In the Court of Common Pleas for Stark County, Ohio

BRUCE VANDERHOFF, DIRECTOR OHIO DEPARTMENT OF HEALTH 246 North High Street Columbus, Ohio 43215	:	Case No. ____ Judge _____
Plaintiff,	:	
v.	:	
HARI GROUP, LLC dba HOUSE OF LORETO 2812 Harvard Ave. NW Canton, OH 44709	:	
and	:	
c/o Statutory Agent, Bharat Thakkar 3922 Wood Road Madison, OH 44057	:	
Defendant.	:	

PLAINTIFF'S MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION UNDER R.C. 3721.08 AND CIV. R. 65

Plaintiff Bruce Vanderhoff ("The Director") is the Director of the Ohio Department of Health ("ODH"). The Director has authority under R.C. Chapter 3721 to grant and monitor licensed nursing homes.

Defendant Hari Group, LLC owns and operates the House of Loreto ("HL"), a nursing home located at 2812 Harvard Ave. NW Canton, OH 44709. The Director has concluded that there is a real and present danger to the residents due to HL's failures to have proper staffing and to provide safe and effective health care to its residents.

The Director asks that this Court issue a temporary restraining order and preliminary injunction order under R.C. 3721.08(B) and Civ.R. 65 requiring Defendant Hari Group, LLC to

1. Not admit any further residents at the nursing home located at 2812 Harvard Ave. NW, Canton Ohio 44709.

2. Cooperate with the Ohio Department of Health and the Ombudsman from the Department of Aging to forthwith transfer all residents to other nursing homes or other appropriate care settings.

3. Comply with all staffing, health and safety requirements for nursing homes found under Ohio and federal law while any residents are present.

A memorandum in support is attached.

Respectfully submitted,

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Plaintiff,	:	Judge _____
v.	:	
HARI GROUP, LLC dba HOUSE OF LORETO Defendant.	:	

MEMORANDUM IN SUPPORT

INTRODUCTION

R.C. 3721.08(B) authorizes the Director to "petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger."

The Director is seeking this temporary restraining order and preliminary injunction because residents at the HL nursing home in Canton, Ohio are in a real and present danger of immediate and serious physical harm or death. The Director does not raise these allegations lightly This nursing home is so badly run and is so dangerous that

the Director feels compelled to immediately seek court authorization to close the nursing home and to transfer the residents to other nursing homes.

ODH Surveyors have repeatedly inspected HL and seen a rapid deterioration of care to its residents. On or about December 16, 2025, ODH notified HL that twelve of its residents had been in "Real and Present Danger" since November 12, 2025, due to shockingly poor care. There were only twenty-nine residents present at HL, so over a third of the residents are in Real and Present Danger. (As of January 10, 2026, there were twenty-seven residents present.)

Since the end of October, HL has been without a full-time registered nurse to act as the director of nursing ("DON"). Ohio law requires that a nursing home have a full-time registered nurse who "predominately" works during the day. Specifically, this means that the DON must be present at least five days a week, for at least eight-hours at a time. Adm.Code 3701-17-08(B).

Instead, HL has used a part-time, night-shift nurse to act as the DON. During the entire month of December 2025, she worked between one and three eight-hour shifts per week -- all during the night shift.

Although there is a licensed nursing home administrator, she is hands-off to an extreme degree, delegating almost all work to the "executive director" -- an individual with no health care license.

The net result is that HL is doing a terrible job at even the most basic medical tasks for nursing home residents. Residents are injured in falls, yet the facility does not figure out why they are falling, nor take steps to prevent further falls. This is even after there have been serious injuries, with one resident suffering intercranial bleeding and a broken clavicle.

HL is also failing to assure that patients receiving powerful blood thinners (such as Coumadin/warfarin) are (1) receive proper blood testing to assure that they will not spontaneously bleed to death and (2) reporting the results of the testing to prescribers. For one patient, HL continued to administer warfarin even after a physician discontinued the order.

HL is causing unnecessary pain and harm to patients who are supposed to be receiving wound care. For one resident, HL's staff thought that wound care was being done by a private duty nurse -- it wasn't. The resident ended up with much more serious injuries in his legs, while complaining that he was in a lot of pain. Not surprising because HL failed to administer pain medication to the resident for eleven days.

On December 16, 2025, the Department verbally notified HL that there was a "real and present danger" as a result of three rules violations.

ODH issued a 196 page survey to HL on January 2, 2026, detailing the terrible care that HL has provided to its residents.

On January 10, 2026, ODH surveyors returned to HL for an unannounced inspection. HL had failed to take its residents out of real and present danger. The only nurse on staff was an LPN from an agency (working her second time at the facility). The manager on duty was the laundry manager. There continued to be resident falls without any follow-up investigation, staff could not find the results of a warfarin blood test for a resident, and a hospice patient was denied pain medication.

LAW

"'Real and present danger' means immediate danger of serious physical or life-threatening harm to one or more occupants of a home." R.C. 3721.01(A)(14).

"'Home' means an institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home for the aging, and a veterans' home[.]" R.C. 3721.01(A)(1)(a).

"Unless the department of medicaid or contracting agency has taken action under section 5165.77 of the Revised Code to appoint a temporary manager or seek injunctive relief, if, in the judgment of the director of health, real and present danger exists at any home, the director may petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise

eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger." R.C. 3721.08(B).

"Each nursing home will:

(1) employ a registered nurse to serve as director of nursing:

(a) This standard may be met by two registered nurses who share the position as co-directors of nursing.

(b) The director of nursing or co-directors of nursing will be on duty five days per week, eight hours per day predominantly between the hours of six a.m. and six p.m. to direct the provision of nursing services.

(c) The nursing home will post the name of the director of nursing in a place easily accessible to residents, resident's families or sponsors, and staff.

(2) Designate another registered nurse in its employ to serve as acting director of nursing in the event the director of nursing or co-directors of nursing are absent from the nursing home due to illness, vacation or an emergency situation. The nursing home will post the name of the acting director of nursing in a place easily accessible to residents, residents' families or sponsors, and staff."

Adm.Code 3701-17-08(B).

THERE ARE REAL AND PRESENT DANGERS TO THE RESIDENTS OF HL

HL has operated as a nursing home in Ohio since approximately 1963. In March 2025, ODH authorized Hari Group, LLC to purchase HL.

HL Has No Qualified Leadership.

The current executive director for HL told an ODH surveyor on or about December 18, 2025, that Hari Group, LLC purchased HL sight unseen and that Hari Group, LLC did not have any experience running a healthcare business. Exhibit A, Survey at 13.

When HL purchased House of Loreto, a very experienced nursing home administrator was in place. However, HL acknowledged to a surveyor that the administrator did not have operational control or decision-making authority. Survey at 15. The nursing home administrator resigned in August 2025. Survey at 14.

Although HL does have a licensed nursing home administrator, the *de facto* administrator is the executive director. She does not have a license to be a nursing home administrator. Exhibit A, Exhibit A, Survey at 16.[1] When she was hired, she was listed as "sales/marketing" with no job description. *Id.* In an interview on or about December 3, 2025, she told an ODH surveyor that she had no clinical background and had nothing to do with the nursing department. *Id.* at 17.

The owner of Hari Group, LLC told surveyors in December 2025 that his son Parth Thakker primarily oversees operations within the facility, but that the son was currently on an extended vacation in India. Mr. Thakker does not have a nursing license, nor is he a licensed nursing home administrator.

[1] All references to exhibits are to the documents attached to the verified complaint.

The facility lacks a director of nursing ("DON"). An individual was working as the "interim" DON but has been on an extended leave of absence since the end of October 2025 with an unknown return to work date. Exhibit A, Survey at 18.

HL has installed a part-time night-shift nurse as the DON. She reported to ODH surveyors that she was "thrusted" into the acting DON position. Exhibit A, Survey at 18.

A DON must be "on duty five days per week, eight hours per day predominately between the hours of six a.m. and six p.m. to direct the provision of nursing services." Adm.Code 3701-17-08(B)(1)(b).

The DON is a part-time employee who only works at night. During the week of November 30, she worked two eight hours shifts. During the week of December 7, she again worked two eight-hour shifts. The week of December 14, the DON worked three eight-hour shifts. The week of December 21, the DON worked only one eight-hour shift. Exhibit A, Survey at 19. The DON has not worked any daytime hours since the prior DON went on medical leave. Exhibit A, Survey at 18.

HL failed to post anything to identify the acting DON to staff, residents or visitors a requirement of Adm.Code 3701-17-08(B)(2).

On December 29, 2025, HL reported that it did not have any interviews scheduled to hire a new DON. Exhibit A, Survey at 20.

On December 30, 2025, the executive director told surveyors that she was not participating in any day-to-day activities of the facility or participating in any corrective action efforts. Exhibit A, Survey at 20.

When confronted with various failings, the administrator repeatedly cited the lack of a full-time DON as a primary reason. Exhibit A, Survey at 22.

On January 7, 2026, HL supplied an "Abatement Plan." HL claims that it had recently engaged a job search for a director of nursing. It states, in total:

> Qualified DON -- Leaderstat and Tobin & Assoc -- contracts are pending for interim DON assignment. Both companies are both actively looking for candidates.

Exhibit B, Plan of Correction at 1.

Not coincidentally, HL's own policies require it to have to have its residential care overseen by a board. All agree that it does not have such a governing board. 42 CFR 483.70(d) requires nursing homes to comply with their own governing policies.

ODH conducted an unannounced monitoring visit on January 10, 2026. The faculty administrator was not available during the inspection -- either by phone or in person. Exhibit C, 1-10-26 Monitoring Visit Report. HL had still not arranged for a full-time RN to act as the DON.

When ODH surveyors arrived, the manager in charge of HL was the laundry supervisor. The Executive Director (who does not have a health care license), after receiving a phone call, did drive in. She was unable to provide key documents explaining

repeatedly that she was "limited" because she does not have a nursing background. Exhibit C, 1-10-26 Monitoring Visit Report.

Only one nurse was on site when surveyors arrived, an LPN that was hired through an agency. It was her second day at the facility and her training apparently only consisted of having a list of phone numbers to call. Exhibit C, 1-10-26 Monitoring Visit Report.

The LPN reported that there was a problem with a medication order for a resident and she was unable to get guidance from any individual employed by HL. Exhibit C, 1-10-26 Monitoring Visit Report.

The second-shift LPN arrived during the monitoring visit. She reported that this was her first time at the facility. She was given a report from the daytime nurse (working her second shift ever at the facility), but not given a tour, or provided information about the locations of supplies, fresh water, applesauce for medication administration, overflow or a contact list for administration. Exhibit C, 1-10-26 Monitoring Visit Report.

HL Is Failing To Prevent Falls After Residents Have Serious Injuries

One of the most basic jobs for a nursing home is to try to minimize the risk that residents will fall. Adm.Code 3701-17-10(E)(10). And if there is a fall, nursing homes must figure out why the fall happened and try to take any necessary steps to prevent repeat falls. Adm.Code 3701-17-14(B) ("Each nursing home will provide adequate supervision of residents who are assessed for risk of falls[.]")

HL does not have a log or system to track incidents and accidents. Exhibit A, Survey at 21.

When asked to list all falls and accidents, the administrator had to go through each resident's progress notes to determine who had fallen in the facility since November 2025. Exhibit A, Survey at 21-22.

The administrator reported that HL did not have any nurses who knew how to update care plans after a resident fell. Exhibit A, Survey at 22.

The most egregious example is with Resident #5. Resident #5 was admitted with both cognitive impairment and a high risk of falls because she: (1) used assisted devices, (2) had a weak gait, (3) had a history of falls, and (4) "forgot or overestimated" her physical abilities. Exhibit A, Survey at 79. Her fall risk was listed as 80 (45 and above is high risk). Exhibit A, Survey at 79.

Between November 26 and December 30, Resident #5 fell ***eight*** times. She had actual harm from those falls. On December 3, 2025, Resident #5 received sutures on her head after a fall. On December 6, 2025, Resident #5 broke her clavicle and suffered an intercranial bleed. Exhibit A, Survey at 77. On December 13, 2025, Resident #5 was hospitalized again after another fall. Exhibit A, Survey at 78. She had further documented falls on December 21, 24, and 30. Exhibit A, Survey at 77.

The intercranial brain bleed had serious implications for Resident #5. During hospitalization on December 13th, doctors discovered a deep vein thrombosis in her left

leg. Doctors could *not* treat with anti-coagulants because of her brain bleed. This was the impetus for the family to shift Resident #5 to hospice treatment at HL. Exhibit A, Survey at 78.

After each fall, HL should have documented that it (1) had conducted an investigation with root cause analysis to figure out why Resident #5 was falling, and (2) to implement additional steps to address her safety needs and to prevent further falls. Exhibit A, Survey at 77. "On 12/09/25 at 5:40 p.m. interview with the administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #5. The administrator revealed she had located some incident reports and some documentation in the medical records but again, there was no system in place to determine a root cause and ensure appropriate follow-up was completed. The Administrator stated she had no nurses who knew how to update care plans and she did not know why." Exhibit A, Survey at 87-88.

A certified nurse assistant told surveyors that there was "no list of residents who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents (including Resident #5) who reside in the facility." Exhibit A, Survey at 90.

At the January 10th monitoring visit, ODH surveyors learned that there had been two additional falls since the previous survey on January 2nd.

On January 4, 2026, Resident #18 slid out of bed. There was no root cause analysis, nor were any new interventions put into place other than to "remind" staff to keep bed in lowest, position, keep a mat on the floor, keep call light in reach, and to check resident "more frequently." Exhibit C, 1-10-26 Monitoring Visit Report.

On January 6, 2026, Resident #26 was found on the floor, sitting in her own excrement. The resident has dementia. The resident does not have a fall risk plan of care. The post fall assessment included the question, "Based on the above information, draw conclusion as to possible cause of this fall event." The answer: "incontinence." Exhibit C, 1-10-26 Monitoring Visit Report.

HL again failed to conduct a thorough after-fall investigation and root cause analysis. Notably, ODH issued a survey on January 2nd directing HL to do so. HL has still not implemented a comprehensive fall management system. Exhibit C, 1-10-26 Monitoring Visit Report.

HL Is Not Properly Monitoring Patients on Blood Thinners

Warfarin is a powerful blood thinner that is notoriously dangerous if over-administered. (The most common brand name is Coumadin.) The FDA requires that patients receiving warfarin to have regular blood tests to assure that the patient won't die of spontaneous bleeding.[2]

[2] The FDA requires this "Black Box warning" for warfarin:

The Home was not notifying practitioners when they received test results for patients on warfarin. Three residents (#4, #12 and #27) had orders for warfarin. But there were "no specific orders for the frequency of laboratory testing, inconsistent documentation of when testing was completed and communicated to the provider, and the resident records did not consistently contain evidence of the laboratory testing being completed when it should have been." Exhibit A, Survey at 22-23. "These residents experienced side effects including bleeding due to critically elevated INR results, hematuria and required transport to the emergency room and hospital admission due to elevated INR results." Exhibit A, Survey at 23.

The administrator admitted on December 8, 2025, that the Home "did not have a process for generating a list of residents who were to have laboratory testing completed, and no clinical staff within the facility to monitor the laboratory testing orders had been completed/drawn." Exhibit A, Survey at 24. The administrator stated that not having a DON lead to a lack of oversight regarding warfarin.

> Warfarin sodium can cause major or fatal bleeding. Bleeding is more likely to occur during the starting period and with a higher dose (resulting in a higher INR). Risk factors for bleeding include high intensity of anticoagulation (INR >4.0), age ≥65, highly variable INRs, history of gastrointestinal bleeding, hypertension, cerebrovascular disease, serious heart disease, anemia, malignancy, trauma, renal insufficiency, concomitant drugs (see PRECAUTIONS), and long duration of warfarin therapy. Regular monitoring of INR should be performed on all treated patients. Those at high risk of bleeding may benefit from more frequent INR monitoring, careful dose adjustment to desired INR, and a shorter duration of therapy. Patients should be instructed about prevention measures to minimize risk of bleeding and to report immediately to physicians signs and symptoms of bleeding (see PRECAUTIONS: Information for Patients).

https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/009218s108lbl.pdf

A nurse practitioner who had ordered warfarin for patients stated that HL was not placing her orders *or* the test results into the electronic medical records for residents. Exhibit A, Survey at 23. There were multiple instances when she had not been notified of laboratory results. Exhibit A, Survey at 24. She could not easily raise her concerns because there was no full-time DON. Exhibit A, Survey at 23.

A physician who acted as medical director for a short period of time reported that testing was not being conducted. Exhibit A, Survey at 25. They physician also reported that "coumadin was still being administered to Resident #12 after it was discontinued[.]" Exhibit A, Survey at 25.

At the January 10th monitoring visit, ODH surveyors saw that there was an order for PT/INR testing to be completed on January 5, 2026, for Resident #12. (This is the test to assure that patients taking warfarin do not spontaneously bleed to death.) During the monitoring visit, staff was unable to find the testing results. Exhibit C, 1-10-26 Monitoring Visit Report.

HL Is Not Providing Basic Infection Control

Infection control is another base-line requirement for nursing homes. HL does not have a licensed healthcare professional overseeing the infection prevention and control -- a requirement of Adm.Code 3701-17-11(A). Exhibit A, Survey at 61-62.

The administrator told surveyors that there was no one with the ability to provide medical input to oversee the program. Exhibit A, Survey at 62. She was aware that there

were multiple issues with not having effective systems in place and that there was no oversight with the nurses. Exhibit A, Survey at 62.

Staff at HL complained that they did not have basic infection-control supplies such as hand-sanitizer and germicidal wipes. Exhibit A, Survey at 65. The administrator admitted that there were no germicidal wipes. Exhibit A, Survey at 66.

HL Is Not Providing Appropriate Wound Care

The Home failed to take basic steps with patients with existing wounds. See Adm.Code 3701-17-01(JJ)(1) (skilled nursing care includes "irrigations" and "application of dressings"). The most egregious case involved Resident #6. Between November 1 and December 20, there are twenty-two days where the Home did not document providing the daily-required treatments for a leg wound. Exhibit A, Survey at 33. When asked, an LPN incorrectly explained that all wound care was completed by a private duty nurse -- something which was simply wrong. Exhibit A, Survey at 33. After being notified that there was no private duty nurse, the LPN attempted to perform wound care but admitted that she did not know how to measure wounds. Exhibit A, Survey at 33. The LPN did not use required infection-control protection (including wearing a gown). When asked, she was unsure if the facility had gowns available. Exhibit A, Survey at 35. The most egregious case involved Resident #6. Between November 1 and December 20, there are twenty-two days where the Home did not document providing the daily-required treatments for a leg wound. Exhibit A, Survey at 33. When asked, an LPN incorrectly

explained that all wound care was completed by a private duty nurse -- something which was simply wrong. Exhibit A, Survey at 33. After being notified that there was no private duty nurse, the LPN attempted to perform wound care but admitted that she did not know how to measure wounds. Exhibit A, Survey at 33. The LPN did not use required infection-control protection (including wearing a gown). When asked, she was unsure if the facility had gowns available. Exhibit A, Survey at 35.

Resident #4 had wounds in both of his legs. There was a physician order requiring dressing changes on Monday, Wednesday and Friday. Exhibit A, Survey at 30. HL did not document that these dressing changes occurred on eight occasions in October and November 2025. Exhibit A, Survey at 30.

On November 20, the dressing change order for Resident #4 was changed from day shift to night shift. But the RN (acting as DON) said that "she did not do the dressing when she worked because she did not want to wake Resident #4 up, medicate the resident for pain, then do a dressing change in the middle of the night." Exhibit A, Survey at 31. Resident #4's son showed photos to the surveyor of "open wounds expositing the fat layers. The wounds were red and appeared to have been bleeding. The bilateral leg ulcers were extensive and covered the anterior surface from approximately two inches below the knee to just above the resident's ankle. The resident's son shared these wound were very painful for Resident #4." Exhibit A, Survey at 31-32. No wonder. The facility did not document that it had given Patient #4 any oxycodone (ordered for twice a day) at

all between November 14 and 24. Exhibit A, Survey at 41. Making matters worse, Resident #4 is one of the individuals taking warfarin, so the appearance of bleeding is that much more serious.

Not Documenting Administration of Medications

The facility repeatedly failed to document that it had administered medications to Residents #4, #12 and #27. Adm.Code 3701-17-17(B)("medicines and drugs are to ... be recorded on the resident's medication administration record.")

Among her many problems, Patient #4 was in congestive heart failure. In addition to the oxycodone mentioned above, HL failed to document that it had properly administered Lasix (a diuretic), Metropolol (blood pressure medication), and Clorazepate (an anti-anxiety medication.)

Resident #12's records also showed lack of evidence of administered medications. This included atorvastatin (a cholesterol medication), Dilitazem (for atrial fibrillation) and Levothyroxine (for thyroid problems).

Resident #27 did not receive Allopurinol (for uric acid build-up), and Gabapentin.

The records did not show that the pharmacy was notified why the medications were not administered as ordered. An LPN reported that medicines for residents were frequently not available. The administrator admitted that there was no proactive plan to prevent missed medications.

At the January 10th monitoring visit, ODH surveyors learned that Resident #16 returned from the hospital after being treated for abdominal abscesses. The resident returned on January 3, 2026, with orders to be treated as a hospice patient. This included as-needed orders for pain medicine (hydrocodone) and anti-anxiety medications (Ativan). The Resident reported pain and was very agitated on January 4, 2026 -- but HL had not arranged for the hydrocodone or Ativan to be delivered. Resident #16 did not receive the medications until 5:30 p.m. the next day. Exhibit C, 1-10-26 Monitoring Visit Report.

Other Deficiencies

Among these many horrors, the facility's controlled substance reconciliation was deeply problematic with numerous discrepancies. Adm.Code 3701-17-17(H). An LPN reported that the facility had "the most confusing and unusual" narcotic logging system she had encountered. Exhibit A, Survey at 45.

There were no "contingency" medications on hand. Adm.Code 3701-17-17(E)(3). That is, there was not a store of commonly used medications that could be used if a Resident needed a medication that had not been previously prescribed.

There was no one on the staff identified as a facility infection preventionist. There were no facility control logs to track and trend infections in the facility. Adm.Code 3701-17-08(E)(5); Adm.Code 3701-17-11(A).

The Director Has Concluded That There Are Adequate Facilities To House The Residents of HL.

Before filing this motion, the Director confirmed with ODH staff that there are adequate nursing home facilities in the Canton area that can house the residents. ODH staff has already contacted the Ombudsman with the Department of Aging to prepare for the transfer of residents if this motion is granted.

REQUESTED RELIEF

The Director asks that the Court issue the following order:

For good cause show, it is ORDERED consistent with R.C. 3721.08(B) that Defendant Hari Group, LLC dba House of Loreto shall:

1. Not admit any further residents at the nursing home located at 2812 Harvard Ave. NW, Canton Ohio 44709.
2. Cooperate with the Ohio Department of Health and the Ombudsman from the Department of Aging to forthwith transfer all residents to other nursing homes or other appropriate care settings.
3. Comply with all staffing, health and safety requirements for nursing homes found under Ohio and federal law while any residents are present.

Respectfully submitted,

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Counsel for Plaintiff
Bruce Vanderhoff, Director of the Ohio Department of Health

CERTIFICATE OF SERVICE

I certify that in addition to requesting the Clerk of Courts to issue summons on the Defendants named in this lawsuit, on January 12, 2026, I also served a copy of the foregoing upon the following by personal service:

HARI GROUP, LLC
dba HOUSE OF LORETO
2812 Harvard Ave. NW
Canton, OH 44709

and

c/o Statutory Agent,
Bharat Thakkar
3922 Wood Road
Madison, OH 44057

/s/ Henry G. Appel
HENRY G. APPEL (0068479)
Principal Assistant Attorney General