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Mike Foley
CLERK OF COURTS MONTGOMERY COUNTY OHIO

IN THE COURT OF COMMON PLEAS
MONTGOMERY COUNTY, OHIO

THE ESTATE OF RONALD H. WYSONG Through Estate Representative Wendy House c/o Eadie Hill Trial Lawyers 3100 E. 45th St., Suite 400 Cleveland, Ohio 44127 Plaintiff, vs. SANCTUARY AT WILMINGTON PLACE AKA AHF OHIO, INC. 264 Wilmington Ave. Dayton, Ohio 45420 Also Serve c/o Registered Agent: AHF OHIO, INC 5920 Venture Dr. Suite 100 Dublin, Ohio 43017 and AHF MANAGEMENT CORP. c/o Registered Agent: JOHN M. HAEMMERLE 5920 Venture Dr. Suite 100 Dublin Ohio 43017 and AHF OHIO, INC. c/o Registered Agent: DINSMORE AGENT CO. 191 W. Nationwide Blvd. Suite 300 Columbus, Ohio 43215 and AMERICAN HEALTH FOUNDATION, INC. c/o Registered Agent:	CASE NO. 2023 CV 00151 JUDGE ANGELINA N. JACKSON **FIRST AMENDED COMPLAINT** **WITH JURY DEMAND AND AFFIDAVIT OF MERIT ATTACHED**

JOHN M. HAEMMERLE)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
)
and)
)
AHF HOME OFFICE, INC.)
c/o Registered Agent:)
JOHN M. HAEMMERLE)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
)
and)
)
MARK T. HAEMMERLE)
AHF OHIO, INC.)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
)
and)
)
SUZANNE M. LEHMAN)
AHF OHIO, INC.)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
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and)
)
JOHN M. HAEMMERLE)
AHF OHIO, INC.)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
)
and)
)
J. MICHAEL HAEMMERLE)
AHF OHIO, INC.)
5920 Venture Dr.)
Suite 100)
Dublin, Ohio 43017)
)
and)

MATT LEHMAN
AHF OHIO, INC.
5920 Venture Dr.
Suite 100
Dublin, Ohio 43017

and

COLLEEN JOHNSON, RN
AHF OHIO, INC.
5920 Venture Dr.
Suite 100
Dublin, Ohio 43017

and

CHRISTINE DOSLAND, LNHA
264 Wilmington Ave.
Dayton, Ohio 45420

and

TONI HUNTER, RN
264 Wilmington Ave.
Dayton, Ohio 45420

and

ALTO HEALTH CARE STAFFING aka
CIRRUS CONCEPT CONSULTING, LLC
c/o Registered Agent:
LESLIE KAHN
1 Elizabeth Place, Suite 110
Dayton, OH 45417

and

CIRRUS CONCEPT PEO, LLC
c/o Registered Agent:
LESLIE KAHN-BELL
1260 Walnut Valley Lane
Centerville, OH 45458

and

CIRRUS CONCEPT HR, LLC

c/o Registered Agent:
LESLIE KAHN-BELL
1260 Walnut Valley Lane
Centerville, OH 45458

and

DeAyra Scandrick
3114 W. Riverview Ave.
Dayton, Ohio 45406

Defendants.

Pursuant to the Court's scheduling order and Ohio Revised Code Section 2323.451(D)(1)-(2), Plaintiff The Estate of Ronald H. Wysong, through its Estate Representative, Wendy House, files its First Amended Complaint against the above-named Defendants, states and avers upon information and belief as follows:

INTRODUCTION

1. This action involves multiple claims (negligence, recklessness, wrongful death, Resident's Rights Law violations, misleading advertising, civil conspiracy, and fraud) for Defendants' non-existent and grossly inadequate care of Ronald H. Wysong, a nursing home resident at Sanctuary at Wilmington Place, that led to his pain, suffering, and wrongful death on January 16, 2022.

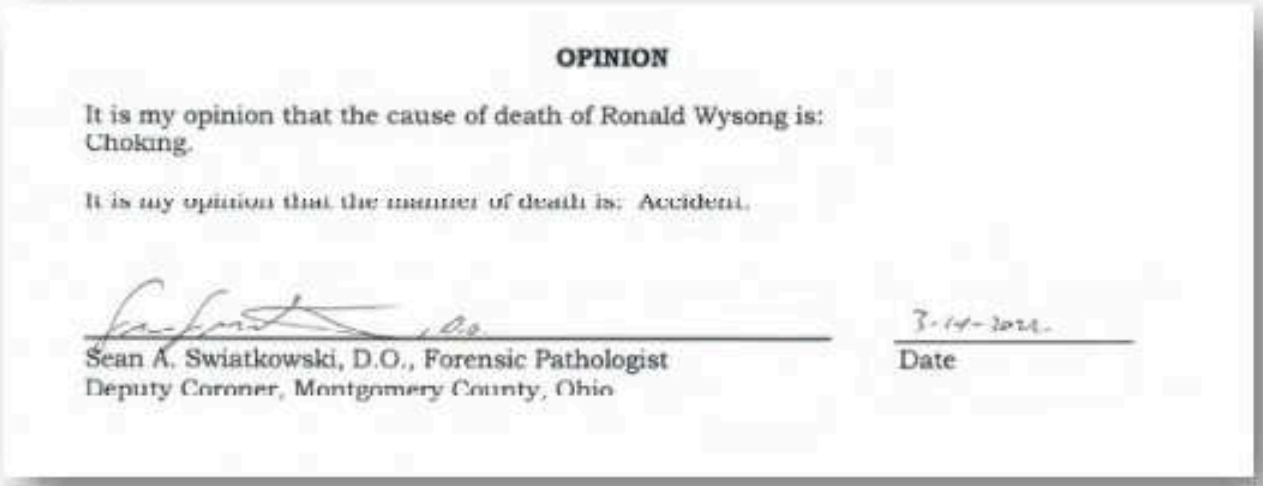
2. Ronald H. Wysong's assigned aide on January 16, 2022, Defendant DeAyra Scandrick, was from a temporary staffing agency, Defendant Alto Health Care Staffing. Upon observing him choking and gagging, she gave him an emesis basin (a bucket) and left him alone for fifteen (15) minutes. When she returned, Ronald H. Wysong was unresponsive. Ronald H. Wysong's s nurse was on break smoking a cigarette, leaving the aide to find another nurse to render CPR. CPR was started and stopped, provided

inappropriately and ineffectively, and emergency equipment could not be found, again delaying care. When the "crash cart" was found, the equipment was broken. Ronald H. Wysong wanted to live. He protected his right of choice by electing to have advance directives and a medical power of attorney.

3. Due to Sanctuary at Wilmington Place having temporary staff, staff who go on break without ensuring adequate coverage of their hall while they are out, professional medical staff who are not certified to provide emergency care to residents, and staff not familiar with emergency care and emergency procedures, Ronald H. Wysong was not afforded his right to live.

4. Sanctuary at Wilmington and its corporate ownership was aware of problems with advance directives as they had a previous deficiency for it. Not only is there a history of the crash cart not being inspected twice daily as the policy states, but on the day of Ronald H. Wysong's death, after all medical staff involved knew the suction machine did not work, it still was not inspected.

5. The Montgomery County Coroner's Office performed an autopsy of Ronald H. Wysong's body and determined that "the cause of death of Ronald Wysong is: Choking" and "that the manner of death is: Accident," meaning it was not caused by natural events.



OPINION

It is my opinion that the cause of death of Ronald Wysong is:
Choking.

It is my opinion that the manner of death is: Accident.

Sean A. Swiatkowski, D.O., Forensic Pathologist
Deputy Coroner, Montgomery County, Ohio

3-14-2022.
Date

The official cause of death as determined by Montgomery County Coroner's Office is choking and the manner of death is accident.

6. Plaintiff requests a trial by jury.

7. An Affidavit of Merit is attached.

8. Plaintiff brings this action for compensation for the harms and losses sustained as the result of the negligence, recklessness, conscious disregard, reckless disregard, misleading advertising, civil conspiracy, fraud and 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.

9. 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

10. Defendant, Sanctuary at Wilmington Place aka AHF Ohio Inc., ("Facility") is an Ohio nonprofit that is located at 264 Wilmington Ave., Dayton, Ohio 45420 and was responsible for providing care and services to residents, including Ronald H. Wysong.

11. Defendant, American Health Foundation, Inc. (AHF), is an Ohio nonprofit corporation that is located at 5920 Venture Drive, Suite 100, Dublin, Ohio 43017. Through its wholly owned subsidiaries, AHF establishes, acquires, owns, supervises, monitors, and directs nursing homes in different states around the country.

12. Defendant, AHF Management Corp., is an Ohio nonprofit corporation that is located at 5920 Venture Drive, Suite 100, Dublin, Ohio 43017. AHF Management is a wholly owned subsidiary of AHF with a common board of directors, executives, and officers, corporate offices, and key employees. AHF Management Corp. handles the day-to-day activities of AHF. AHF was formed to provide management to AHF's nursing homes, including Sanctuary at Wilmington Place. AHF Management also oversees and exerts financial control over the nursing homes owned by AHF, including Sanctuary at Wilmington Place.

13. AHF Management Corp's revenue is derived from the management fees it received from AHF's nursing homes, including Sanctuary at Wilmington Place. These fees are based on agreements that AHF Management Corp. establishes with AHF nursing homes. The management fee agreements are not arm's length transactions where both sides act independently and in their own self-interest, because both parties are owned and controlled by AHF.

14. Defendant, AHF Home Office, Inc., is an Ohio nonprofit corporation that is located at 5920 Venture Drive, Suite 100, Dublin, Ohio 43017. AHF Home Office, Inc., is a wholly owned subsidiary of AHF with a common board of directors, executives, and officers, corporate offices, and key employees. AHF Home Office Inc.'s only revenue comes from the management fees it collects from the various AHF facilities that have contracted with their affiliated entities.

15. Defendant, AHF Ohio Inc., is an Ohio nonprofit corporation that is located at 5920 Venture Dr., Suite 100, Dublin, Ohio 43017. AHF Ohio is a wholly owned subsidiary of AHF with a common board of directors, executives, and officers. AHF Ohio does business as four (4) nursing homes, including Sanctuary at Wilmington Place.

16. Sanctuary at Wilmington Place is a sixty-three (63) bed nursing home facility located at 264 Wilmington Avenue, Dayton, Ohio 45420, and is the nursing home where the events in this case occurred (sometimes referred to as "Facility" or "Sanctuary").

17. Defendant, Mark T. Haemmerle, was Treasurer and Secretary of AHF Management Corp. and President and Secretary of AHF and AHF Ohio, who was aware of the serious deficiencies present at Sanctuary and other AHF facilities. He failed to rectify those deficiencies as AHF undertook a concentrated effort to increase the number of residents in the buildings (census) while reducing the budget and resources to such a degree that appropriate and safe care was not and could not be provided on a routine basis when it was known that these deficiencies had previously resulted in grossly inadequate patient care and injuries, and would result in additional grossly inadequate care and injuries.

18. Defendant, Suzanne M. Lehman, was president of AHF Management Corp. in charge of AHF's operations, and functioned as co-CEO with Mark T. Haemmerle. Suzanne M. Lehman oversaw all of AHF's nursing homes. Her responsibilities included, but were not limited to, the quality of care provided to the facilities, budgetary issues, plans of correction for deficiencies, hiring and firing decisions for key roles, contract negotiations, union negotiations, and employee relations and policies. Suzanne M. Lehman was aware of the serious deficiencies present at Sanctuary and other AHF facilities and failed to rectify those deficiencies as AHF undertook a concentrated effort to increase the number of residents in the buildings (census) while reducing the budget and resources to such a degree that appropriate and safe care was not and could not be provided on a routine basis when it was known that these deficiencies had previously

resulted in grossly inadequate patient care and injuries, and would result in additional grossly inadequate care and injuries.

19. Defendant, Matt Lehman, was Vice President of Operations of AHF Management who was aware of the serious deficiencies present at Sanctuary and other AHF facilities. He failed to rectify those deficiencies as AHF undertook a concentrated effort to increase the number of residents in the buildings (census) while reducing the budget and resources to such a degree that appropriate and safe care was not and could not be provided on a routine basis when it was known that these deficiencies had previously resulted in grossly inadequate patient care and injuries, and would result in additional grossly inadequate care and injuries.

20. Defendant, J. Michael Haemmerle, was Secretary of AHF Management who was aware of the serious deficiencies present at Sanctuary and other AHF facilities. He failed to rectify those deficiencies as AHF undertook a concentrated effort to increase the number of residents in the buildings (census) while reducing the budget and resources to such a degree that appropriate and safe care was not and could not be provided on a routine basis when it was known that these deficiencies had previously resulted in grossly inadequate patient care and injuries, and would result in additional grossly inadequate care and injuries.

21. Defendant, John M. Haemmerle, was Chairman of AHF Management who was aware of the serious deficiencies present at Sanctuary and other AHF facilities. He failed to rectify those deficiencies as AHF undertook a concentrated effort to increase the number of residents in the buildings (census) while reducing the budget and resources to such a degree that appropriate and safe care was not and could not be provided on a routine basis when it was known that these deficiencies had previously resulted in grossly

inadequate patient care and injuries, and would result in additional grossly inadequate care and injuries.

22. Defendants, AHF, AHF Management, Corp., AHF Home Office Inc., AHF Ohio and its corporate leadership Mark T. Haemmerle, Suzanne M. Lehman, John M. Haemmerle, and J. Michael Haemmerle, are referred to individually and at times collectively as the "Corporate Defendants."

23. The Corporate Defendants employ, manage, and direct the care and service providers who were responsible for Ronald H. Wysong's care, treatment, and safety at Sanctuary at Wilmington Place aka AHF Ohio Inc., while they were a resident there, and/or are responsible for creating unsafe conditions at the Facility through their control of the Facility management including inadequate agency staffing that directly led to Ronald H. Wysong's injuries and untimely and wrongful death on January 16, 2022.

24. The Corporate 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.

25. The Corporate Defendant organization controls the other corporations in a way that is so complete that the corporations have no separate mind, will, or existence of their own; is exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity; and injury or unjust loss resulted to the Plaintiff from such control and wrong, meaning the Defendants should be held directly liable for such harms and losses.

26. The Corporate Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Sanctuary at Wilmington Place aka AHF Ohio Inc. directly or through their domination and control of any putative entity license holder.

27. Defendant, Colleen Johnson, is a Registered Nurse, licensed to practice nursing in the State of Ohio, who worked for AHF Management Corp., providing clinical oversight of Sanctuary and responsible for reporting and correcting deficiencies in care. Colleen Johnson was aware of a several-year history of deficiencies at Sanctuary, poor nursing practices, instances of resident neglect and abuse, violations of statutorily protected Resident's Rights, an absence of nurses certified in the most basic aspects of care, including CPR. She failed to take corrective action when it was known that these deficiencies were the cause of resident harm and would result in additional resident harm unless corrective action was taken, which did occur to Ronald H. Wysong on January 16, 2022.

28. Defendant, Christine Dosland, is a Licensed Nursing Home Administrator and was the highest-ranking employee at Sanctuary at Wilmington Place, who served at the direction and under the control of the Corporate Defendants, charged with the responsibility of ensuring that Sanctuary is operated effectively and efficiently, that Resident's Rights are met, that staff are trained, and procedures are followed.

29. Defendant, Toni Hunter, is a Registered Nurse, licensed to practice nursing in the State of Ohio, who was responsible for the nursing services provided to Ronald H. Wysong on January 16, 2022, at Sanctuary, including services provided by licensed practical nurses and nursing assistants or aides.

30. Defendant ALTO HEALTH CARE STAFFING aka CIRRUS CONCEPT CONSULTING, LLC is an Ohio corporation located at One Elizabeth Place #110, Dayton, OH 45417, which provides health care nurse and aide staffing to facilities in Ohio including Sanctuary at Wilmington Place in concert with Defendants CIRRUS CONCEPT PEO, LLC and CIRRUS CONCEPT HR, LLC.

31. Defendant CIRRUS CONCEPT PEO, LLC is an Ohio corporation located at One Elizabeth Place #110, Dayton, OH 45417, which provides health care nurse and aide staffing to facilities in Ohio including Sanctuary at Wilmington Place in concert with Defendants CIRRUS CONCEPT CONSULTING, LLC and CIRRUS CONCEPT HR, LLC.

32. Defendant CIRRUS CONCEPT HR, LLC is an Ohio corporation located at One Elizabeth Place #110, Dayton, OH 45417, which provides health care nurse and aide staffing to facilities in Ohio including Sanctuary at Wilmington Place in concert with Defendants CIRRUS CONCEPT PEO, LLC and CIRRUS CONCEPT CONSULTING, LLC.

33. Defendants CIRRUS CONCEPT CONSULTING, LLC, CIRRUS CONCEPT PEO, LLC, and CIRRUS CONCEPT HR, LLC, are referred to as "Alto Staffing Defendants."

34. The Alto Staffing Defendants employed some of the staff providing care to residents at Sanctuary at Wilmington Place, including to Ronald Wysong.

35. Defendant DeAyra Scandrick is a nurse or nursing aide, employed by one or more of the Alto Staffing Defendants, licensed to practice in the State of Ohio, who was responsible for services provided to Ronald H. Wysong at Sanctuary on January 16, 2022.

VICARIOUS LIABILITY

36. The Corporate Defendants and Alto Staffing Defendants employed or directed the care providers who were responsible for ensuring Ronald H. Wysong's care and safety at Sanctuary, including on January 16, 2022.

37. The Corporate Defendants manage, control, and/or employ the nursing staff at the Sanctuary.

38. Ronald H. Wysong's family looked to the Corporate Defendants for care based upon their representations.

39. Numerous employees or agents of the Defendants were negligent, reckless, and/or willful and wanton in their disregard for the rights and safety of Ronald H. Wysong including, but not limited to Toni Hunter, RN, DeAyra Scandrick, and numerous unnamed nurses and nursing aides, who are seen on camera remaining indifferent to his distress or providing grossly substandard care on January 16, 2022.

40. The Corporate Defendants and the Alto Staffing Defendants are vicariously liable for the negligent actions of their respective and/or joint employees and agents (respondeat superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including agency or temporary nursing staff, 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

41. 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.

42. Venue is proper in Montgomery 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

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

44. 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.

45. The Corporate Defendants manage, control, and/or employ the nursing staff at Sanctuary.

46. The Corporate Defendants exercise actual control over Sanctuary's management and operations to maximize revenue, 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 families 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; and

l. training on responding to patients in distress, preforming CPR, and ensuring equipment is operable, including all items on the crash cart for resuscitation.

47. As the result of this control, the Corporate 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 Ronald H. Wysong, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

Reporting Data – Nursing Home

48. The Corporate 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."

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

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

51. Medicare uses some of this data submitted by Corporate 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)

52. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Sanctuary and others operated and/or controlled by the Corporate 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.

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

54. 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.

55. 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.

56. 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."

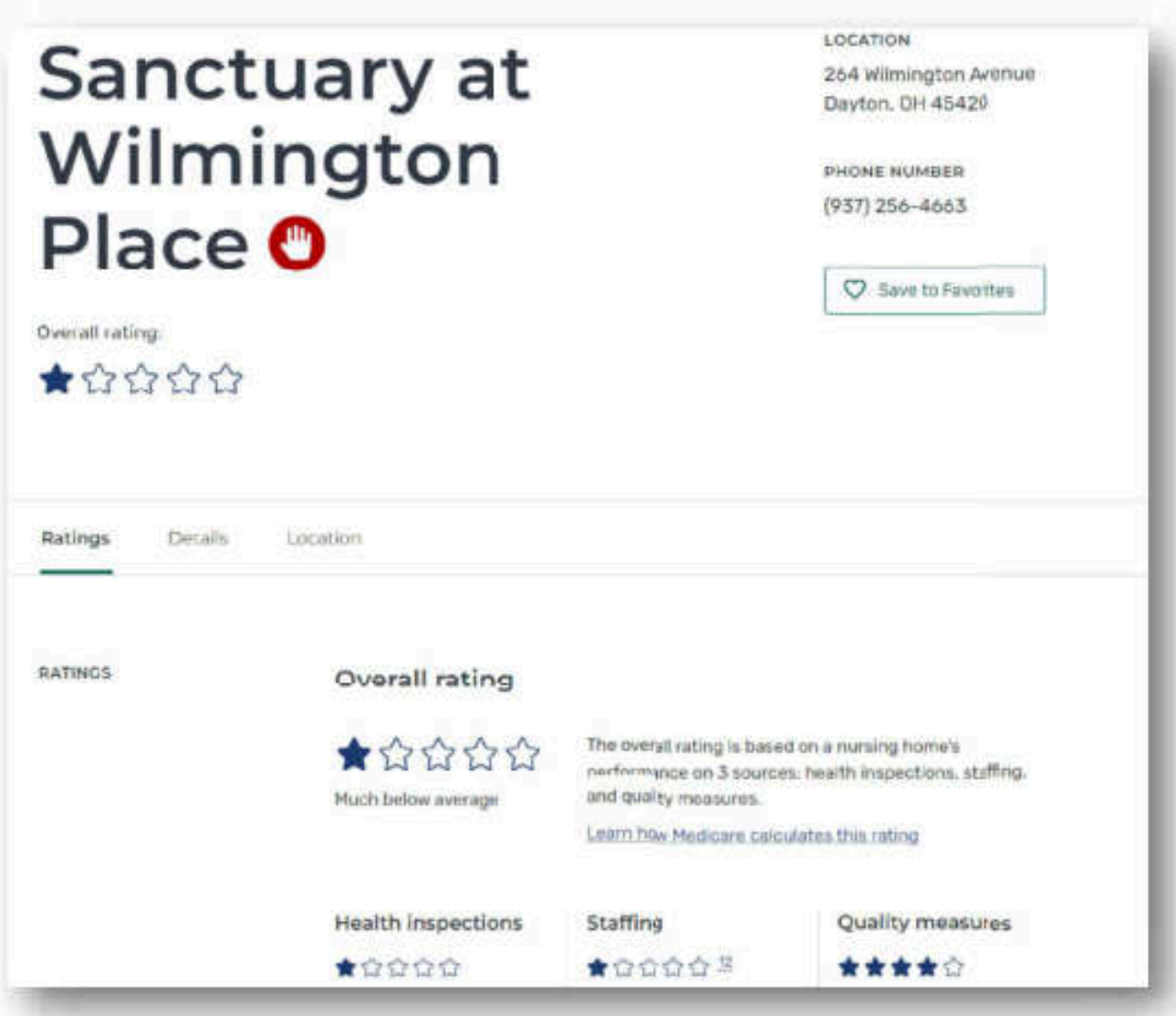
57. When these Resource Utilization Group scores are combined for all residents in a nursing home facility, the nursing home knows exactly how many minutes of nursing and nursing aide care should be provided, on average, to meet the expected care needs of their residents.

Systemic Understaffing and Ronald H. Wysong's Care

58. The Corporate Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Sanctuary at Wilmington Place was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Ronald H. Wysong during the period he was a resident at the Facility.

59. The Corporate Defendants engaged in a systemic practice to understaff Sanctuary at Wilmington Place to maximize resident census and therefore revenue at the expense of their residents' care.

60. The Corporate 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.



61. Staffing Hours per patient day, taken from the CMS website:

Staffing Rating Star:	**Sanctuary at Wilmington Place**	**State Average**	**National Average**
The average number of residents per day	53.2	67.2	77.7
Total number of licensed nurse staff hours per resident day	4 hrs. 7 min.	3 hrs. 35 min.	3 hrs. 46 min.
RN hours per day	22 min.	37 min.	40 mins.

LVN (LPN) hours per day	1 hr. 7 mins.	56 min.	53 min.
Nurse Aide Hours per day	2 hrs. 38 min.	2 hrs. 1 min.	2 hrs. 13 min.
Nurse staff hours per resident per day on the weekend	3 hrs. 31 min.	3 hrs. 6 min.	3 hrs. 15 mins.
Staff Turnover: Nursing	83%	57.6%	53.5%
Staff Turnover: RN	100%	55.6%	52.3%
Staff Turnover: Administrator	The facility did not submit the required data, or the data did not meet the minimal requirements.	0.9%	0.8%

62. This lack of sufficient staff directly resulted in Ronald H. Wysong not receiving basic and necessary services to prevent, among other things, neglect and abuse leading to his injuries and death.

63. The Corporate Defendants also exercise operational and managerial control, and apply this income-over-safety model, at facilities throughout the country including the following additional facilities in the State of Ohio:

a. The Sanctuary of the Ohio Valley
2932 S 5th St.
Ironton, Ohio 45638

b. The Sanctuary at Tuttle Crossing
5500 Frantz Rd.
Dublin, Ohio 43017

c. Samaritan Care Center and Village
806Washington St
Medina, Ohio 44256

Misleading Advertising

64. In an effort to persuade the families of residents 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.

65. For example, the Corporate Defendants claim in their public advertising: "*The Sanctuary at Wilmington Place offers attentive care focused on each resident's needs. Our approach is to give individualized attention to all residents as a means to provide for their comfort and well-being and enable each resident to function at their highest possible level.*"[1]



[1] https://www.ahfohio.com/the-sanctuary-at-wilmington-place/

66. Defendants seek to further entice families to place their loved ones in their care with the following promises: "*The physical and emotional well-being of our residents will always be our first priority. Our staff is committed to making our communities a friendly and inviting environment for all residents who make us a part of their lives. We enhance the quality of our residents' lives through compassionate and individualized care. We value the time we spend with our residents and the impact we make on each other's lives.*"[2]



67. 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

[2] https://www.ahfohio.com/

staffed to provide the promised care than what is actually the practice of the Corporate Defendants with regard to staffing the Facility.

68. 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 revenue and syphon resources at the expense of patient safety.

History of Deficiencies at Sanctuary

69. On November 26, 2019, the Facility was cited for (i) failing to honor the resident's right to formulate advance directives; and (ii) failing to observe each nurse aide's job performance and give regular training by ensuring annual performance reviews were completed.

70. On March 19, 2021, the Facility was cited for failing to provide enough food/fluids to maintain a resident's health.

71. On June 26, 2021, an investigation was conducted due to allegations that (i) between $1,000 and $1,200 of purchases were made on a male resident's credit card by the Activities Director. Purchases were for women's clothing (the resident was male). She did not return to work after the allegations were made; and (ii) a recliner purchased by a resident and signed for by a staff member could not be found after a resident passed away. The Facility was cited for: (i) failure to respond appropriately to all violations; (ii) failing to timely report suspected abuse, neglect, or theft, and report the results of the investigation to the proper authorities; and (iii) failing to protect each resident from the wrongful use of the resident's belongings and money.

72. On September 20, 2021, the Facility was cited for (i) failing to provide and implement an infection prevention and control program by not disinfecting the

glucometers; and (ii) failing to ensure drugs and biologicals are in the original containers, labeled correctly, and stored properly.

73. On February 24, 2022, the Facility was cited for: (i) failing to protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody; (ii) failing to provide basic life support, including CPR, prior to the arrival of emergency medical personnel, subject to physician orders and the resident's advance directives; (iii) failing to timely report suspected abuse, neglect, or theft and report the results of the investigation to the proper authorities. (REPEAT DEFICIENCY); and (iv) failing to ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well-being.

Negligence and Recklessness with Ronald H. Wysong's Care

January 1, 2022

74. Ronald H. Wysong became a resident of Sanctuary at Wilmington Place on January 1, 2022. Ronald H. Wysong's advance directive code status was "full code, "meaning he wanted CPR in the event that he became unresponsive and was not breathing.

75. Sanctuary acknowledged that Ronald H. Wysong had impaired cognition, an abnormal swallowing problem and required a clear liquid, and mechanically altered diet, which means that Defendants knew that Ronald H. Wysong was at risk of choking.

76. On January 7, 2022, Ronald H. Wysong was documented to have a pressure injury, aka a bedsore, to his lower back region called the coccyx. The bedsore was a Stage 3.

77. A bed sore is an injury to the skin and tissue under it. Sitting or lying in the same position will begin to cut off the flow of blood to that area, blocking oxygen and vital nutrients from maintaining healthy tissue. When the tissue becomes starved of blood flow for too long of a period of time it begins to die, and a pressure injury starts to form.

78. In a Stage 3 bedsore, the break in the skin extends through the dermis (second skin layer) into the subcutaneous and fat tissue.

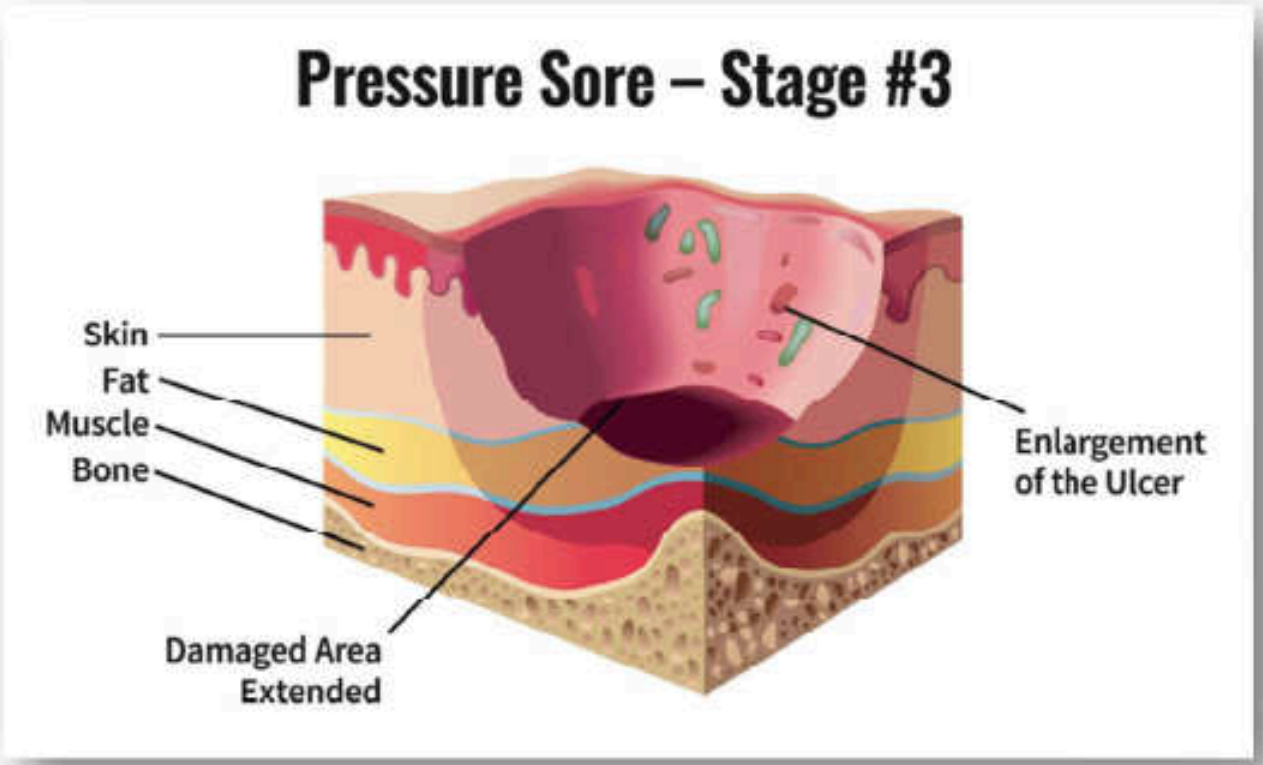
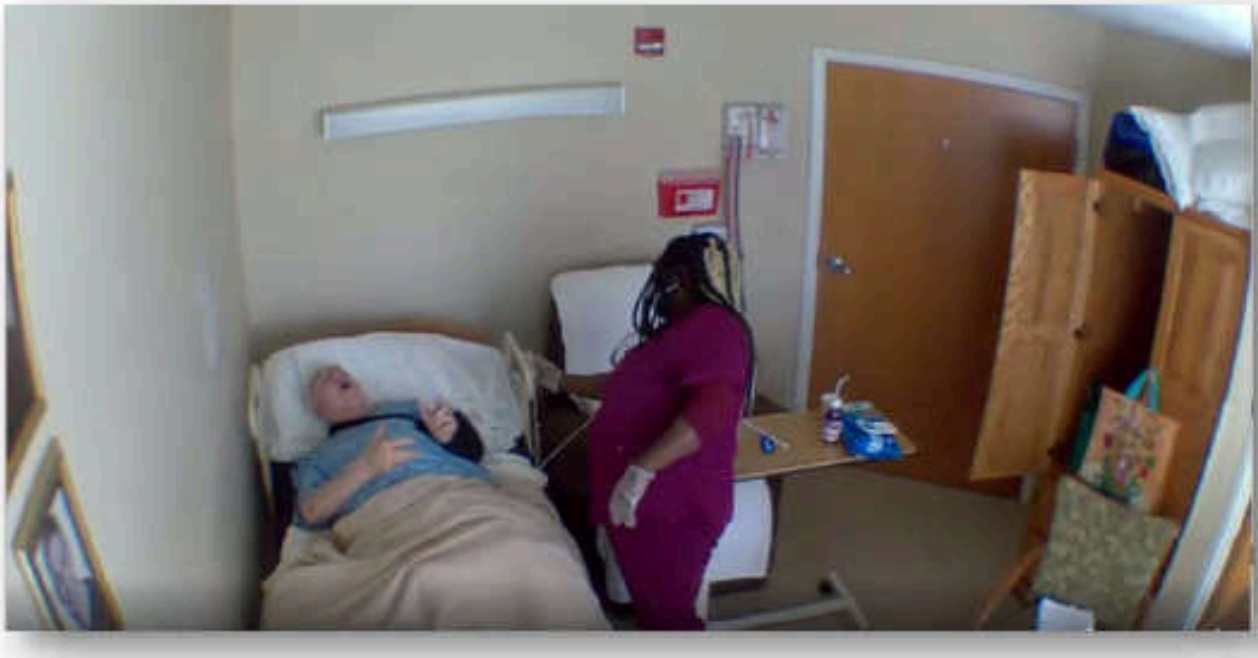


Image of a Stage 3 bedsore. Photo courtesy of https://www.sci-info-pages.com/skin-and-pressure-sores/

January 16, 2022

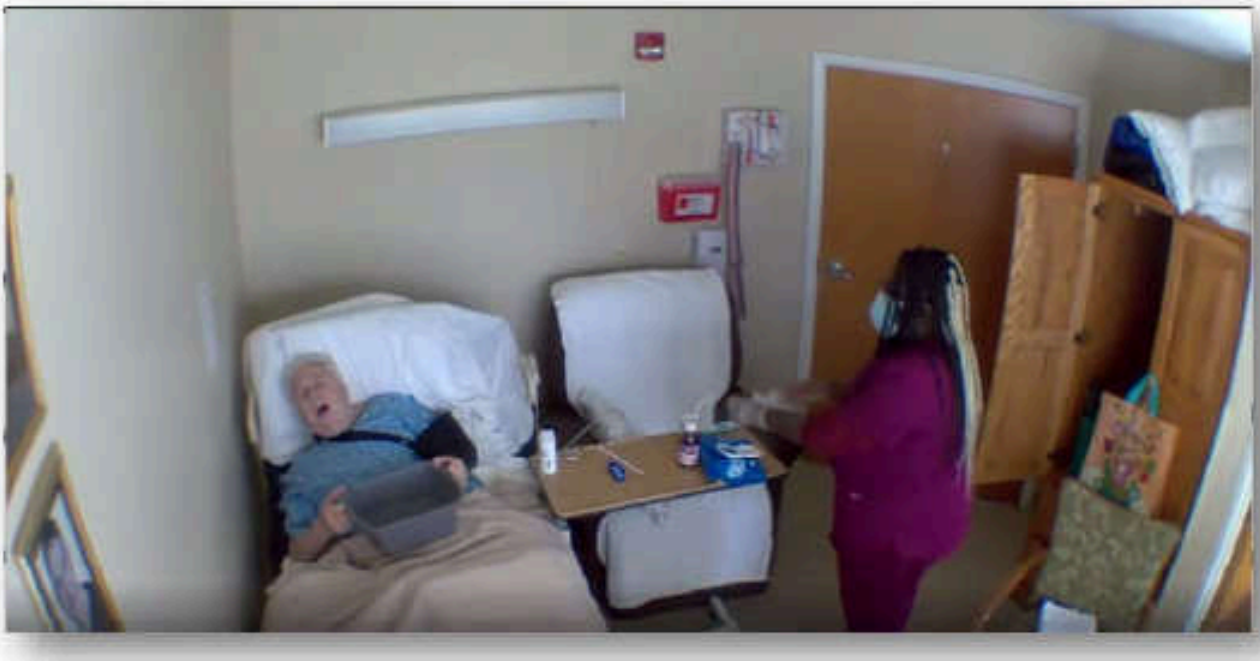
79. Ronald H. Wysong's assigned nursing aide on January 16, 2022, DeAyra Scandrick, was from a temporary staffing agency, the Alto Staffing Defendants.

80. At 2:22 p.m., on January 16, 2022, Ronald H. Wysong's nursing aide observes him having difficulty breathing when he mutters "help me." Ronald H. Wysong was visibly struggling to breathe.



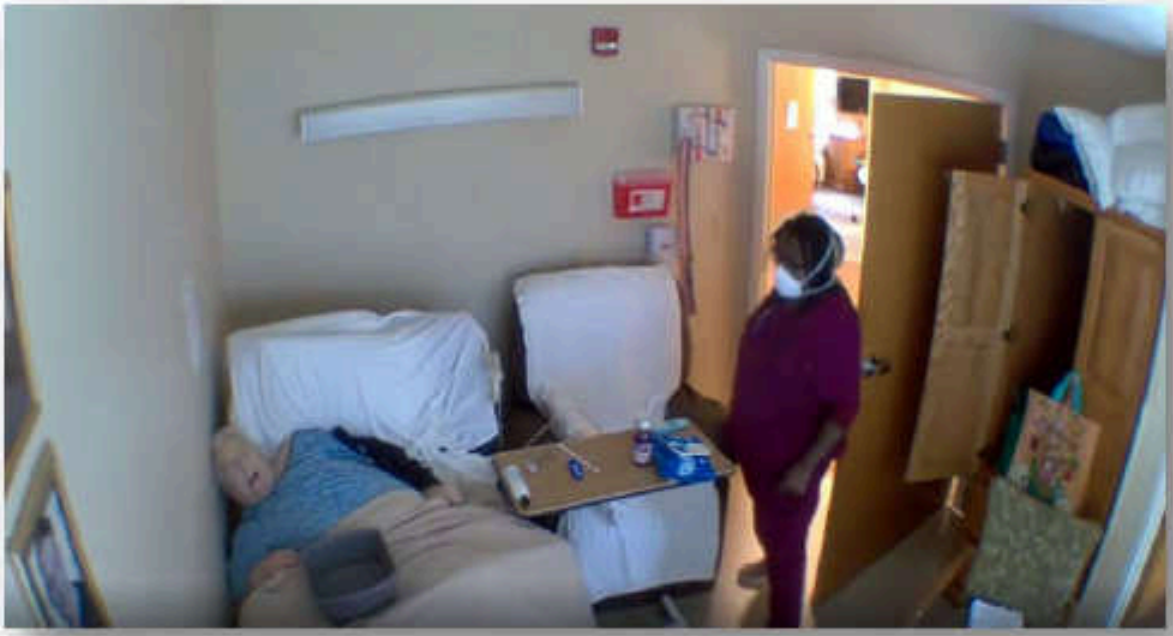
2:52 p.m. January 16, 2022. Ronald H.Wysong is lying on his back. A female staff member in burgundy scrubs slightly raises his bed. Ronald H. Wysong's left arm is in a sling. He is in distress. He is coughing and choking. Ronald H. Wysong says "help me." Sanctuary's staff member ignores his plea for help.

81. At 2:55 p.m., Ronald H. Wysong is visibly in distress, choking, and asking for help, as the same nursing aide hands him an emesis basin (vomit bucket). She leaves him alone in his room without checking on why he was having difficulty breathing or alerting nursing or medical staff that he is in distress or in need of assistance.



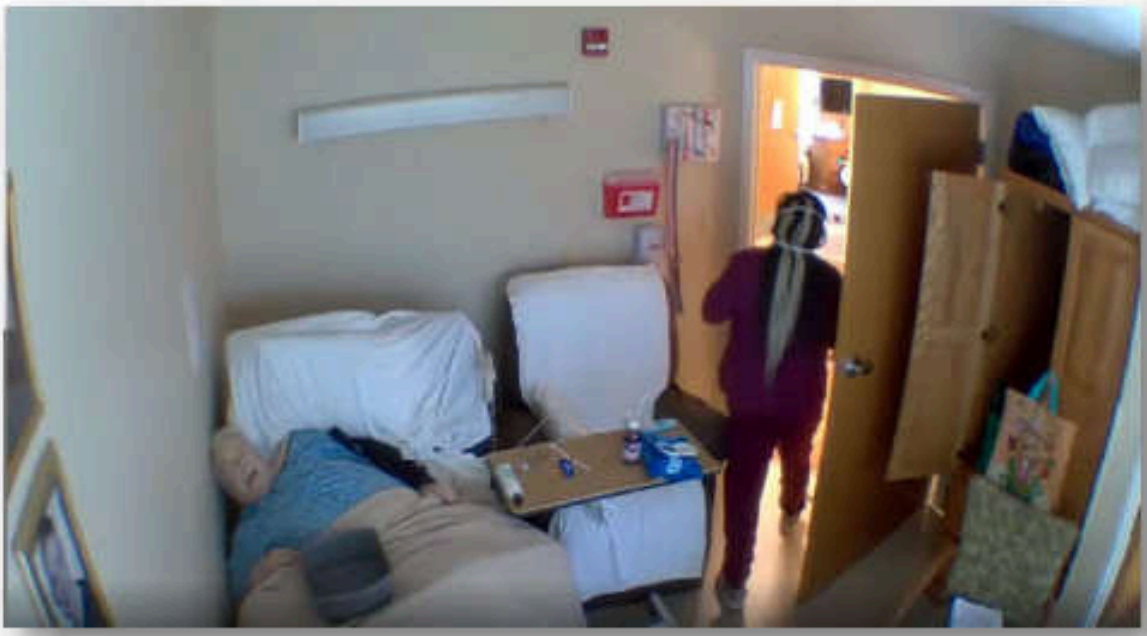
2:55 p.m. January 16, 2022. Ronald H. Wysong on back, choking. Instead of doing anything to assist Ronald H. Wysong that would save his life, she places an emesis basin (aka bucket) on his lap and leaves the room.

82. At 3:15 p.m., the same nursing aide returns to his room and finds Ronald H. Wysong unresponsive, slumped against the wall with his mouth open. He is pale and appears unresponsive.



3:15 p.m. January 16, 2022. Same staff member who gave the bucket comes back in for the first time. Ronald H. Wysong slumped to his right with his head against the wall and laying on the bed. The staff member did not start CPR or check to see what, if anything, was wrong with her patient.

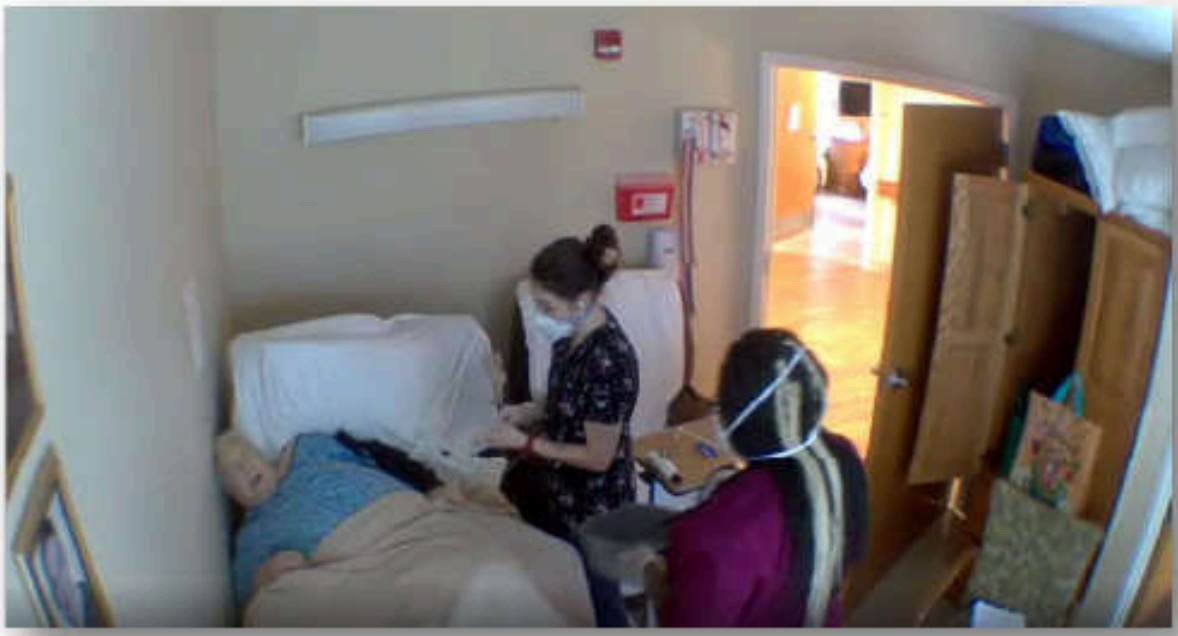
83. Despite knowing something was very wrong with Ronald H. Wysong, the staff member who left him in the room choking twenty (20) minutes earlier, walked of the room without checking to see if he is breathing, taking any vital statistics or attempting CPR.



3:15 p.m., January 16, 2022. Same staff member who gave the bucket and found Ronald H. Wysong slumped to his right with his head against the wall casually walks out of his room without administering any medical assistance to her patient.

84. Ronald H. Wysong's nurse is on break smoking a cigarette in her car, leaving the aide to find another nurse to render CPR.

85. At 3:16 p.m., Ronald H. Wysong's nursing aide reenters the room with a nurse who is wearing a dark floral colored scrub top. The nurse who enters the room says, "Hi Ron" and pats his chest, likely checking to see if he is responsive.



3:16 p.m., January 16, 2022. Same staff member who gave the bucket comes back in with another staff member who pats Ronald H. Wysong's chest, presumably looking for responsiveness. The staff member who gave Ronald H .Wysong the bucket moves it from Ronald H. Wysong's bed to the table.

86. The two people leave Ronald H. Wysong alone in the room.

87. At 3:19 p.m., three(3) female staff members enter the room. A nurse in a white scrub top and pink headband enters the room. She walks over to the bed, appears to check for a radial pulse, and says "Ronald." She continues to say "Ronald" as she grabs his face.

88. At 3:20:18 p.m., the nursing aide is picking bedding up off the floor as the nurse in the pink head band enters the room again calling for someone on the radio and saying "Fuck! Fuck!" She adjusts the bed and leaves. She enters the room again and says "Fuck!"

89. At 3:20:58 p.m. the nurse in the white scrub top and pink headband appears to have been doing chest compressions but stops and throws her hands in the air. A female nursing staff member in the room asks the nurse, "want them to call 911?" The nurse responds by saying, "No please wait because we will get sued. He is a full code and we have to keep doing CPR until they get here." She then leaves the room.



3:20 p.m., January 16, 2022. Almost a half hour after struggling to breath and after Ronald H. Wysong began choking, a staff member finally attempts CPR.

90. Ronald H. Wysong was lying on a low air loss mattress. When CPR was started, staff did not move Ronald H. Wysong to the floor, deflate the mattress, or place a backboard under him to provide a firm surface but, rather, attempted to perform chest compressions while he remained lying on a low air loss mattress. This rendered CPR ineffective because without a firm surface under the body, chest compressions simply push the entire body into the mattress rather than compress the chest.

91. None of the Defendants' nursing personnel who responded to Ronald H. Wysong had active CPR certification.

92. After a few seconds of chest compressions/CPR, the staff stops performing chest compressions/CPR on Ronald H. Wysong.

93. At 3:21 p.m., a staff member finally requests a crash cart.

94. At 3:22 p.m., another staff member, wearing a dark colored jacket enters the room and begins performing chest compressions/CPR.

95. As the new staff member begins chest compressions/CPR, Ronald H. Wysong remains on the mattress and his chest and head bounce uncontrollably.

96. A "crash cart" is a set of drawers, trays, and/or shelves on wheels used in hospitals and nursing homes for transportation and dispensing of life saving medication and equipment at the site of a medical emergency. The cart carries instruments for CPR, medical supplies, and medications needed to treat a person in or near cardiac arrest or another life-threatening condition. Contents of a crash cart typically include monitor/defibrillators, suction devices, and bag valve masks (BVMs) of different sizes, advanced cardiac life support (ACLS) drugs, first line drugs for treatment of common problems such as: adenosine, dextrose, epinephrine for IM use, naloxone, nitroglycerin, and others, drugs for rapid sequence intubation, endotracheal tubes and other intubating equipment, and drugs for peripheral and central venous access.



An example of a "crash cart."

97. A nursing aide was told to retrieve the "crash cart" but initially could not find the crash cart believing that the cart she was looking for was red when, in fact, it was tan, further delaying life-saving intervention.



An example of a portable suction machine.

98. At 3:26 p.m., a "crash cart" is brought into Ronald H. Wysong's room. However, the suction machine was not operable and malfunctioning preventing life-saving intervention.

99. The inspection sheet on the crash cart revealed that it had not been routinely checked, including on January 16, 2022, as is required by policy.

100. At 3:26 p.m., EMS arrives and asked the people in the room if they knew what happened and a staff member says, "went in earlier and he was okay, went in again and he wasn't." That staff member was not in the room when Ronald H. Wysong began choking and she was not in the room until several minutes after he was found unresponsive.

101. EMS, using their own equipment, suctioned an entire canister of fluid from Ronald H. Wysong's airway.

102. EMS attempts CPR, using several devices to try and revive Ronald H. Wysong for over thirty (30) minutes.

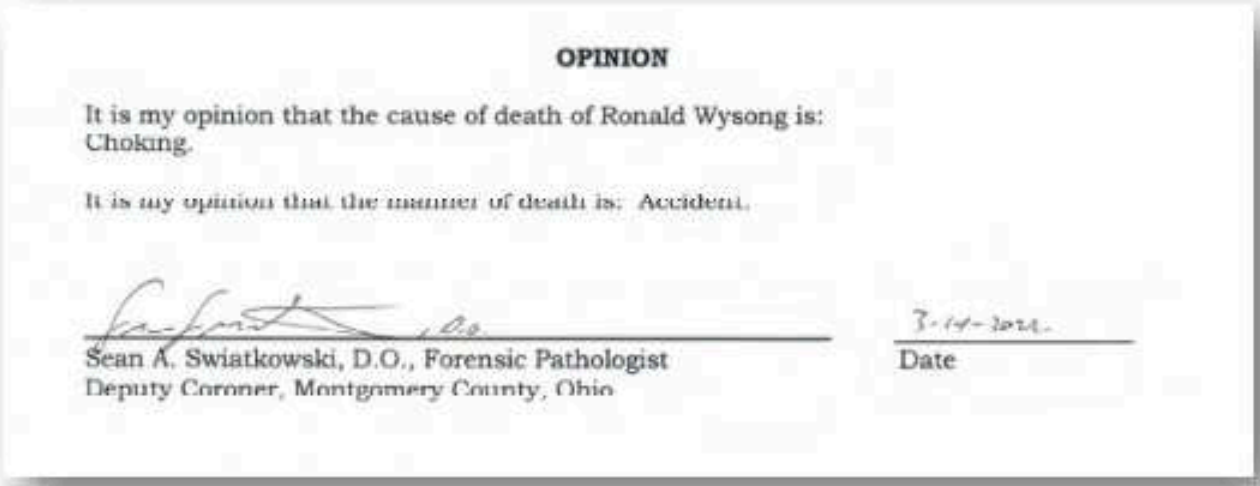
103. At 4:00 pm, EMS ceased CPR and covered Ronald H. Wysong's body with a white blanket.

104. Ronald H. Wysong was dead.



4:00 p.m., January 16, 2022. EMS covered Ronald H. Wysong's lifeless body after dying from choking and suffocation.

105. The Montgomery County Coroner's Office performed an autopsy of Ronald H. Wysong's body and determined that "the cause of death of Ronald Wysong is: Choking" and "that the manner of death is: Accident," meaning it was not due to a natural disease process.



OPINION

It is my opinion that the cause of death of Ronald Wysong is:
Choking.

It is my opinion that the manner of death is: Accident.

Sean A. Swiatkowski, D.O., Forensic Pathologist
Deputy Coroner, Montgomery County, Ohio

3-14-2022
Date

The official cause of death as determined by Montgomery County Coroner's Office is choking and the manner of death is accident.

106. Due to the facility having temporary staff, staff who go on break without ensuring adequate coverage of their hall while they are out, professional medical staff who are not certified to provide emergency care to residents, and staff not familiar with emergency care and emergency procedures, Ronald H. Wysong was not afforded his right to live.

FIRST CAUSE OF ACTION
(NEGLIGENCE/MEDICAL NEGLIGENCE RECKLESSNESS)

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

108. Ronald H. Wysong depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

109. The Defendants had a duty to provide proper care and treatment to Ronald H. Wysong and to avoid causing injury to Ronald H. Wysong.

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

111. The Defendants' failure to provide proper care and treatment included, but is not limited to:

a. Choosing to put inadequate prevention and response interventions in place to prevent injuries;

b. choosing to provide inadequate resident observation, supervision, and monitoring;

c. choosing to provide improper training to staff members regarding resident monitoring, assessment, response, and treatment;

d. choosing to provide too few, and/or underqualified nursing staff members for resident needs at each facility to protect and provide adequate care to residents like Ronald H. Wysong;

e. choosing to not provide accurate, adequate, or timely information to Ronald H. Wysong's family;

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

g. choosing to violate orders relating to care of Ronald H. Wysong;

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

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

j. choosing not to provide appropriate care to Ronald H. Wysong while they were a resident of the Facility; and

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

112. These actions constituted a conscious disregard for Ronald H. Wysong'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.

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

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

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

116. The Defendants and their medical and nursing staff provided care to Ronald H. Wysong that fell below the standard of care expected of medical care and nursing home organizations, under the same or similar circumstances.

117. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

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

119. WHEREFORE, Plaintiff demands judgment against all Defendants, jointly, in an amount more than Twenty-Five Thousand & 00/100 Dollars ($25,000.00), for conscious pain and suffering, loss of enjoyment, together with costs of suit, attorneys' 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)

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

121. As a direct and proximate result of the negligence/recklessness described above, Ronald H. Wysong sustained injuries that caused his untimely and wrongful death.

122. Ronald H. Wysong'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.

123. WHEREFORE, Plaintiff demands judgment against all Defendants jointly, in an amount more than Twenty-Five Thousand & 00/100 Dollars ($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)

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

125. Defendants, directly or through their employees or agents, violated Ronald H. Wysong'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; and

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

126. The Defendants failed to ensure Ronald H. Wysong was free from neglect when staff did not respond timely or correctly to a medical emergency on January 16, 2022.

127. These violations are evidence of negligence and conscious disregard of Ronald H. Wysong's rights and safety and give rise to a statutory cause of action.

128. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Ronald H. Wysong suffered conscious pain, suffering, and disability, and other harms and losses

129. WHEREFORE, Plaintiff demands judgment against all Defendants jointly, in an amount more than Twenty-Five Thousand & 00/100 Dollars ($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.

FOURTH CAUSE OF ACTION
(CIVIL CONSPIRACY)

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

131. The Corporate 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.

132. This understanding constitutes a malicious combination to injure residents of the Facility, including Ronald H. Wysong.

133. In pursuance of this common plan or design to commit tortious acts, the Corporate 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.

134. The conspiracy caused injury to and death of Ronald H. Wysong.

135. WHEREFORE, Plaintiff demands judgment against the Corporate Defendants, in an amount more than Twenty-Five Thousand & 00/100 Dollars ($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.

FOURTH CAUSE OF ACTION
(FRAUD)

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

137. The Corporate Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Sanctuary at Wilmington Place.

138. Not only did the Corporate Defendants conceal this information, but they also publicly and privately represented that they provide exceptional, personalized services in an effort to induce the family of Ronald H. Wysong and similarly situated potential customers to place their loved ones in their care and custody.

139. 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 Ronald H. Wysong's family and other potential customers into placing their loved ones in the care and custody of Sanctuary at Wilmington Place and other AHF nursing homes.

140. Ronald H. Wysong's family members of other potential customers reasonably relied on the Corporate Defendants' representations and concealments regarding the degree of care they provide.

141. The result of these inducements and concealments was that Ronald H. Wysong's family, and the family of numerous other residents, allowed their loved one to be placed in the Corporate Defendants' facilities.

142. As a direct and proximate result of the Corporate Defendants' actions, representations, and concealments, Ronald H. Wysong suffered conscious pain and suffering, and death.

143. As a direct and proximate result of the Corporate Defendants' actions, representations, and concealments, Ronald H. Wysong's next-of-kin have experienced harms and losses as a result of his death, including those damages set forth in Ohio's wrongful death statute— R.C. 2125.02.

WHEREFORE, Plaintiff demands judgment against the Corporate Defendants, jointly, in an amount in excess of Twenty-Five Thousand & 00/100 Dollars ($25,000.00), together with costs of suit, attorneys' 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
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Counsel for Plaintiff

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 former 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 Ronald H. Wysong while a resident of Sanctuary at Wilmington Place aka AHF Ohio Inc., from January 1, 2022, through his discharge due to death on January 16, 2022, as well as the reasonable administration of such a facility.

4. I have reviewed all medical records reasonably available to The Estate of Ronald H. Wysong concerning the allegations contained in the complaint.

5. To a reasonable degree of medical probability, the Defendants Sanctuary at Wilmington Place aka AHF Ohio, Inc., AHF Management Corp., AHF Ohio Inc., American Health Foundation, Inc., AHF Home Office Inc., Mark T. Hammerle, Suzanne Lehman, John Haemmerle, J. Michael Haemmerle, Matt Lehman, Colleen Johnson, RN, Christine Dosland, LNHA, Toni Hunter, RN, Alto Health Care Staffing aka Cirrus Concept Consulting, LLC, Cirrus Concept PEO, LLC, Cirrus Concept HR, LLC, DeAyra Scandrick, and numerous unnamed nursing staff members who on January 16, 2022 attended to and improperly aided Mr. Wysong or failed to render aid to Mr. Wysong breached the standard of care and those breaches in the standard of care caused Mr. Wysong to suffer pain and suffering and his untimely and wrongful death.

FURTHER AFFIANT SAYETH NAUGHT.

Mark Shoag MD
MARK SHOAG, MD

SWORN TO BEFORE ME and subscribed in my presence this 27th day of June 2023.
Mark Shoag who produced an Ohio driver's license.

NOAH FRAZIER
Notary Public - State of Florida
Commission # HH49059
Expires on September 30, 2024

Noah Frazier
NOTARY PUBLIC Noah Frazier
State of Florida
County of Alachua

Notarized online using audio-video communication