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COMMON PLEAS DIVISION

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PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

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

PAGES FILED: 41

EFR200

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

LAUREN CARTER By and through her Legal Guardian, Gregory Carter c/o Michael Hill Trial Law 815 Superior Ave., Ste. 623 Cleveland, Ohio 44112 and GREGORY CARTER Individually, c/o Michael Hill Trial Law 815 Superior Ave., Ste. 623 Cleveland, Ohio 44112 Plaintiffs, vs. TAKODA TRAILS AKA MILLER HOLDINGS TAKODA, INC. 350 Kolb Dr Fairfield, Ohio 45014 Also Serve c/o Registered Agent: L & M Statutory Agent, LLC 100 N. Main Street Suite 350 Chagrin Falls, Ohio 44022 and EMPOWERING PEOPLE, INC. DBA CLW DBA CREATIVE LEARNING WORKSHOP DBA TAKODA TRAILS 1268 North River Rd. NE Warren, Ohio 44483 Also Serve c/o Registered Agent: Matthew J Parker 2460 Elm Road, Ste 500 Warren, Ohio 44483	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND** Previously filed Case No.: A 2204380

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and)
)
FOUNDATIONS HEALTH, LLC)
c/o Registered Agent:)
Ohio Agent Solutions, Inc.)
25000 Country Club Blvd., Suite 255)
North Olmsted OH 44070)
)
and)
)
FOUNDATIONS HEALTH SOLUTIONS, LLC)
c/o Registered Agent:)
Ohio Agent Solutions, Inc.)
25000 Country Club Blvd., Suite 255)
North Olmsted OH 44070)
)
and)
)
EMPOWERING PEOPLE WORKSHOP, INC.,)
DBA CLW DBA CREATIVE LEARNING)
WORKSHOP)
c/o Registered Agent:)
Matthew J Parker)
2460 Elm Road, Ste 500)
Warren, Ohio 44483)
)
and)
)
EMPOWERING PEOPLE MANAGEMENT,)
INC.)
c/o Registered Agent:)
L & M Statutory Agent, LLC)
100 N. Main Street Suite 350)
Chagrin Falls, Ohio 44022)
)
and)
)
FAIRFIELD VILLAGE REALTY, LLC)
c/o Registered Agent:)
Christopher L. Keller)
5710 Wooster Pike Ste 122,)
Cincinnati, Ohio 45227)
)
and)
)
DESATIN CURTIS)

360 Carver Place)
Hamilton, Ohio 45011)
)
Defendants.)
)

Plaintiffs Lauren Carter, by and through her next friend and legal guardian, Gregory Carter, and Gregory Carter, individually, for their refiled Complaint against the above-named Defendant(s), state and aver upon information and belief:

INTRODUCTION

1. This action involves Takoda Trails, an intermediate care facility for developmentally disabled adults with multiple disability diagnoses or intense behavioral needs, an Empowering People, Inc. company, and Empowering People's daytime adult care center Creative Learning Workshop's repeated disregard for the health and well-being of Lauren Carter, a 37-year-old, developmentally disabled woman who suffers from cerebral palsy, cortical blindness (she is legally blind), and reduced mental capacity.

2. Lauren is legally incompetent and has been under a legal guardianship since reaching adulthood. Her father, Gregory Carter, has been appointed as her legal guardian. See Case No. PG08-03-0042, Probate Court of Butler County.

3. Any applicable statutes of limitation for Lauren's causes of action have been tolled by operation of O.R.C. §2305.16 due to her legal incompetence.

4. Despite her limitations, Lauren can walk on her own. Lauren utilizes a wheelchair for instances in which she requires vehicular or other long-distance transportation.

5. Lauren is not capable of safely eating and swallowing food on her own. She requires feeding via a gastrostomy tube (G-tube). The purpose of the G-tube is to prevent the possibility of any food entering Lauren's esophagus which could result in choking.

6. Due to her disabilities, Lauren requires around-the-clock care. Lauren's family entrusted her care to Takoda Trails, an intermediate care facility for people with similar disabilities. Lauren was admitted to Takoda Trails in December of 2002 and has remained a resident since that time.

7. While under Takoda Trails' and CLW's care and supervision, their staff has regularly subjected Lauren to recurrent incidents of neglect and abuse, including cutting her throat, abandoning her in a hot van for hours (twice), sleeping while on duty supposedly supervising her, broken bones, burns, and physical and emotional abuse.

8. Empowering People was aware of significant, dangerous, and even deadly incidents causing harm and injury to residents by staff neglect, abuse, or assault, as well as unexplained injuries, but chose to understaff the facility, not put in supervisory equipment like cameras, hire underqualified staff, fail to adequately train or supervise their staff, and permit, ratify, and cover up employee misconduct, leaving incredibly vulnerable and defenseless residents, who cannot self-report abuse, in the hands of a single, underqualified staff member on night shifts, totally unsupervised, without cameras or another way to identify, report, or prevent abuse and neglect of residents, all while advertising to families of potential residents that they "have both the ability and experience to serve this population with EXCELLENCE."

9. There is a pattern of concerning incidents without adequate response from Empowering People, Takoda Trails, and CLW to prevent future incidents.

10. On October 18, 2003, Lauren received eighteen (18) stitches to her hand after allegedly getting it caught in a door at Takoda Trails. Her family and legal guardian was never notified of this incident. According to witness reports, Takoda Trails is uncertain as to where and how this injury happened.

11. On May 8, 2006, staff at Fairfield High School where Lauren attended became concerned about a burn on Lauren's arm. The school believed that Lauren had been burnt by a hairdryer due to a grill-shaped pattern in the burn. Takoda Trails' staff was notably uncooperative with the investigation.

12. On February 28, 2008, Kimberly Charles, a Medical Records Specialist at Takoda Trails, witnessed an aide at Takoda Trails forcibly push Lauren, who is legally blind, into her wheelchair.

13. On January 6, 2010, Lauren was forcibly restrained in her wheelchair by CLW staff. Notably, Lauren is able to walk and only utilizes a wheelchair for long-distance transportation to ensure her safety. Such restraint is abuse.

14. On July 21, 2011, a hot summer day, Lauren was left on a transport bus by CLW staff for approximately two hours. When she was finally found, she was in distress, drenched in sweat, and had an elevated body temperature.

15. On October 2, 2014, the Takoda Trails staff who were assigned to provide Lauren with 24-hour care were found asleep on duty. Multiple residents—all of whom suffer significant disabilities as a prerequisite for admittance—were without care during that period.

16. On November 18, 2014, Lauren sustained a broken clavicle. The family was not notified of this incident. The origins and circumstances of the injury remain unknown.

17. On August 25, 2019, Lauren was hospitalized due to food backing up into her esophagus and out through the surgical site of her G-tube. When proper care is provided, neither of these things should be possible.

18. On the overnight shift on November 30, 2021, Takoda Trails once again left Lauren and the 9 other residents alone with a lone caretaker, DeSatin Curtis. When the night shift began, Lauren was in her pajamas, and unharmed. When the day shift began, DeSatin Curtis was reportedly acting strangely, went to her car for a period of time, and changed clothes. Lauren was discovered with a serious laceration (cut) to the throat that required 12 stitches to close. DeSatin Curtis denied knowledge of how this occurred, changed her story, and failed to cooperate with investigations. Police investigation of her building at Takoda Trails could not identify any non-human source for the laceration. Lauren's pajamas, which she was last seen wearing by other staff, had been washed. Detectives also determined that blood had been cleaned from the hallway outside of Lauren's room. Curtis was noted to provide differing versions of events. Curtis was not fired for her involvement with Lauren's injury, but only after failing to cooperate with the investigation.

19. The Defendants knew DeSatin Curtis had a history of violent conduct. In 2018, she was charged with disorderly conduct in Hamilton County Municipal Court Case No. C/18/CRB/33409. The description of the violation states that Curtis "recklessly engaged in turbulent behavior to wit; fighting witnessed by several apartment residents."

20. A month prior to Lauren's throat being cut, Curtis was identified as the principal person of interest in a substantiated Major Unusual Incident (MUI) against a different resident at Takoda Trails, but the Defendants still allowed her to be the lone supervisor over their vulnerable, defenseless, and high-needs residents, without so much

as a working surveillance camera in the building to document how she treated the residents.

21. On July 18, 2022, once again CLW staff left Lauren on a hot transport bus. The person who left her on the bus was the Administrator of the CLW facility—the person responsible for training others for conducting safety head-counts to prevent a repeat of the incident from 2011. This time, Lauren was left on the hot bus for a period of approximately five hours.

22. Plaintiffs bring 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 their 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.

23. Plaintiffs seek 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.

24. Plaintiffs request a trial by jury.

DEFENDANTS

25. Takoda Trails aka Fairfield Center aka Miller Holdings Takoda, Inc. is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Takoda Trails aka Fairfield Center aka Miller Holdings Takoda, Inc.

26. Foundations Health Solutions, LLC, is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Takoda Trails aka Fairfield Center aka Miller Holdings Takoda, Inc.

27. CLW aka Creative Learning Workshop aka Empowering People Workshop, Inc. is an Ohio corporation that holds itself out to the public as a provider of residential and intermediate care and programming for persons with disabilities, through its agents, operatives and / or employees and does business as CLW aka Creative Learning Workshop aka Empowering People Workshop, Inc. CLW is also used by Empowering People, Inc.

28. Empowering People Management, Inc. is an Ohio corporation that holds itself out to the public as a provider of residential and intermediate care, through its agents, operatives and / or employees and does business as Empowering People Management, Inc.

29. Fairfield Village Realty, LLC is an Ohio limited liability corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Fairfield Village Realty, LLC.

30. Empowering People, Inc., is an Ohio for-profit corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees, and operates and controls the other Defendant entities, excepting Foundations Health, LLC, which exercises ultimate control over Empowering People, Inc.

31. Foundations Health, LLC, is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and operates and controls the other Defendant entities.

DIRECT AND VICARIOUS CORPORATE LIABILITY

32. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., Fairfield Village Realty, LLC, Takoda Trails, and CLW ("Corporate Defendants") employ, manage, and direct the care and service providers who were responsible for Lauren Carter's care, treatment, and safety at Takoda Trails and CLW and / or are responsible for creating unsafe conditions at Takoda Trails and CLW through their control of the Takoda Trails and CLW management that directly led to Lauren Carter's injuries.

33. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., and Fairfield Village Realty, LLC direct and control operations at Takoda Trails and CLW and are therefore directly liable for the harms caused by such mismanagement without regard to piercing the corporate veil.

34. Foundations Health, LLC, 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 they should be held directly liable for such harms and losses.

35. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., and Fairfield Village

Realty, LLC collectively own, manage, control, and/or are responsible for the care delivered to residents of Takoda Trails and CLW directly or through their domination and control of any putative entity license holder.

36. Some or all of the Corporate Defendants employ the care providers who were responsible for ensuring Lauren Carter's care and safety at Takoda Trails and CLW.

37. Lauren Carter and her family looked to Corporate Defendants for care based upon their representations.

38. Corporate Defendants are vicariously liable for the negligent actions of their employees and agents (respondent superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including residential care providers.

JURISDICTION AND VENUE

39. 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.

40. 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

Who is Lauren Carter?

Photo of Lauren Carter.

41. Lauren Carter is a 35-year-old woman with cerebral palsy and cortical blindness.

42. Lauren smiles.

43. Lauren enjoys going on walks.

44. Lauren enjoys listening to country music.

45. Lauren was admitted to Takoda Trails in December 2002 for long-term residential care.

Defendants' Negligence and Recklessness with Lauren Carter

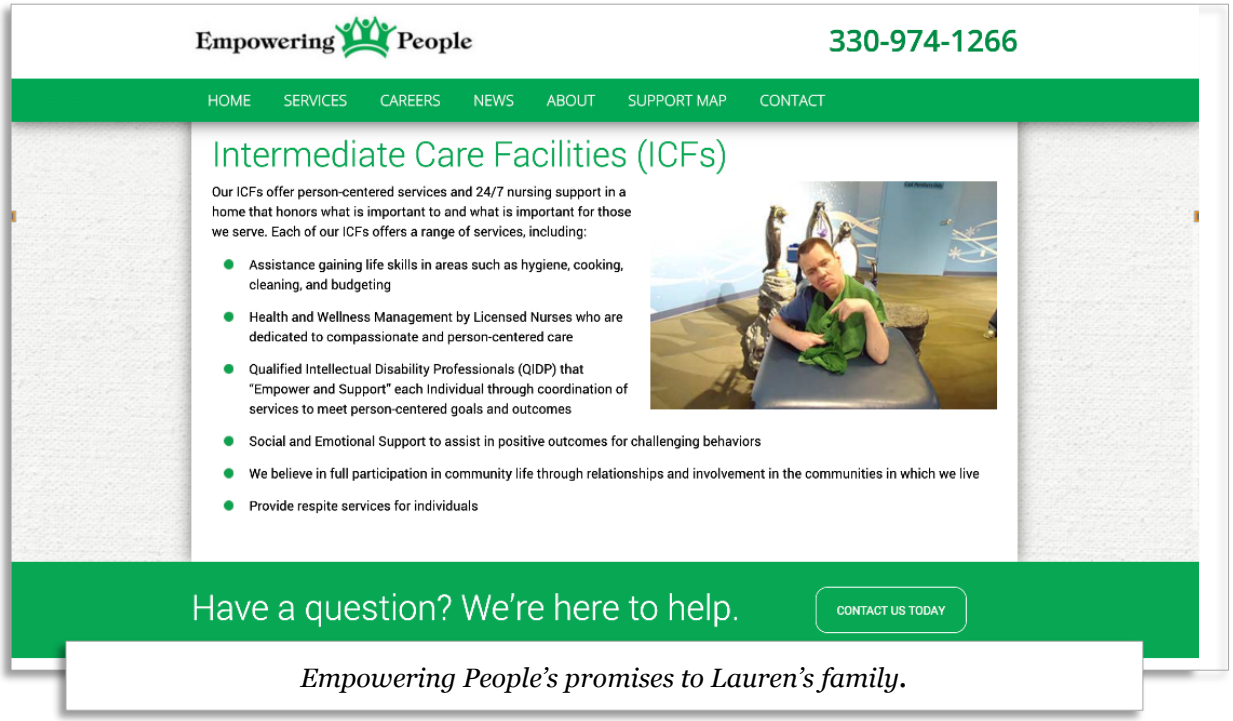
46. Corporate Defendants accepted Lauren Carter as a resident/attendee for long-term care for issues related to cerebral palsy.

47. Corporate Defendants agreed to accept Lauren Carter into their facility and provide care to her in exchange for monetary payment.

48. Takoda Trails and CLW knew Lauren Carter's care needs when they accepted her into their care.

49. Lauren Carter endured mental and physical pain suffering as a direct and proximate result of Corporate Defendants' failure to provide adequate care due to understaffing the facility.

50. Takoda Trails promised Lauren Carter and her family person-centered services and 24/7 nursing support:



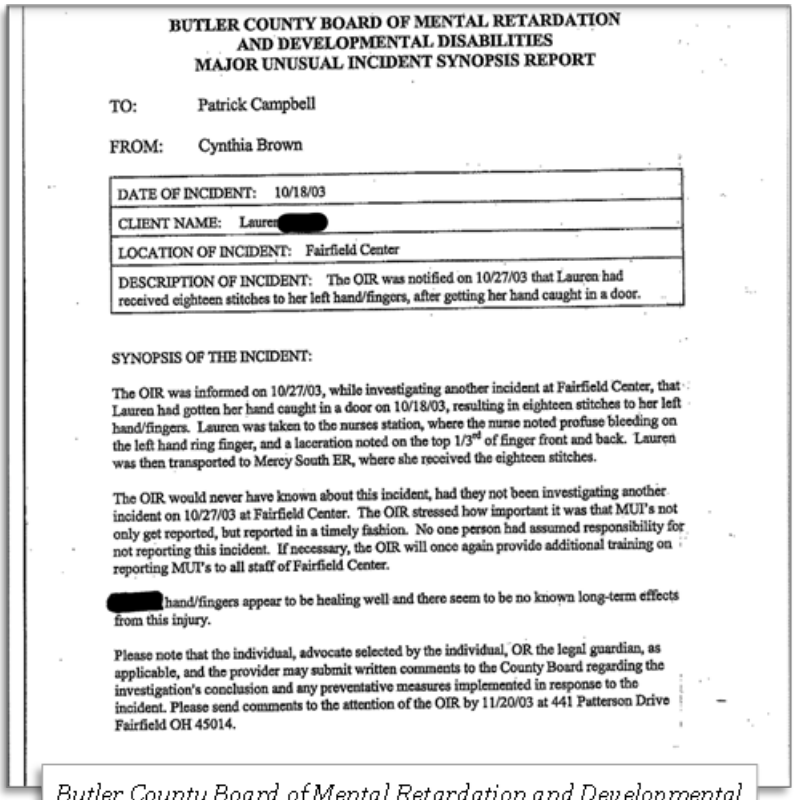
Empowering People's promises to Lauren's family.

October 18, 2003 – Laceration to Lauren's Hand, Requiring Eighteen (18) Stitches

51. On October 18, 2003, Lauren received eighteen (18) stitches to her hand after allegedly getting it caught in a door. Her family was never notified of this incident.

According to witness reports, the facility is uncertain as to where and how this injury actually happened. The injury bled so profusely that Lauren was transferred to the hospital where she received 18 stitches.

52. On October 27, 2003, the Butler County Board of Mental Retardation and Developmental Disabilities inadvertently heard about Lauren's injury while at the Takoda



BUTLER COUNTY BOARD OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
MAJOR UNUSUAL INCIDENT SYNOPSIS REPORT

TO: Patrick Campbell

FROM: Cynthia Brown

DATE OF INCIDENT: 10/18/03
CLIENT NAME: Lauren [redacted]
LOCATION OF INCIDENT: Fairfield Center
DESCRIPTION OF INCIDENT: The OIR was notified on 10/27/03 that Lauren had received eighteen stitches to her left hand/fingers, after getting her hand caught in a door.

SYNOPSIS OF THE INCIDENT:

The OIR was informed on 10/27/03, while investigating another incident at Fairfield Center, that Lauren had gotten her hand caught in a door on 10/18/03, resulting in eighteen stitches to her left hand/fingers. Lauren was taken to the nurses station, where the nurse noted profuse bleeding on the left hand ring finger, and a laceration noted on the top 1/3rd of finger front and back. Lauren was then transported to Mercy South ER, where she received the eighteen stitches.

The OIR would never have known about this incident, had they not been investigating another incident on 10/27/03 at Fairfield Center. The OIR stressed how important it was that MUI's not only get reported, but reported in a timely fashion. No one person had assumed responsibility for not reporting this incident. If necessary, the OIR will once again provide additional training on reporting MUI's to all staff of Fairfield Center.

[redacted] hand/fingers appear to be healing well and there seem to be no known long-term effects from this injury.

Please note that the individual, advocate selected by the individual, OR the legal guardian, as applicable, and the provider may submit written comments to the County Board regarding the investigation's conclusion and any preventative measures implemented in response to the incident. Please send comments to the attention of the OIR by 11/20/03 at 441 Patterson Drive Fairfield OH 45014.

Butler County Board of Mental Retardation and Developmental Disabilities Incident Synopsis Report.

Trails investigating a separate case for another reason. An investigation determined that the facility failed to report the MUI in a timely manner. (See **Exhibit 01**).

March 23, 2006 – Bite Marks on Lauren's Shoulder

53. On March 23, 2006, Fairfield High School nurse, Nina Ross, reported that Lauren came to school with a bite mark on her left shoulder. (See **Exhibit 02**).

April 3, 2006 – Burn on Lauren's Arm

54. On April 3, 2006. Fairfield High School nurse, Nina Ross, reported that Lauren came to school with a burn on her arm. (See **Exhibit 02**).

55. Lauren's teacher, Tony Huff at Fairfield High School, also believed the injury to Lauren's arm to be a burn. He also reached out to Takoda Trails regarding his concerns with this burn and potential abuse.

May 8, 2006 - Abrasions on Lauren's Back

56. On May 8, 2006, Fairfield High School nurse Nina Ross reported that Lauren came to school with two (2) fresh abrasions on her back (See **Exhibit 02**).

STATEMENT:
On 5/8/06 Nina Rose, nurse at Fairfield HS, reported to Cathy Hagins that she had concerns about Lauren. She reported Lauren came to school on 3/23/06 with a bite mark on her left shoulder. On 4/3/06 a burn was noted on her harm and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. Ms. Rose indicated she has attempted to discuss this with Fairfield Center and they become defensive. PPI is unknown at this time.
<Sandy L Donathan Added on 5/9/2006>

STATEMENT:
A. Allegation
On 5/8/06 Nina Rose, nurse at Fairfield High School, reported that Lauren [redacted] came to school on 3/23/06 with a bite mark on her left shoulder, on 4/3/06 a burn was noted on her arm and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. This was filed as an MUI for Alleged Physical Abuse.

Cathy Hagins Statements on the ODMR/DD Incident Report

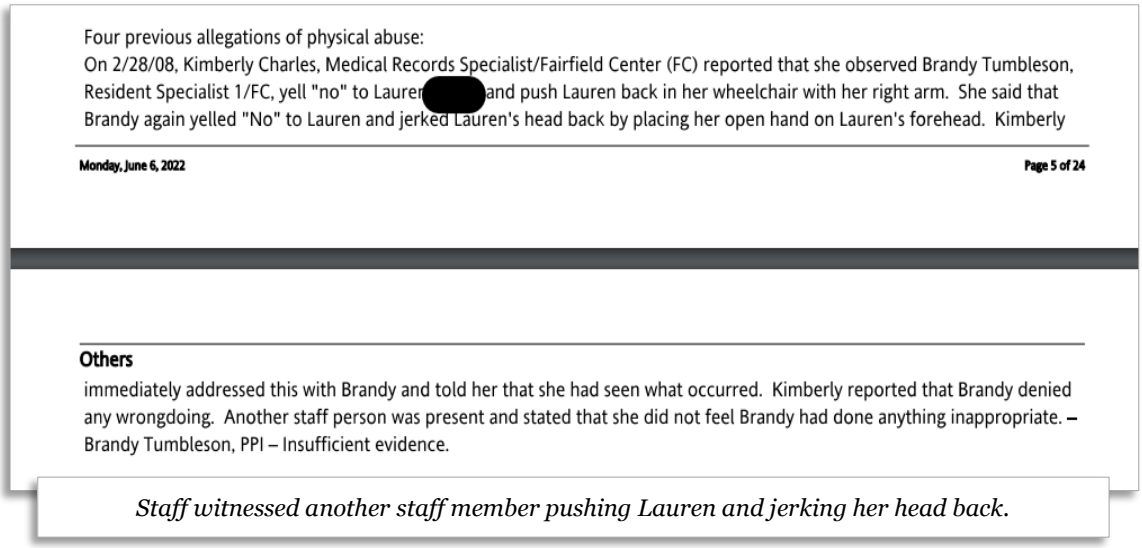
57. Fairfield High School nurse Nina Ross attempted to discuss these injuries and her concerns with Takoda Trails. However, staff quickly became defensive. These incidents were filed as an MUI for alleged physical abuse (See **Exhibit 02)**.

that he has never seen anyone cause harm to Lauren [illegible]
Documentation submitted by FHS indicates that there was a great deal of communication between FHS and FFC regarding Lauren's injuries. Lauren's teacher, Tony Huff, at FHS, sent e-mails to FFC regarding his concerns. On 3/29/06, he asked about the "burn" on Lauren's arm. The response from Mickelle Fuhrman, Home 500 Manager/FFC was that "the mark on her arm was made by her shirt. We also noticed it. Her shirt was too tight and she laid on it." The correspondence from Conrad Clowers indicates that FFC continued to believe the area was a rash while the Mr. Huff continued to believe it was a burn. Mr. Huff documented from 3/29/06 – 4/11/06 that the burn was still visible on Lauren's arm. Regardless of their opinions, the photograph of this injury indicates that this is a burn, likely from a hair dryer.

The findings following the ODMR/DD Investigation found that the injury was in fact a burn from a hairdryer.

February 28, 2008 - Witnessed Physical Abuse

58. On February 28, 2008, Kimberly Charles, a Medical Records Specialist at Takoda Trails reported that she observed Resident Specialist Brandy Tumbleson yell at Lauren twice, push her back into her wheelchair, and jerk Lauren's head back (See **Exhibit 03**).



Four previous allegations of physical abuse:
On 2/28/08, Kimberly Charles, Medical Records Specialist/Fairfield Center (FC) reported that she observed Brandy Tumbleson, Resident Specialist 1/FC, yell "no" to Lauren [redacted] and push Lauren back in her wheelchair with her right arm. She said that Brandy again yelled "No" to Lauren and jerked Lauren's head back by placing her open hand on Lauren's forehead. Kimberly

Monday, June 6, 2022 Page 5 of 24

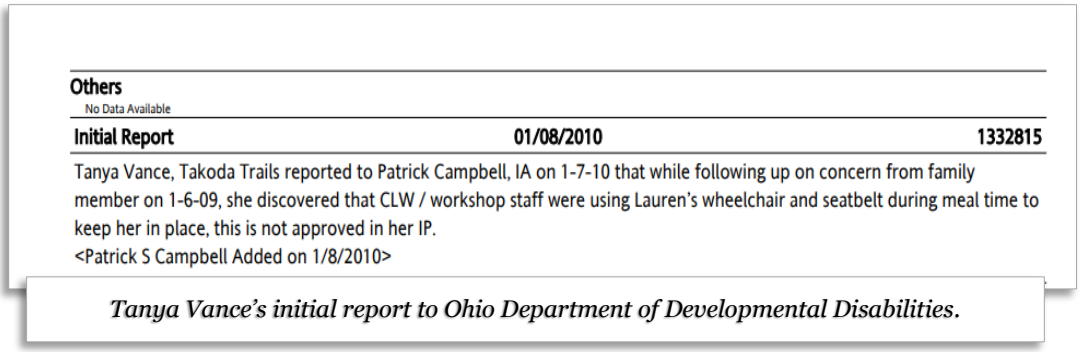
Others

immediately addressed this with Brandy and told her that she had seen what occurred. Kimberly reported that Brandy denied any wrongdoing. Another staff person was present and stated that she did not feel Brandy had done anything inappropriate. – Brandy Tumbleson, PPI – Insufficient evidence.

Staff witnessed another staff member pushing Lauren and jerking her head back.

January 7, 2010 - Lauren's involuntary restraint

59. On January 7, 2010, Tanya Vance from Takoda Trails reported to Patrick Campbell, the investigating agent, that she had discovered that CLW workshop staff were using seatbelts to keep Lauren in her wheelchair. This was not approved in Lauren's care plan or by her family (See **Exhibit 04**).



Others

No Data Available

Initial Report	01/08/2010	1332815

Tanya Vance, Takoda Trails reported to Patrick Campbell, IA on 1-7-10 that while following up on concern from family member on 1-6-09, she discovered that CLW / workshop staff were using Lauren's wheelchair and seatbelt during meal time to keep her in place, this is not approved in her IP.
<Patrick S Campbell Added on 1/8/2010>

Tanya Vance's initial report to Ohio Department of Developmental Disabilities.

60. As noted previously, Lauren is ambulatory. Use of a wheelchair in this manner is an unlawful restraint on Lauren's liberty.

61. The Ohio Department of Developmental Disabilities opened up an investigation regarding this report. The findings were substantiated on February 22, 2010 (See **Exhibit 04**).

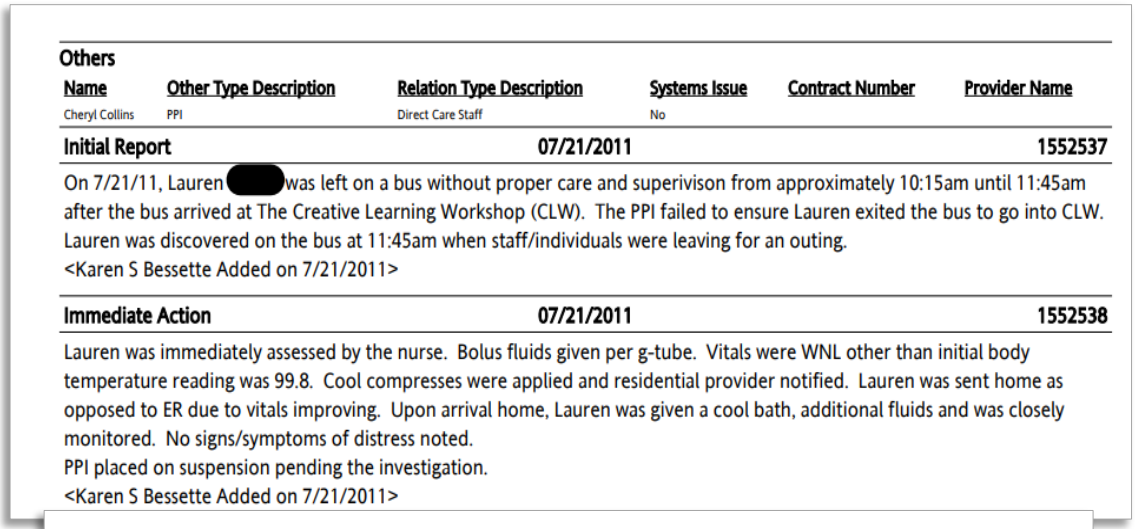
Findings and Conclusions	02/22/2010	1349387
Based on the information gathered, this is an Unapproved Behavior Support without justification. It was not to ensure Lauren's or anyone else's immediate health and safety. <Karen S Bessette Added on 2/22/2010>		
Cause And Contributing Factors	**02/22/2010**	**1349388**
Plan was not followed. <Karen S Bessette Added on 2/22/2010>		

ODDD's findings and conclusions on the wheelchair restraint report.

July 21, 2011 – First Bus Incident

62. On July 21, 2011, a hot summer day, while in the care of CLW, Lauren was left on a transport bus by CLW employee Cheryl Collins for about two (2) hours. Lauren was unable to escape. When she was finally found, she was in distress and had an elevated body temperature.

63. Following Lauren being left on the transport bus, an incident report with the DODD was created that same day. Their investigation was substantiated (See **Exhibit 05**).



Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
Cheryl Collins	PPI	Direct Care Staff	No		

Initial Report 07/21/2011 1552537

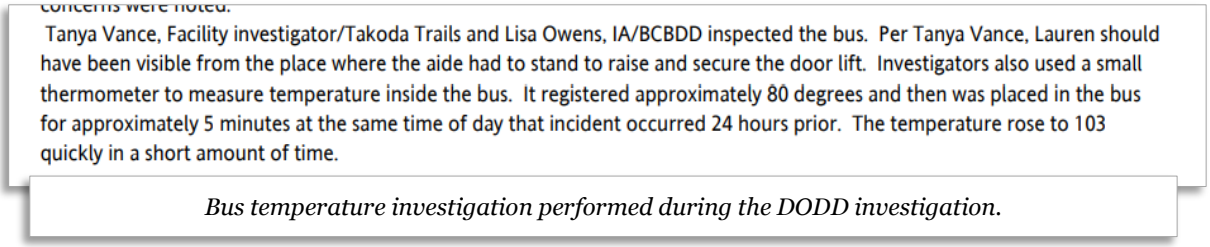
On 7/21/11, Lauren [redacted] was left on a bus without proper care and superivison from approximately 10:15am until 11:45am after the bus arrived at The Creative Learning Workshop (CLW). The PPI failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:45am when staff/individuals were leaving for an outing.
<Karen S Bessette Added on 7/21/2011>

Immediate Action 07/21/2011 1552538

Lauren was immediately assessed by the nurse. Bolus fluids given per g-tube. Vitals were WNL other than initial body temperature reading was 99.8. Cool compresses were applied and residential provider notified. Lauren was sent home as opposed to ER due to vitals improving. Upon arrival home, Lauren was given a cool bath, additional fluids and was closely monitored. No signs/symptoms of distress noted.
PPI placed on suspension pending the investigation.
<Karen S Bessette Added on 7/21/2011>

Initial report made with the DODD.

64. During this investigation, investigators used a small thermometer to measure the temperature inside the bus. Their thermometer test day mimicked the weather on the day that Lauren was left on the bus. Outside of the bus, the thermometer registered eighty (80) degrees Fahrenheit. After only five (5) minutes of the thermometer being left on the bus, the temperature quickly rose to one-hundred-and-three (103) degrees Fahrenheit (See **Exhibit 05**).



concerns were noted.
Tanya Vance, Facility investigator/Takoda Trails and Lisa Owens, IA/BCBDD inspected the bus. Per Tanya Vance, Lauren should have been visible from the place where the aide had to stand to raise and secure the door lift. Investigators also used a small thermometer to measure temperature inside the bus. It registered approximately 80 degrees and then was placed in the bus for approximately 5 minutes at the same time of day that incident occurred 24 hours prior. The temperature rose to 103 quickly in a short amount of time.

Bus temperature investigation performed during the DODD investigation.

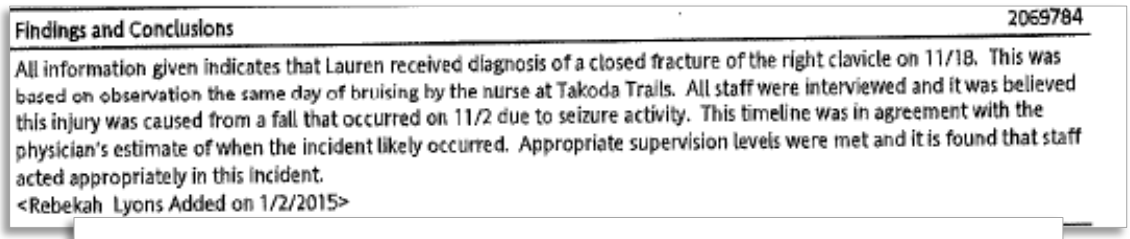
November 18, 2014 – Diagnosed with Broken Clavicle

65. On November 18, 2014, Lauren was diagnosed with a broken clavicle. The Ohio Department of Developmental Disabilities completed an incident report and investigation.

66. Sandy Osterberger, LPN, was preparing to administer Lauren her medication when she noticed yellow bruising measuring approximately 4 inches x 6 inches. She also noted a 1 cm x 1 cm raised area to the right of Lauren's scapula.

67. Lauren was scheduled to see an orthopedic surgeon that afternoon, Dr. Gangle, where she was diagnosed with a broken clavicle.

68. Staff blamed Lauren's broken clavicle on a fall on November 2, 2014, over two weeks prior to the discovery of her injury (See **Exhibit 06**).



Findings and Conclusions 2069784

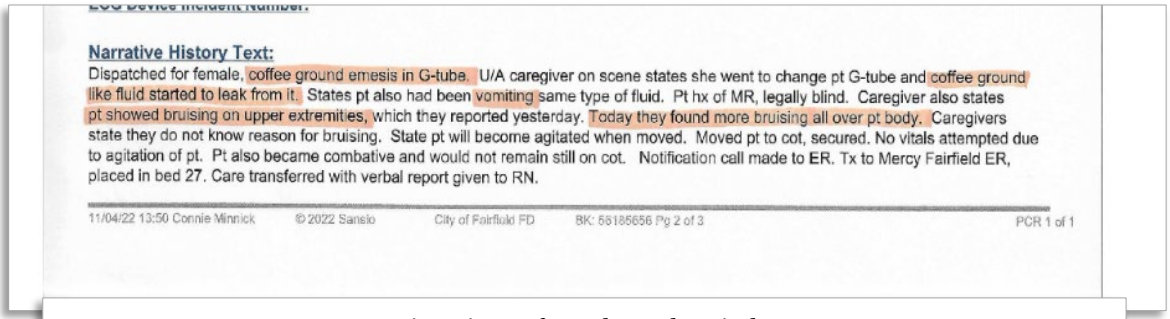
All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.
<Rebekah Lyons Added on 1/2/2015>

Findings and Conclusions of DODD's Incident Report.

August 25, 2019 - Hospitalization for Bowel Obstruction

69. On August 25, 2019, staff at Takoda Trails noted skin discoloration to all four of Lauren's extremities and coffee ground enemas. Lauren was sent to the Mercy Fairfield ER for further evaluation.

70. Emergency medical services personnel noted that Lauren had coffee ground enemas leaking from her g-tube and that she had been vomiting the same type of fluid. She also had bruising all over her body. (See **Exhibit 07**).

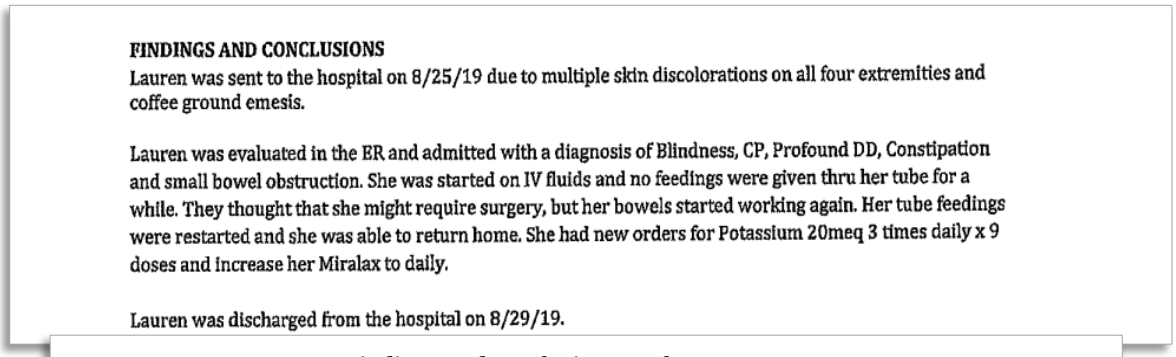


Narrative History Text:
Dispatched for female, coffee ground emesis in G-tube. U/A caregiver on scene states she went to change pt G-tube and coffee ground like fluid started to leak from it. States pt also had been vomiting same type of fluid. Pt hx of MR, legally blind. Caregiver also states pt showed bruising on upper extremities, which they reported yesterday. Today they found more bruising all over pt body. Caregivers state they do not know reason for bruising. State pt will become agitated when moved. Moved pt to cot, secured. No vitals attempted due to agitation of pt. Pt also became combative and would not remain still on cot. Notification call made to ER. Tx to Mercy Fairfield ER, placed in bed 27. Care transferred with verbal report given to RN.

11/04/22 13:50 Connie Minnick © 2022 Sansio City of Fairfield FD BK: 58185656 Pg 2 of 3 PCR 1 of 1

Narrative History from the Prehospital report.

71. Emergency Room physicians determined that Lauren had a bowel obstruction. They initially believed the obstruction would require surgery. However, luckily, Lauren's bowels started working properly again without surgery. She was discharged from the hospital on August 29, 2019 (See **Exhibit 08**).



FINDINGS AND CONCLUSIONS
Lauren was sent to the hospital on 8/25/19 due to multiple skin discolorations on all four extremities and coffee ground emesis.

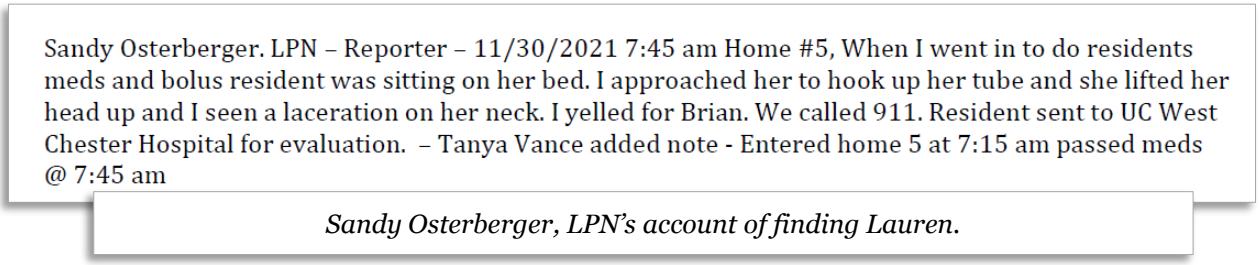
Lauren was evaluated in the ER and admitted with a diagnosis of Blindness, CP, Profound DD, Constipation and small bowel obstruction. She was started on IV fluids and no feedings were given thru her tube for a while. They thought that she might require surgery, but her bowels started working again. Her tube feedings were restarted and she was able to return home. She had new orders for Potassium 20meq 3 times daily x 9 doses and increase her Miralax to daily.

Lauren was discharged from the hospital on 8/29/19.

Findings and conclusions on the MUI Report.

November 30, 2021 – Lauren's Throat Slashing

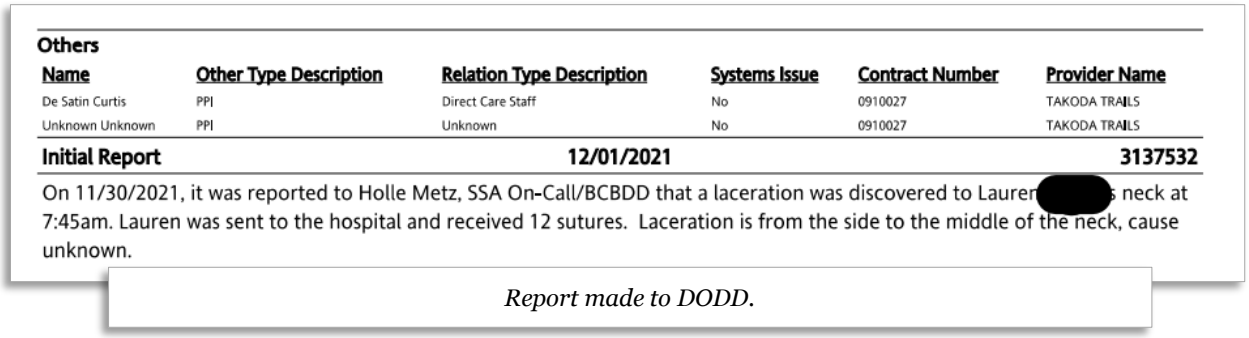
72. On November 30, 2021, Sandy Osterberger, LPN found Lauren in her room, with her throat slashed. (See **Exhibit 03**).



Sandy Osterberger. LPN – Reporter – 11/30/2021 7:45 am Home #5, When I went in to do residents meds and bolus resident was sitting on her bed. I approached her to hook up her tube and she lifted her head up and I seen a laceration on her neck. I yelled for Brian. We called 911. Resident sent to UC West Chester Hospital for evaluation. – Tanya Vance added note - Entered home 5 at 7:15 am passed meds @ 7:45 am

Sandy Osterberger, LPN's account of finding Lauren.

73. It was reported to Holle Metz, SSA on-call BCBDD that a laceration was discovered on Lauren's neck at 7:45 a.m. from the side to the middle of her neck (See **Exhibit 03**).



Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
De Satin Curtis	PPI	Direct Care Staff	No	0910027	TAKODA TRAILS
Unknown Unknown	PPI	Unknown	No	0910027	TAKODA TRAILS

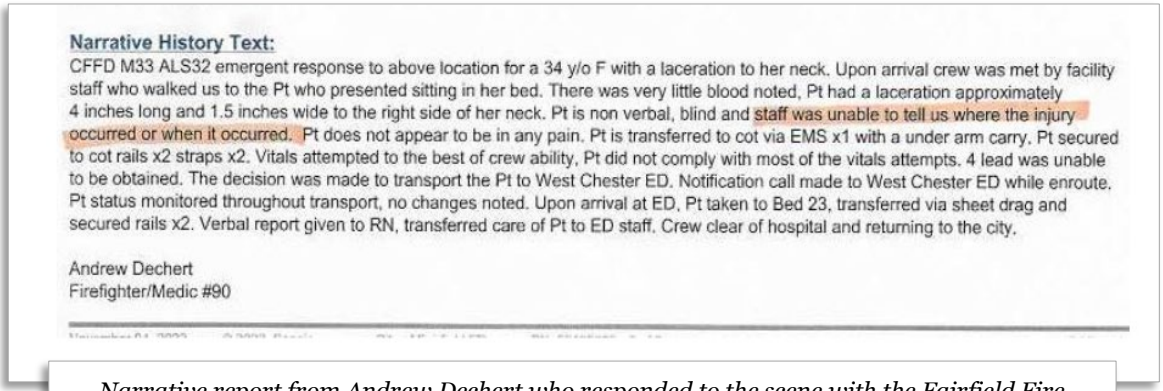
Initial Report **12/01/2021** **3137532**

On 11/30/2021, it was reported to Holle Metz, SSA On-Call/BCBDD that a laceration was discovered to Lauren [redacted]s neck at 7:45am. Lauren was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause unknown.

Report made to DODD.

74. Emergency medical services were called.

75. Andrew Dechert, firefighter/medic with the Fairfield Fire Department noted in his report that there was very little blood at the scene. He also noted that the laceration to Lauren's throat was approximately 4 inches long and 1.5 inches wide located to the right of her neck (See **Exhibit 09**).



Narrative History Text:

CFFD M33 ALS32 emergent response to above location for a 34 y/o F with a laceration to her neck. Upon arrival crew was met by facility staff who walked us to the Pt who presented sitting in her bed. There was very little blood noted, Pt had a laceration approximately 4 inches long and 1.5 inches wide to the right side of her neck. Pt is non verbal, blind and staff was unable to tell us where the injury occurred or when it occurred. Pt does not appear to be in any pain. Pt is transferred to cot via EMS x1 with a under arm carry. Pt secured to cot rails x2 straps x2. Vitals attempted to the best of crew ability, Pt did not comply with most of the vitals attempts. 4 lead was unable to be obtained. The decision was made to transport the Pt to West Chester ED. Notification call made to West Chester ED while enroute. Pt status monitored throughout transport, no changes noted. Upon arrival at ED, Pt taken to Bed 23, transferred via sheet drag and secured rails x2. Verbal report given to RN, transferred care of Pt to ED staff. Crew clear of hospital and returning to the city.

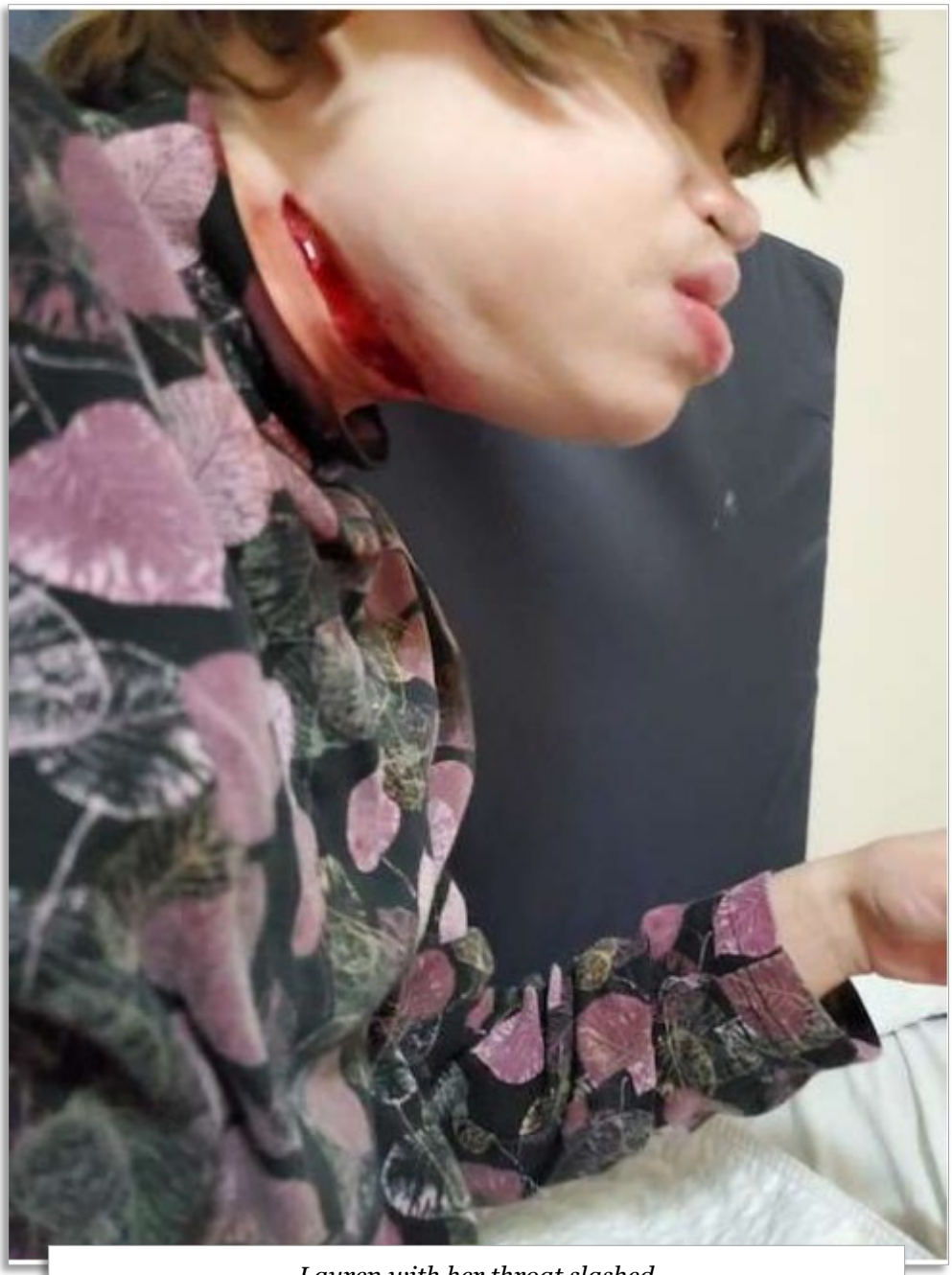
Andrew Dechert
Firefighter/Medic #90

Narrative report from Andrew Dechert who responded to the scene with the Fairfield Fire Department.

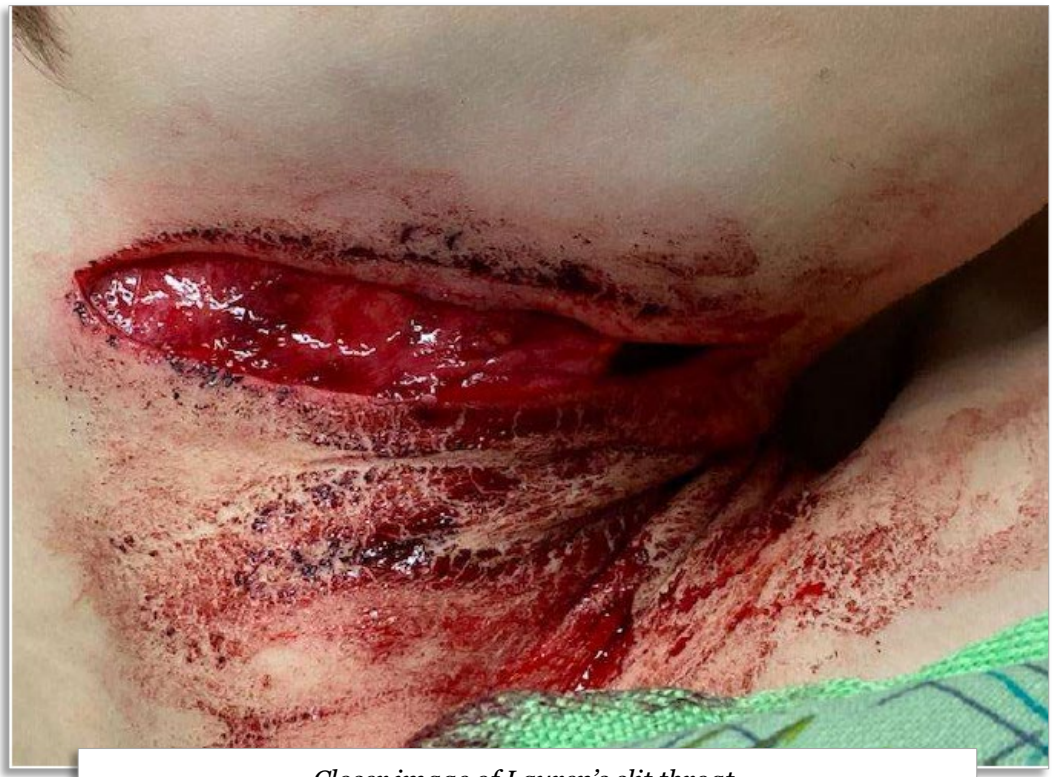
76. Lauren's neck injury required twelve (12) sutures to close.

77. Emergency Room personnel informed Lauren's father, Gregory Carter, that they did not believe this was an accident.

78. The following images depict this wound and may be disturbing to some viewers.



Lauren with her throat slashed



Closer image of Lauren's slit throat.

Lauren's throat after the 12 sutures.

79. The Fairfield Police Department investigated this incident. They "had great concern for this injury. Lauren is blind and could not have done this to herself."

80. Sgt. Pete Lagemann, the Supervisor of Investigations with the Fairfield Police Department stated that there was blood in the hallway that had been cleaned up. He also stated that Lauren's clothes had been changed and she had then been placed back in bed (See **Exhibit 03**).

Interim Report	12/01/2021	3137549

**Intake IA spoke with Sgt. Pete Lagemann, Supervisor of Investigations/Fairfield PD. He stated there is an open investigation. They are conducting interviews and do have great concern for this injury. Lauren is blind and could not have done this to herself. Additionally, there was blood in the hallway that had been cleaned up and Lauren was changed and put back to her bed by someone. Category will be changed to suspected physical abuse, PPI still unknown.
<Rebekah Lyons Added on 12/1/2021>

Sgt. Pete Lagemann's interim report to DODD.

81. Defendant DeSatin Curtis, the sole staff member on duty during the events surrounding Lauren's throat being slashed, became uncooperative with police and did not show up for her second interview.

82. Sgt. Pete Lagemann's police report stated that he believed that DeSatin Curtis was aware of Lauren's neck injury and failed to seek medical attention or call the on-call nurse (See **Exhibit 03**).

Extension Request Update	03/30/2022	3186055

IA was able to input from Doctor recommended by Butler County Coroner. IA also spoke to the detective from the case to clarify points in her report. At that time it was discovered that one of the staff did not fully cooperate with the investigation and did not return for an interview. IA contact provider and they removed the staff from schedule until interview was arranged. IA is waiting to see if staff complies, and is also seeking to question this staff as well.
<Campbell, Patrick Added on 3/30/2022>

A staff member refused to cooperate with police, which raised red flags for investigators.

83. Police believe Defendant Curtis knew about Lauren's throat slashing, cleaned up the blood, and changed Lauren's clothes.

84. According to medical professionals that the Fairfield Police Department spoke to, the injury would have had to have happened on Defendant Curtis's shift, several

hours before medical attention was sought for Lauren. This is corroborated by the fact that the blood on Lauren's neck had dried by the time the cut was reported.

85. The Fairfield Police Department spoke to Michelle Truett, QA RN with BCBDD. They provided her photos of Lauren's neck incised wound for review. Ms. Truett believed there would have been more bleeding than what the images showed.

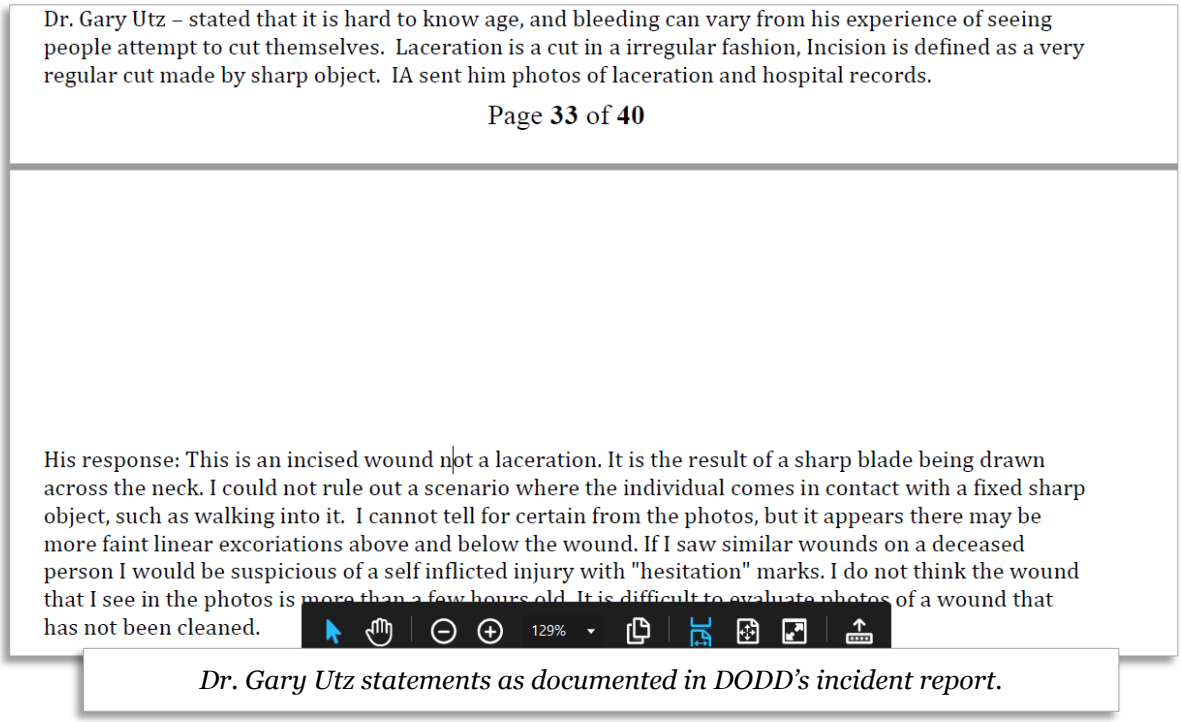
86. The Fairfield Police Department spoke with Kathy Tallon, QA RN with BCBDD. They showed her photos of Lauren's injuries for review. According to documentation, Kathy was unsure as to how such an injury could occur "accidently," but that the object used to make the cut would have had to have been sharp to cause a clean cut (See **Exhibit 03**).

> Michelle Truett, QA RN with BCBDD – Reviewed photos of injuries with Michelle, She did think that there would have been more bleeding than what the photos show. That the way Lauren holds her head could have naturally help put pressure on the wound. She was not sure about estimating how old the wound was. The review was mainly for any possible thoughts or cause or what to look for, mainly a sharp object.
>
> Kathy Tallon, QA RN with BCBDD– Reviewed photos of injuries with Kathy, she contact IA she was not sure how such a injury could occur accidently, but would have been from a sharp object the cut was very clean. IA had seen photos of kite string injuries and she reviewed them as well. She advised to check the shirts collar and blanket. IA did check the shirt and bedding at home visit and did not find any sharp objects.

Opinions of Michelle Truett, QA RN with BCBDD and Kathy Tallon QA RN with BCBDD as listed in DODD's Incident Report.

87. The Fairfield Police Department spoke with Dr. Gary L. Utz, a pathologist in Cincinnati, Ohio. Dr. Utz has been a practicing doctor for more than twenty (20) years, and he received his degree from the University of Cincinnati College of Medicine.

88. Dr. Utz believed the incision came from a sharp object. He also believed that the injuries were more than a few hours old (See **Exhibit 03**).



Dr. Gary Utz – stated that it is hard to know age, and bleeding can vary from his experience of seeing people attempt to cut themselves. Laceration is a cut in a irregular fashion, Incision is defined as a very regular cut made by sharp object. IA sent him photos of laceration and hospital records.

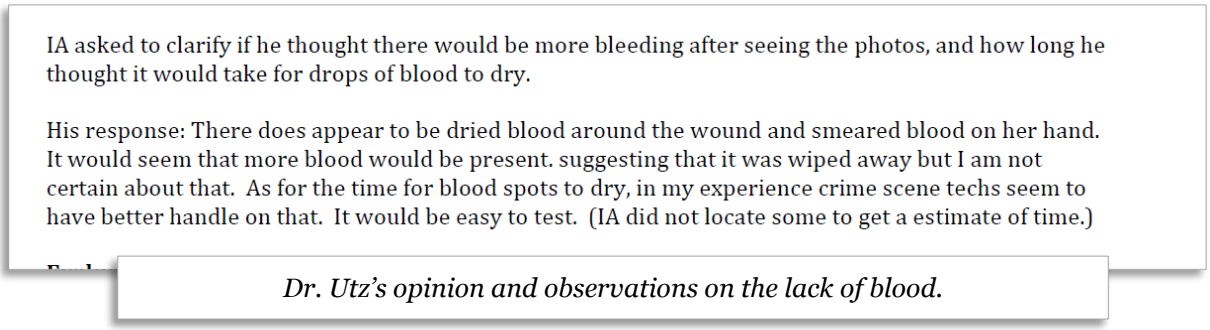
Page **33** of **40**

His response: This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear excoriations above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

129%

Dr. Gary Utz statements as documented in DODD's incident report.

89. Dr. Utz thought there would be more bleeding. He noted dried blood around the wound and smeared blood on Lauren's hand. The lack of blood suggested that blood had been wiped away. (See **Exhibit 03**).

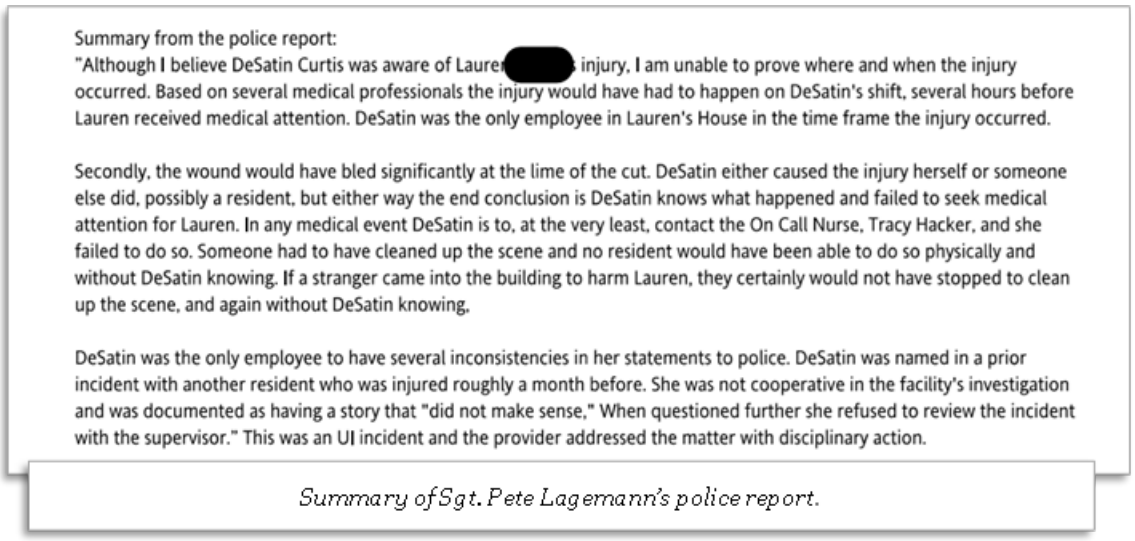


IA asked to clarify if he thought there would be more bleeding after seeing the photos, and how long he thought it would take for drops of blood to dry.

His response: There does appear to be dried blood around the wound and smeared blood on her hand. It would seem that more blood would be present. suggesting that it was wiped away but I am not certain about that. As for the time for blood spots to dry, in my experience crime scene techs seem to have better handle on that. It would be easy to test. (IA did not locate some to get a estimate of time.)

Dr. Utz's opinion and observations on the lack of blood.

90. Defendant DeSatin Curtis was named in a prior incident with another injured resident just a month prior to Lauren's neck injury (See **Exhibit 03**). However, she was not released from employment.



Summary from the police report:
"Although I believe DeSatin Curtis was aware of Laure[redacted] injury, I am unable to prove where and when the injury occurred. Based on several medical professionals the injury would have had to happen on DeSatin's shift, several hours before Lauren received medical attention. DeSatin was the only employee in Lauren's House in the time frame the injury occurred.

Secondly, the wound would have bled significantly at the lime of the cut. DeSatin either caused the injury herself or someone else did, possibly a resident, but either way the end conclusion is DeSatin knows what happened and failed to seek medical attention for Lauren. In any medical event DeSatin is to, at the very least, contact the On Call Nurse, Tracy Hacker, and she failed to do so. Someone had to have cleaned up the scene and no resident would have been able to do so physically and without DeSatin knowing. If a stranger came into the building to harm Lauren, they certainly would not have stopped to clean up the scene, and again without DeSatin knowing.

DeSatin was the only employee to have several inconsistencies in her statements to police. DeSatin was named in a prior incident with another resident who was injured roughly a month before. She was not cooperative in the facility's investigation and was documented as having a story that "did not make sense." When questioned further she refused to review the incident with the supervisor." This was an UI incident and the provider addressed the matter with disciplinary action.

Summary of Sgt. Pete Lagemann's police report.

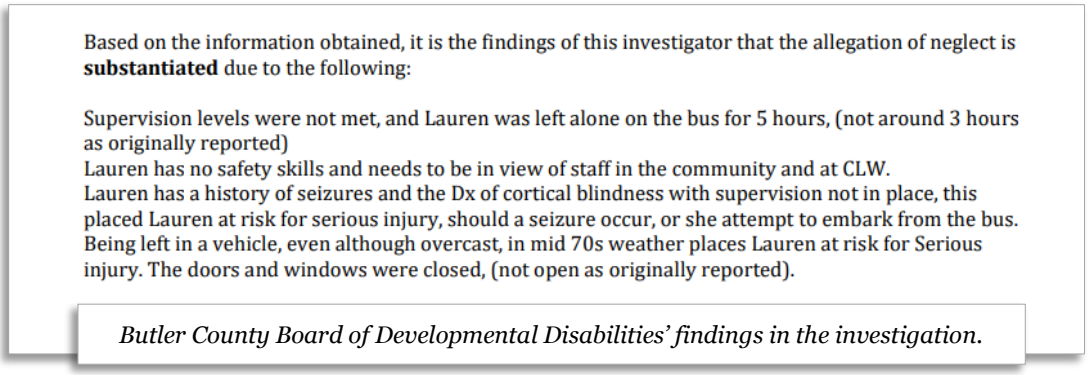
91. Defendant Curtis was eventually terminated from Takoda Trails due to her failure to cooperate with the police investigation.

July 18, 2022 – Second Bus Incident

92. On July 18, 2022, Lauren was transported to CLW by CLW Administrator, Josh Morris, in CLW's transport bus. Morris, the Administrator and person responsible for training staff on performing head counts for bus safety after the First Bus Incident, left Lauren on the bus for a period of five hours.

93. CLW staff lied and said the windows of the bus were down the entire five hours. Camera footage proved this statement to be a lie.

94. This incident was reported to the Butler County Board of Developmental Disabilities. They did an investigation and found the report to be substantiated (See **Exhibit 13**).



Based on the information obtained, it is the findings of this investigator that the allegation of neglect is **substantiated** due to the following:

Supervision levels were not met, and Lauren was left alone on the bus for 5 hours, (not around 3 hours as originally reported)
Lauren has no safety skills and needs to be in view of staff in the community and at CLW.
Lauren has a history of seizures and the Dx of cortical blindness with supervision not in place, this placed Lauren at risk for serious injury, should a seizure occur, or she attempt to embark from the bus.
Being left in a vehicle, even although overcast, in mid 70s weather places Lauren at risk for Serious injury. The doors and windows were closed, (not open as originally reported).

Butler County Board of Developmental Disabilities' findings in the investigation.

CORPORATE CONTROL

95. Corporate Defendants hold themselves out to the public as providers of residential and intermediate care services.

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

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

98. Corporate Defendants manage, control, and / or employ the staff at Takoda Trails and CLW.

99. Corporate Defendants exercise actual control over the Takoda Trail's and CLW's management and operations to maximize profits, including control over facility-level, including:

a. Policies and procedures, including regarding resident supervision and care;

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

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

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

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

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

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

h. Medical record systems and management;

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

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

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

100. As the result of this control, Corporate Defendants make decisions that affect the day-to-day care of residents of the Takoda Trails and CLW, such as the resources available for providing staff and care to residents like Lauren Carter, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

101. Corporate Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that the facilities were sufficiently staffed to meet the individual needs of its residents, including Lauren Carter.

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

103. This lack of sufficient staff directly resulted in Lauren Carter not receiving basic and necessary services to prevent, among other things, neglect and abuse leading to her injuries.

104. Corporate Defendants also exercise operational and managerial control, and apply this profits-over-safety model throughout Ohio. Defendant Empowering People, Inc., alone, operates at the following facilities in the State of Ohio according to their website:

a. Manor Home - Geneva, OH
b. Takoda Trails - Fairfield, OH
c. Vienna Meadows - South Vienna, OH
d. Consumer Choice Inc. - Lisbon, OH
e. Sunrise Homes - Lisbon, OH
f. Affinity Place - Mount Healthy, OH
g. Hunsford - Cincinnati, OH
h. John Gray - Cincinnati, OH
i. Monon Ave. Home - Cincinnati, OH
j. Northbend - Cincinnati, OH
k. Woodbine - Cincinnati, OH
l. Broadfield Care Center - Madison, OH
m. Stewart Lodge - Madison, OH
n. Foundations - New Paris, OH
o. Alliance Group Homes - Alliance, OH
p. Carnegie - Massillon, OH
q. Deborah - Canton, OH

r. Strausser Home - Canal Fulton, OH

s. Sturbridge Home – Alliance, OH

t. Dunbar – EPI Summit – Tallmadge, OH

u. Ellsworth – EPI Summit -Stow, OH

v. Frank – EPI Summit – Barberton, OH

w. Lakeview – EPI Summit – Stow, OH

x. North Thomas – EPI Summit – Tallmadge, OH

y. Pontius – EPI Summit – Uniontown, OH

z. Ritchie – EPI Summit – Stow, OH

aa. Springfield – EPI Summit – Akron, OH

bb. Winchester – EPI Summit – Fairlawn, OH

cc. Empowering People Inc. – Warren, OH

dd. Brookside Care Center – Mason, OH

ee. Cedar Creek – Elyria, OH

Misleading Advertising

105. To persuade the families of patients to become customers, Corporate 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.

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

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

Systemic Understaffing and Lauren Carter's Care

108. Corporate Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Takoda Trails and CLW were sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Lauren Carter during the period she was a resident at Takoda Trails and attendee at CLW.

109. Corporate Defendants engaged in a systemic practice to understaff Takoda Trails and CLW to maximize profits at the expense of its residents' care.

110. This lack of sufficient staff directly resulted in Lauren Carter not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect and abuse leading to her injuries at Takoda Trails and CLW during the period she was a resident and attendee.

FIRST CAUSE OF ACTION
(NEGLIGENCE / RECKLESSNESS)

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

112. Lauren Carter depended on Corporate Defendants, and their respective staff, including Defendant DeSatin Curtis, residential care.

113. Defendants had a duty to provide proper care and treatment to Lauren Carter and to avoid causing her injury.

114. Defendants, including their staff, failed to provide proper care and treatment to Lauren Carter, which they knew or should have known she required, and their negligence was the direct and proximate cause of the injuries that Lauren Carter suffered.

115. Defendants' failure to provide proper care 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 staff members for resident needs at each facility to protect and provide adequate care to residents like Lauren Carter;

e. Choosing to not provide accurate, adequate, or timely information to Lauren Carter's family;

f. Choosing to provide inadequate supervision to prevent accidents and injuries;

g. Choosing to violate orders relating to care of Lauren Carter;

h. Choosing to violate state and federal regulations governing care and staffing levels in facilities by which residents like Lauren Carter are a member of the class of persons intended to be protected from injuries like those she suffered;

i. Failing to ensure the rights and safety of its residents, including Lauren Carter, as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Lauren Carter while she was a resident/attendee; and

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

116. These actions constituted a conscious disregard for Lauren Carter's rights and safety with a great probability of causing substantial harm from this misconduct, by

which—through heedless indifference to the consequences—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 care were rendered, constituting an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct. Defendants were aware of the great probability of harm that could result from their willful, wanton, and/or reckless misconduct.

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

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

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

120. Defendants and their staff provided care to Lauren Carter that fell below the standard of care expected of residential care facilities, under the same or similar circumstances.

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

122. As a direct and proximate result of the negligent and/or willful, wanton and/or reckless actions of the Defendants described above, Lauren Carter sustained

permanent injury and loss including, but not limited to, conscious pain and suffering, and permanent bodily disfigurement.

123. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), for conscious pain and suffering, permanent bodily disfigurement, 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
RESIDENTS' RIGHTS CLAIM

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

125. Defendants, directly or through their employees or agents, violated Lauren Carter's rights as a resident of Defendants' facilities, as enumerated in R.C. 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. Upon admission and thereafter, the right to adequate and appropriate care and services that comprise necessary and appropriate care consistent with the program for which the resident contracted;

d. The right to be free from physical or chemical restraints or prolonged isolation; and

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

126. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Lauren Carter endured conscious pain and suffering, emotional distress, permanent bodily disfigurement, and other injuries.

127. WHEREFORE, Plaintiff demands judgment against Defendants, jointly, in an amount more than 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.

THIRD CAUSE OF ACTION
NEGLIGENT HIRING, SUPERVISION, AND RETENTION

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

129. Corporate Defendants were in an employer-employee relationship with Defendant DeSatin Curtis, Cheryl Collins, Josh Morris, and other staff who caused harm to Lauren Carter.

130. Corporate Defendants' employees were incompetent to provide care and services to Lauren Carter.

131. Corporate Defendants had actual or constructive knowledge of their employees' incompetence, including Defendant DeSatin Curtis.

132. Corporate Defendants' employees' acts or omissions caused injury to Lauren Carter.

133. Corporate Defendants' negligence in hiring, retaining, or supervising their employees is the proximate cause of Lauren Carter's injuries.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit,

attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

FOURTH CAUSE OF ACTION
CIVIL CONSPIRACY

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

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

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

136. This understanding constitutes a malicious combination to injure residents/attendees of the Takoda Trails and CLW, including Lauren Carter.

137. In pursuance of this common plan or design to commit tortious acts, 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.

138. The conspiracy caused injury to Lauren Carter.

139. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount more than 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 Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

FIFTH CAUSE OF ACTION
FRAUD

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

141. Corporate Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Takoda Trails and CLW.

142. Not only did Corporate Defendants conceal this information, but they also publicly and privately represented that they provide exceptional services in an effort to induce the family of Lauren Carter and other potential customers to place their loved ones in their care and custody.

143. 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 Lauren Carter's family and other potential customers into placing their loved ones in the care and custody of Defendants.

144. Lauren Carter's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

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

146. As a direct and proximate result of Defendants' actions, representations, and concealments, Lauren Carter suffered conscious pain and suffering, permanent bodily disfigurement, and other injuries as otherwise described in this Complaint.

147. 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.

SIXTH CAUSE OF ACTION
NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

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

149. Plaintiff Lauren Carter reasonably appreciated the peril which took place when she was injured while in the care of Defendants.

150. Plaintiff Lauren Carter suffered emotional distress as a result of her peril at the hands of Defendants.

151. Plaintiff Gregory Carter was a bystander to the omissions of care suffered by his daughter, Lauren Carter.

152. Plaintiff Greg Carter reasonably appreciated the peril which took place when Lauren Carter was injured while in the care of Defendants.

153. Plaintiff Greg Carter suffered emotional distress because of his awareness of Lauren Carter's peril at the hands of Defendants.

154. 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.

SEVENTH CAUSE OF ACTION
ASSAULT AND BATTERY

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

156. Defendants and their employees willfully threatened or attempted to harm or touch Plaintiff Lauren Carter offensively, which threat or attempt reasonably placed Plaintiff Lauren Carter in fear of such contact, and did make such contact.

157. Defendants and their employees knew with substantial certainty that their act or acts would bring about harmful or offensive contact.

158. Defendants and their employees willfully acted to harm or touch Plaintiff Lauren Carter offensively.

159. Defendants and their employees' acts to harm or touch Plaintiff Lauren Carter offensively resulted in harm or offensive contact with Plaintiff Lauren Carter.

160. Plaintiff Lauren Carter suffered injuries as a result of Defendants' and their employees' acts.

161. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

A TRIAL BY JURY IS HEREBY DEMANDED

Respectfully Submitted,

/s/ Matthew A. Mooney

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Counsel for Plaintiff

Addendum: Reduced font from all caps of patient name to proper format. Changed during station check. Lt. Cooper. 12-3-2021

Addendum: Changed Incident Location Type to Res. Custodial Facility. CBellman 12/21/21

Unable to Sign:

Unable to Sign Reason: Mentally unable (must describe in comments)
Authorized Representative: No authorized representative is available or willing
Authorized Representative Signature: No
Secondary Documentation: Patient Medical Record
Secondary Documentation Signature: No
Comment:
Pt is MRDD non verbal and blind

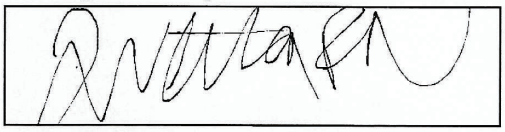
Auth Signature: No **Privacy Sig:** No **Unable to Sign:** Yes **Refused to Sign:** No

Signature Image(s):

Authorization Signature

Privacy Notice Signature

Receiving RN / MD Signature - Jen RN - 11/30/2021 08:33



Technician Signature - Dechert, Andrew - 11/30/2021 08:15

Technician 2 Signature - Miller, Evan - 11/30/2021 08:36

Recommended Service Level: BLS (A0429) / Dispatch Service Level: ALS

Run Type: Emergency

Calculated Mileage: 10.45

Medically Necessary: Yes (5)