

NAILAH K. BYRD
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Court of Common Pleas

New Case Electronically Filed: COMPLAINT
June 30, 2025 10:32

By: MATTHEW A. MOONEY 0093332

Confirmation Nbr. 3539656

ESTATE OF ROSEMARY WHITE, DECEASED

CV 25 120086

vs.

Judge: ANDREW J. SANTOLI

UNIVERSITY HOSPITALS TRIPOINT MEDICAL CENTE, ET AL

Pages Filed: 12

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

ESTATE OF ROSEMARY WHITE, DECEASED, Through Estate Representative Barbara Nord c/o Michael Hill Trial Law 816 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. UNIVERSITY HOSPITALS TRIPOINT MEDICAL CENTER AKA UNIVERSITY HOSPITALS HEALTH SYSTEM, INC., 7590 Auburn Road Concord Township, OH 44077 Also Serve c/o Registered Agent: CT Corporation System 4400 Easton Commons, Suite 125 Columbus, OH 43219 and LAKE HOSPITAL SYSTEM, INC., c/o Registered Agent: CT Corporation System 4400 Easton Commons, Suite 125 Columbus, OH 43219 Defendants.	)	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

Plaintiff, the Estate of Rosemary White, Deceased, through Estate Representative Barbara Nord, for this Complaint against the above-named Defendants, states and avers upon information and belief:

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INTRODUCTION

1. This is a wrongful death case against University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc. ("Facility") for failing to implement basic fall prevention measures and properly monitor 78-year-old Rosemary White.

2. Rosemary required supplemental oxygen via nasal cannula and assistance to get to the restroom due to her weakened condition.

3. On July 3, 2023, Rosemary White presented to University Hospitals TriPoint Medical Center after three or four days of abdominal pains and nausea. She was found to have hyponatremia – low sodium levels in her body – and admitted to the step-down ICU floor for treatment and monitoring.

4. The step-down ICU floor has a much higher nurse-to-patient ratio than a regular nursing floor, due to the high level of care needed by the patients.

5. Rosemary's doctors also ordered that she continue to receive oxygen through a nasal canula, and be placed on a pulse oximeter – a device to continuously measure her blood-oxygen concentration and confirm her body was receiving enough oxygenated blood.

6. Rosemary's bed on the step-down ICU unit was fitted with a bed exit alarm, which would alarm loudly if she tried to get out of bed unassisted. The bed exit alarm could be turned on and off by simply pushing a button on a control panel on the exterior rails of the bed.

7. The nurse aides – called PCAs – set the bed alarms when they come on shift at University Hospitals TriPoint Medical Center's step-down ICU unit, and the nurses then come around right behind the PCAs and check the alarms when they give bedside report.

8. The bed exit alarms give an audible alarm to let the nursing staff know when a patient is getting out of bed unassisted, so the nursing staff can come help the patient and prevent a fall.

9. Late on the night of July 4 or early in the morning of July 5, 2023, a PCA disconnected Rosemary from the pulse oximeter and deactivated the bed exit alarm to get Rosemary up to a bedside commode.

10. When the PCA got Rosemary back to bed, she did not reactivate the bed exit alarm, did not reconnect Rosemary to the pulse oximeter, and did not reapply her nasal cannula.

11. At some point after returning to bed, Rosemary became confused and disoriented due to her blood oxygen levels dropping from not being on her nasal cannula.

12. Because the PCA did not reconnect Rosemary's pulse oximeter, the monitors did not show that she had low blood oxygen levels or give an alert to the nursing staff that she had low blood oxygen levels.

13. Due to her confusion from low blood oxygen levels, Rosemary thought she was back in her home, and got out of bed to go to the restroom without requesting assistance from the nursing staff.

14. Because the PCA did not reactivate the bed exit alarm, the alarm did not go off and alert the nursing staff that Rosemary was getting out of bed unassisted.

15. Shortly after getting out of bed, Rosemary fell to the hard floor of the bathroom and crushed her L1 vertebra.

16. Rosemary laid on the floor in immense pain until approximately 3:20 AM on July 5, when a member of the nursing staff came into her room and found her on the floor.

17. Later that morning, the unit manager of the step-down ICU spoke with Rosemary's daughters and told them that the bed alarms should be set at shift change, that the PCA got her up to the bedside commode, put her back to bed, and did not reengage the alarm at that time.

18. The unit manager of the step-down ICU unit also told Rosemary's daughters that their process is that the PCAs set the bed alarms when they come on shift, and the nurses then come around right behind the PCAs and check the alarms when they give bedside report, "which is the standard work of what we do."

19. An X-ray was taken of Rosemary's spine, which showed that the L1 vertebra had collapsed by about 25% of its original size due to the crush fracture.

20. Over the following days, Rosemary's condition deteriorated. Her physicians ordered powerful opioid pain medications to dull the severe pain caused by her crushed vertebra. The opioid pain medication further depressed her respiratory function.

21. Rosemary's physicians determined she had a poor prognosis and informed Rosemary and her daughters that she was not likely to survive, and recommended she be made hospice.

22. On July 9, 2023, Rosemary and her family accepted the advice of her physicians and made her a hospice patient. Rosemary was discharged the same day to Hospice of the Western Reserve.

23. On July 10, 2023, Rosemary passed away in hospice care.

24. On August 16, 2023, the Chief Medical Examiner of Cuyahoga County, Dr. Thomas Gilson, MD, reviewed Rosemary's case.

25. Dr. Gilson determined that the manner of Rosemary's death was "accidental," identified the fall on July 5, 2023, at TriPoint Medical Center as the accident causing her death, and identified the lumbar spine fracture as a contributing cause of Rosemary's death.

26b. Time of Death: 05:41	26c. Date Pronounced Dead (Month/Day/Year): JULY 10, 2023	26d. Was Case referred to Coroner? YES
26e. Certifier Name and Title: GILSON, THOMAS P MD	26f. License Number: 35.062126	26g. Date Signed: AUGUST 16, 2023
27. Name and Address of Person who Completed Cause of Death: GILSON, THOMAS P, 11001 CEDAR AVE, CLEVELAND, OH, 44106		
28. Part I: Enter the disease, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent black ink.		Approximate Interval: Between Onset and Death
Immediate Cause (Final disease or condition resulting in death): a. ISCHEMIC HEART DISEASE.		UNKNOWN
Sequentially list conditions, if any, leading to the immediate cause: b. Due to (or as Consequence of):		
Enter Underlying Cause Last (Disease or injury that initiated events resulting in death): c. Due to (or as Consequence of):		
d. Due to (or as Consequence of):		
29. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I: END-STAGE EMPHYSEMA, RECENT LUMBAR SPINE FRACTURE.	29a. Was an Autopsy Performed? NO	29b. Were Autopsy Findings Available Prior to completion of Cause of Death? NOT APPLICABLE
30. Did Tobacco Use Contribute to Death? UNKNOWN	31. If Female, Pregnancy Status: NOT APPLICABLE.	32. Manner of Death: ACCIDENT
33a. Date of Injury (Month/Day/Year): JULY 05, 2023	33b. Time of Injury: 03:20	33c. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area): IN TRIPOINT MEDICAL CENTER, AT
33d. Injury at Work? NO		
33e. Location of Injury (Street and Number or Rural Route Number, City or Town, State): 7590 AUBURN ROAD , CONCORD TOWNSHIP, OHIO		
33f. Describe How Injury Occurred: FALL.	33g. If Transportation Injury, Specify:	

HEA 2752 THIS SUPPLEMENTARY CERTIFICATE IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Supplemental death certificate for Rosemary White completed by the Chief Medical Examiner of Summit County, Dr. Thomas Gilson, MD.

26. Plaintiff requests a trial by jury.

27. An Affidavit of Merit is attached.

28. Plaintiff brings this action for compensation for the harms and losses sustained as the result of the negligent and reckless conduct by which the Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct is likely to cause, at the time those services or that treatment or care were rendered, an unreasonable risk of injury, death, or loss to person or property, or

intentional misconduct or willful or wanton misconduct, and other wrongful conduct described herein or discovered during litigation.

DEFENDANTS

29. University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc. is an Ohio corporation that holds itself out as a competent provider of medical care and treatment to the public and through its agents, operatives and / or employees and does business as University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc and provided care and treatment to Rosemary White.

30. Lake Hospital System, 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 a competent provider of medical care and treatment to the public and through its agents, operatives and / or employees and does business as University Hospitals Tripoint Medical Center.

31. The Defendants employ, manage, and direct the care and service providers who were responsible for Rosemary White's care, treatment, and safety at University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc. while they were a patient there, and / or are responsible for creating unsafe conditions at the Facility through their control of the Facility management that directly led to Rosemary White's injuries and untimely and wrongful death on July 10, 2023.

32. 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.

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33. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to patients of University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc. directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

34. The Defendants employ the care providers who were responsible for ensuring Rosemary White's care and safety.

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

36. Rosemary White and their family looked to the Defendants for care based upon their representations.

37. 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 Hosp. & Family Health Ctr.*, 68 Ohio St.3d 435, 628 N.E.2d 46 (1994), agency by estoppel), including visiting physicians and nurse practitioners contracted with any of the Defendants and / or provided to patients.

JURISDICTION AND VENUE

38. 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.

39. Venue is proper in Cuyahoga County, Ohio under Civil Rule 3(B) because, among other reasons: (a) one or more Defendants reside, domicile, or carry on their principal place of business in that county; and (b) part of the claim for relief arose in that county.

Defendants' Negligence and Recklessness with Rosemary White

40. Defendants accepted Rosemary White as a patient for medical care and monitoring following her admission for treatment of hypovolemic hyponatremia, dehydration, and respiratory distress.

41. Defendants agreed to provide care and supervision to Rosemary in exchange for monetary payment.

42. Defendants knew that Rosemary was in a weakened condition, required supplemental oxygen, and needed assistance to ambulate to and from the restroom. They also knew she was at high risk for falling and required close monitoring, including activation of her bed-exit alarm and use of a pulse oximeter.

43. Despite this knowledge, Defendants failed to take appropriate fall-prevention measures. On the night of July 4, 2023, after assisting Rosemary White to the restroom, Defendants' staff failed to reactive her bed-exit alarm, did not reconnect her nasal cannula, and did not reconnect her pulse oximeter.

44. In the early morning hours of July 5, 2023, Rosemary became confused, believed she was at home, and attempted to get out of bed unassisted to use the restroom. With her bed alarm turned off, staff were unaware she exited her bed. Rosemary fell in the restroom and remained on the floor for at least three hours calling for help.

45. As a direct and proximate result of Defendants' negligence and reckless disregard for Rosemary's known medical conditions and fall risk, Rosemary sustained a spinal fracture and ultimately died on July 10, 2023.

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FIRST CAUSE OF ACTION
(WRONGFUL DEATH)

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

47. Rosemary White depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance during her hospitalization.

48. The Defendants had a duty to provide proper care and treatment to Rosemary White and to avoid causing her injury while under their care.

49. Defendants, including their nursing and medical staff, failed to provide the proper care and supervision that Rosemary White required and which Defendants knew or should have known she required. This negligence was the direct and proximate cause of the injuries Rosemary suffered, which ultimately led to her death.

50. Defendants' failure to provide proper care and supervision included, but is not limited to:

a. choosing to ignore known fall risks by failing to activate Rosemary's bed-exit alarm after she was returned to bed;

b. choosing to disconnect and then failing to reconnect Rosemary's pulse oximeter, despite her respiratory distress;

c. choosing to disconnect and then failing to reconnect Rosemary's nasal cannula, despite her respiratory distress;

d. choosing not to provide appropriate staff training regarding fall-prevention protocols and patient monitoring;

e. choosing to provide too few, and/or underqualified, nursing staff members to adequately monitor and care for high-risk patients like Rosemary;

f. choosing not to follow internal policies and procedures related to patient supervision and fall prevention; and

g. such other acts or omissions described in this Complaint or discovered in litigation.

51. These actions constituted a conscious disregard for Rosemary White's rights and safety, with a great probability of causing substantial harm. Through heedless indifference to the consequences, Defendants and / or their staff disregarded a substantial and unjustifiable risk that their conduct was likely to cause injury or death, constituting willful, wanton, and / or reckless misconduct.

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

53. Defendants are also vicariously liable for the willful, wanton, and / or reckless misconduct of their employees and agents.

54. The care provided to Rosemary White by Defendants and their medical and nursing staff fell below the standard of care expected of hospitals and medical providers under the same or similar circumstances.

55. As a direct and proximate result of the negligence / recklessness described above, Rosemary White sustained injuries that caused their untimely and wrongful death.

56. Rosemary White'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.

57. 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

Respectfully submitted,

/s/ Matthew A. Mooney

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Counsel for Plaintiff

STATE OF CALIFORNIA)
)
Sacramento COUNTY)
)
)

AFFIDAVIT OF MERIT

Affiant CHRISTIAN SANDROCK, MD, MPH, FCCD, 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 Critical Care Medicine, licensed in the state of California, board certified in Internal Medicine, Critical Care Medicine, Infectious Disease, and Pulmonary Disease, 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 Rosemary White while a patient at University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc., and Lake Hospital Systems, Inc.

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

5. To a reasonable degree of medical probability, the Defendants, University Hospitals Tripoint Medical Center aka University Hospitals Health System, Inc., and Lake Hospital Systems, Inc., breached the standard of care and the breach caused Rosemary White's injuries and death.

FURTHER AFFIANT SAYETH NAUGHT.

CHRISTIAN SANDROCK, MD, MPH, FCCD

State of Florida County of Broward
SWORN TO BEFORE ME and subscribed in my presence this 23 day of June 2025.
By: Christian Sandrock.

RONY JEAN
Notary Public - State of Florida
Commission # HH 139046
Expires on July 25, 2025

NOTARY PUBLIC RONY JEAN

Notarized remotely online using communication technology via Proof. Type of Identification Produced PASSPORT

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