall.

33. Margaret Hall Realty, 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 CareCore at Margaret Hall.

34. Chaim Hertanu is a resident of Monsey, New York, and the owner of Defendants CareCore at Margaret Hall, LLC, CareCore Health, LLC, and Margaret Hall Realty, LLC. Chaim Hertanu personally performed the tours, inspections, and due-diligence efforts involved with the acquisition of St. Margaret Hall by Defendants, including the inspections and due-diligence efforts over the water supply and hot water circulation system at the facility. Chaim Hertanu is an owner and/or operator of numerous nursing homes in the State of Ohio and across the United States, including CareCore at Margaret Hall, LLC.

35. The Defendants employ, manage, and direct the care and service providers who were responsible for Barbara Raleigh's care, treatment, and safety at CareCore at Margaret Hall aka Saint Margaret Hall, Incorporated while they were a resident there,

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and / or are responsible for creating unsafe conditions at the Facility through their control of the Facility management that directly led to Barbara Raleigh' injuries and untimely and wrongful death on February 10, 2024.

36. 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.

37. The Defendants' 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.

38. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of CareCore at Margaret Hall aka Saint Margaret Hall, Incorporated directly or through their domination and control of any putative entity license holder.

39. CareCore at Margaret Hall aka Saint Margaret Hall, Incorporated, ("Facility") holds themselves out to the public as providers of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees, commonly referred to as "nursing homes."

VICARIOUS LIABILITY

40. The Defendants manage, control, and/or employ the managers, directors, supervisors, maintenance employees, and care providers who were responsible for

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ensuring Barbara Raleigh's care and safety, including ensuring her safety from a contaminated water supply.

41. Barbara Raleigh and her family looked to the Defendants to provide a safe, clean living environment free from hazards including a safe, clean water supply based upon the Defendants' representations.

42. 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).

JURISDICTION AND VENUE

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

44. 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

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

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

47. For nursing homes generally, the largest individual revenue source is residents (filling beds). Facilities and systems maintenance, including the employment of maintenance personnel, is a large expenditure for nursing homes which does not generate

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revenue. This creates a financial incentive to take on more residents while neglecting the physical facilities and systems of the buildings where residents are housed.

48. The Defendants manage, control, and / or employ the managers, directors, supervisors, maintenance employees, and care providers who were responsible for ensuring Barbara Raleigh's care and safety, including ensuring her safety from a contaminated water supply.

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

a. Policies and procedures, including regarding resident care and water supply management;

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 facilities maintenance;

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;

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

50. As the result of this control, the Defendants make decisions that affect the day-to-day care of residents of the Facilities, such as the resources available for upkeep of the building and physical systems including the water supply system for residents like Barbara Raleigh, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

51. The Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that the facilities had a comprehensive water management plan and well-maintained water supply systems to provide safe, clean water to its residents, including Barbara Raleigh.

52. The Defendants engaged in a systemic practice to understaff the Facility's maintenance department and neglect the upkeep of the physical facilities including the water supply to maximize profits at the expense of its residents' safety.

53. This lack of sufficient upkeep of the physical facilities directly resulted in Barbara Raleigh not receiving basic and necessary services including safe, clean water leading to her injuries and death.

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

a. CareCore at the Meadows
11760 Pellston Ct, Cincinnati, OH 45240

b. CareCore at Lakeridge
7220 Pippin Rd, Cincinnati, OH 45239

c. CareCore at Lima
599 S Shawnee St, Lima, OH 45804

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d. CareCore at Montgomery
7777 Cooper Rd., Cincinnati, OH 45242

e. CareCore at Westmoreland
230 Cherry St., Chillicothe, 45601

f. CareCore at Willowood
1186 Hadcock Rd., Brunswick, OH 44212

g. Garden Park Health Center
3536 Washington Ave., Cincinnati, OH 45229

h. CareCore at Mary Scott
3109 Campus Drive, Dayton, OH 45406

i. CareCore at Mentor
8881 Schaefer St., Mentor, OH 44060

Misleading Advertising

55. 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 safe, clean living environment that they know they are incapable of providing.

56. 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 equipped to provide a safe, clean living environment than what is actually the practice of the Defendants with regard to the upkeep of the Facility.

57. 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.

Defendants' Negligence and Recklessness with Barbara Raleigh

58. Defendants accepted Barbara Raleigh as a nursing home resident for rehabilitation following a fall at home.

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59. Defendants agreed to accept Barbara Raleigh into their facility and provide care to them in a safe, clean living environment in exchange for monetary payment.

60. Defendants knew that Barbara Raleigh required access to a clean and safe water supply when they accepted Barbara Raleigh as a resident, and that Barbara – like all of their residents – was susceptible to suffering severe harm and/or death due to a water supply contaminated with *Legionella* bacteria and other opportunistic pathogens.

61. Defendants failed to provide a clean and safe water supply to Barbara Raleigh, and caused Barabara to be exposed to *Legionella* bacteria.

62. Barbara Raleigh endured mental and physical pain suffering, leading to her untimely and preventable death as a direct and proximate result of Defendants' failure to provide adequate care due to understaffing the facility.

FIRST CAUSE OF ACTION
(NEGLIGENCE / RECKLESSNESS)

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

64. Barbara Raleigh depended on the Defendants to provide physical facilities that were reasonably safe to accommodate her as a resident, including providing a safe, clean water supply free of *Legionella* bacteria and other opportunistic pathogens.

65. The Defendants had a duty to provide physical facilities that were reasonably safe to accommodate nursing home residents like Barbara Raleigh, including providing a safe, clean water supply free of *Legionella* bacteria and other opportunistic pathogens. Defendants likewise had a duty to perform a reasonable inspection and due-diligence of the water supply at the facility in the process of acquiring the facility to ensure

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that the facility's water supply was safe and free of *Legionella* bacteria and other opportunistic pathogens

66. The Defendants, including their managers, directors, supervisors, maintenance employees, and care providers, negligently, recklessly, willfully, and/or wantonly failed to provide physical facilities that were reasonably safe to accommodate Barbara Raleigh as a resident, including a safe, clean water supply, and/or failed to perform a reasonable inspection and due-diligence of the water supply at the facility in the process of acquiring the facility to ensure that the facility's water supply was safe and free of *Legionella* bacteria and other opportunistic pathogens, which they knew or should have known would result in harm and/or death to Barbara Raliegh, and their negligence was the direct and proximate cause of the injuries that Barbara Raleigh suffered.

67. The Defendants' actions constituted a conscious disregard for Barbara Raleigh'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 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.

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

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

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

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

72. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), for conscious pain and suffering, loss of enjoyment, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

SECOND CAUSE OF ACTION
(NURSING HOME RESIDENT RIGHTS VIOLATION R.C. 3721.13)

73. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

74. The Defendants, directly or through their employees or agents, violated Barbara Raleigh'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;

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

75. These violations are evidence of negligence and conscious disregard of Barbara Raleigh's rights and safety, and give rise to a statutory cause of action.

76. As a direct and proximate result of the Defendants' violations of R.C. 3721.13, Barbara Raleigh conscious pain, suffering, and disability, and other harms and losses including death.

77. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount in excess of $25,000.00, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and / or equitable.

THIRD CAUSE OF ACTION
(CIVIL CONSPIRACY)

78. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

79. The 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 and fail to maintain a safe, clean water supply of 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. not provide the safe accommodations promised to residents, by intentionally neglecting the maintenance of the physical facilities and systems, paid for by residents' and their families' dollars;

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e. misrepresenting the quality and safety of the physical facility to entice families to entrust their loved ones to their care; and

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

80. This understanding constitutes a malicious combination to injure residents of the Facility, including Barbara Raleigh.

81. 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.

82. The conspiracy caused injury to Barbara Raleigh

83. 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
(FRAUD)

84. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

85. The Defendants concealed facts concerning the safety of the physical facility and systems, including the water supply, at the Facility.

86. Not only did the Defendants conceal this information, they publicly and privately represented that they provide exceptional physical facilities in an effort to induce the family of Barbara Raleigh and other potential customers to place their loved ones in their care and custody.

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87. 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 Barbara Raleigh's family and other potential customers into placing their loved ones in the care and custody of the Defendants.

88. Barbara Raleigh's family and the family members of other potential customers reasonably relied on the Defendants' representations and concealments regarding the quality and safety of their physical facilities and systems.

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

90. As a direct and proximate result of the Defendants a actions, representations, and concealments, Barbara Raleigh suffered conscious pain and suffering, and an untimely death.

91. WHEREFORE, Plaintiffs demand 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.

FIFTH CAUSE OF ACTION
(WRONGFUL DEATH)

92. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

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93. Barbara Raleigh depended on the Defendants to provide physical facilities that were reasonably safe to accommodate her as a resident, including providing a safe, clean water supply free of *Legionella* bacteria and other opportunistic pathogens.

94. The Defendants had a duty to provide physical facilities that were reasonably safe to accommodate nursing home residents like Barbara Raleigh, including providing a safe, clean water supply free of *Legionella* bacteria and other opportunistic pathogens, and to perform a reasonable inspection and due-diligence of the water supply at the facility in the process of acquiring the facility to ensure that the facility's water supply was safe and free of *Legionella* bacteria and other opportunistic pathogens.

95. The Defendants, including their managers, directors, supervisors, maintenance employees, and care providers, negligently, recklessly, willfully, and/or wantonly failed to provide physical facilities that were reasonably safe to accommodate Barbara Raleigh as a resident, including a safe, clean water supply, and failed to perform a reasonable inspection and due-diligence of the water supply at the facility in the process of acquiring the facility to ensure that the facility's water supply was safe and free of *Legionella* bacteria and other opportunistic pathogens, which they knew or should have known would result in harm and/or death to Barbara Raliegh, and their negligence was the direct and proximate cause of the injuries that Barbara Raleigh suffered.

96. The Defendants' actions constituted a conscious disregard for Barbara Raleigh'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 of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct.

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

97. Defendants, directly or through their employees or agents, violated Barbara Raleigh'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;

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

98. These violations are evidence of negligence and conscious disregard of Barbara Raleigh' rights and safety, and give rise to a statutory cause of action.

99. Barbara Raleigh 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.

100. These actions constituted a conscious disregard for Barbara Raleigh' 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.

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

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

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

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

105. The Defendants' misconduct is 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.

106. As a direct and proximate result of the negligence / recklessness described above, Barbara Raleigh sustained injuries that caused their untimely and wrongful death.

107. Barbara Raleigh' 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.

108. 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.

A TRIAL BY JURY IS HEREBY DEMANDED

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Respectfully Submitted,

/s/ Matthew A. Mooney

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

Affiant KAPIL GULATI, MD, having been first duly sworn, states:

1. I am an adult, have no known disability preventing my truthful testimony, and have personal knowledge of the matters contained within this affidavit.

2. I am a full-time practicing physician in the field of Internal Medicine, licensed in the state of Ohio, board certified in Internal Medicine, spending more than 50% of my professional time providing direct patient care.

3. Through my specialized knowledge, skill, training, experience, and education, I am familiar with the standard of care applicable to the medical and nursing care and treatment that was provided to Barbara K. Raleigh while a resident of CareCore at Margaret Hall, LLC, CareCore Health, LLC, and Margaret Hall Realty, LLC.

4. I have reviewed all medical records reasonably available to Estate of Barbara K. Raleigh, Deceased concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants, CareCore at Margaret Hall, LLC, CareCore Health, LLC, Margaret Hall Realty, LLC, and Chaim Hertanu breached the standard of care and the breach caused Barbara K. Raleigh's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

KAPIL GULATI, MD

SWORN TO BEFORE ME and subscribed in my presence this 13th day of July, 2026.

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

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