[Cite as *Ross v. Community Living Experiences, Inc.*, 2026-Ohio-3921.]

IN THE COURT OF APPEALS OF OHIO
THIRD APPELLATE DISTRICT
MARION COUNTY

ESTATE OF KEVIN A. ROSS, DECEASED,

PLAINTIFF-APPELLANT,

v.

COMMUNITY LIVING EXPERIENCES, INC., ET AL.,

DEFENDANTS-APPELLEES.

CASE NO. 9-26-26

OPINION AND JUDGMENT ENTRY

Appeal from Marion County Common Pleas Court
General Division
Trial Court No. 2024 CV 0119

Judgment Affirmed

Date of Decision: October 5, 2026

APPEARANCES:

C. Joseph McCoy **for Appellant**

Mary McWilliams Dengler **for Appellees**

WALDICK, J.

{¶1} Plaintiff-appellant, Estate of Kevin A. Ross ("Ross"), brings this appeal from April 17, 2026 judgment of the Marion County Common Pleas Court granting summary judgment in favor of defendant-appellee, ViaQuest[1] ("ViaQuest"). For the reasons that follow, we affirm.

Background

{¶2} Ross suffered from disabilities since birth. He had a history of hypertension, panic disorder, articulation disorder, and moderate intellectual disability. He was unable to live independently, or manage his own affairs, and he required assistance with all of his medical care. For nearly his entire life, Ross was a permanent resident of an adult living facility.

{¶3} In March of 2023, Ross was 44 years old and he was living at a residence referred to as the "Marseilles Galion" home in Marion. Community Living Experiences, Inc. ("CLE"), provided care for Ross, which included supervision and medication administration. However, the Marseilles Galion home

[1] Numerous ViaQuest entities were named in Ross's complaint including ViaQuest Nursing Services, LLC, ViaQuest Inc. dba ViaQuest Nursing Services, ViaQuest LLC, and Habitation Services, Inc. dba ViaQuest Nursing Services. We will refer to these defendants generally as "ViaQuest."

was not owned by CLE.[2] The CLE employees that dealt with Ross were referred to as Direct Support Providers ("DSPs").

{¶4} Ross was unable to administer his own medication, so certified CLE DSPs would provide Ross with his daily medications. Ross's medications included ziprasidone for anxiety, lamotrigine for mood swings, clonazepam for panic disorder, triamterene for hypertension, metoprolol for hypertension, losartan potassium for hypertension, and, as relevant to this case, olanzapine and clozapine, which were both antipsychotic medications. By all indications, Ross had been on the same psychiatric medication regimen for several years.

{¶5} CLE contracted with ViaQuest for ViaQuest to provide certain nursing services to CLE's "consumers."[3] The nursing services provided by ViaQuest included, *inter alia*, reviewing physician's orders for each resident, completing a "Medication Administration Record" ("MAR") for each resident based on physician's orders, and submitting the MAR to CLE. ViaQuest had no responsibility for prescribing or directly administering medication to CLE's consumers. In addition, ViaQuest provided on-call nursing advice if CLE staff had questions or concerns about a resident.

[2] To be clear, the Marseilles Galion home was also not owned by ViaQuest or any other defendant in this case. The record indicates Ross paid rent to "Northland Homes."
[3] CLE referred to the residents they serviced as "consumers."

{¶6} On the evening of March 16, 2023, Ross had a headache and a CLE DSP provided him two 500mg acetaminophen.[4] Ross was awakened at 9:30 p.m., roughly an hour after taking the acetaminophen, and Ross indicated he was feeling better.

{¶7} The next morning, on March 17, 2023, Ross was awakened by a DSP at 6 a.m. Ross showered, dressed for "work" then went to the living room for his medications. Ross packed his lunch and sat down for breakfast. "[Ross] was laughing and joking as usual." Ross was then taken to "Dreamshine for work," which was described as an adult "dayhab" facility.[5] Ross was later returned to the Marseilles Galion residence.

{¶8} At approximately 4:30 p.m., Ross again complained to a DSP of a headache. Ross was given two 500mg acetaminophen for his headache and by 5:30 p.m. he indicated he was feeling better. Ross was supposed to attend a "gala" that evening, and a CLE staff member indicated she would stay at the Marseilles Galion residence with Ross if he did not want to go to the gala. However, Ross indicated he wanted to go to the gala, so he was taken there by a DSP.

[4] There was a disagreement between the parties as to whether Ross had a standing order, or "PRN", from a doctor indicating that acetaminophen should be administered as-needed to Ross. However, there is no indication from the record that consumption of acetaminophen played a role in Ross's death.

[5] Ross allegedly liked Dreamshine because it had a swimming pool and activities that he would do.

{¶9} Ross was at the gala from approximately 6 p.m. to 8 p.m. He did not eat at the gala.[6] Ross was returned to the Marseilles Galion residence shortly after 8 pm. He was provided with his usual medications and he went to bed.

{¶10} Around 9:30 p.m., Ross awakened and again complained of a "bad headache." The DSP present gave Ross another two 500mg acetaminophen. The DSP's shift ended and she left the Marseilles Galion residence just before 10 p.m.

{¶11} Another CLE DSP started her shift working at Marseilles Galion at 10 p.m. Between 10 p.m. and 10:50 p.m., Ross vomited on himself. The DSP instructed Ross to take a shower and to clean himself up. Ross showered, then afterward when he was walking down the hallway he collapsed onto the floor. The DSP contacted her supervisor at CLE and the supervisor instructed the DSP to have another resident assist in turning Ross over and to begin CPR on Ross. The DSP was also instructed to call 911.

{¶12} The DSP called 911, but initially just requested assistance with lifting Ross. EMS was dispatched for a lift-assist as "non-emergent."[7] EMS learned on the way to the Marseilles Galion residence that CPR was in progress on Ross so the response was upgraded to "emergent."

[6] Testimony from a DSP indicated that it was not uncommon for Ross not to eat in front of other people. However, there are some indications that Ross was not feeling well at the time.
[7] The CLE DSP who was at the Marseilles Galion home when Ross collapsed was not deposed in this case because she was deceased.

{¶13} Upon arriving at the scene, EMS found Ross with no pulse. Ross was transported to Marion General Hospital. At 2:11 a.m. on March 18, 2023, Ross was pronounced dead.

{¶14} After an autopsy was performed, the cause of death was determined by the coroner to be "clozapine and olanzapine toxicity." In other words, Ross had died due to an overdose of two specific psychiatric medications he was taking. The coroner indicated it was an "accidental overdose."[8] Ross had been on the same psychiatric medications for 5-6 years prior to his death. Ross's expert indicated that toxicity from clozapine and olanzapine "is a well-known cause of ventricular arrhythmia and death."

{¶15} Notably, at no time did CLE or any of its employees contact ViaQuest regarding Ross's headaches or regarding any issues with his medication.

{¶16} On March 15, 2024, Ross's estate filed a complaint against CLE and ViaQuest alleging, *inter alia*, medical negligence, negligence, and wrongful death. ViaQuest filed an answer denying Ross's claims.

{¶17} Discovery ensued and depositions were taken of numerous witnesses. ViaQuest then filed a motion for summary judgment arguing that the evidence

[8] ViaQuest produced an expert opinion challenging the coroner's determination of the cause of death. ViaQuest's expert indicated that the levels of olanzapine and clozapine were consistent with the dosage prescribed by Ross's physician. The expert opined that postmortem redistribution was the reason the levels of clozapine and olanzapine were high in the postmortem toxicology screen. CLE also produced expert testimony indicating that Ross died of a sudden cardiac death. CLE's expert testified in a disposition that the psychiatric medications have side effects that could destabilize the electrical systems of the heart, and he believed more likely than not this was the cause of Ross's death.

showed that: 1) ViaQuest was not responsible for the daily distribution or administration of medications to Ross; 2) ViaQuest had no duty to provide on-site care and had no hands-on contact with residents at the Marseilles Galion house; 3) ViaQuest had no duty to supervise day-to-day distribution and administration of medication by CLE employees; 4) ViaQuest had no duty to provide training services to CLE staff after 2021 at the Marseilles-Galion house; 5) ViaQuest had a limited role at the Marseilles Galion house; and 6) ViaQuest's preparation of the MAR and medication count three weeks prior to Ross's death was too remote in time to establish any causal connection.

{¶18} On March 16, 2026, the trial court issued a decision granting ViaQuest's motion for summary judgment on all claims, reasoning as follows:

> In the case at bar, Plaintiff is bringing claims for medical negligence, wrongful death, and a violation of resident's rights. The Plaintiff alleges that Mr. Kevin Ross died as a result of an overdose of medications given to him by Community Living Experiences (hereinafter "CLE[”]) staff. Plaintiff's theory is that medications were improperly administered and that CLE staff failed to properly monitor and take action regarding Mr. Ross's symptoms leading up to his death.
>
> The medications at the Marseilles Galion residence where Mr. Ross lived were given by CLE staff per instructions contained on a Medication Administration Record (hereinafter "MAR[”]). The MAR was prepared monthly for each resident based on orders issued from the resident's prescribing physician. ViaQuest was responsible for preparing the MAR based on physician's orders given to ViaQuest through CLE and providing that medical administration record to CLE staff. ViaQuest visited the Marseilles Galion Road home where Mr. Ross lived every three months to do checks on the medications. It is

not alleged that there was any issue with the actual packaging of the medications, or that the MAR was prepared incorrectly. Plaintiff's assertions with the medication deal with the timing and/or manner in which it was actually distributed. Absent allegations of deficiencies with the medications in the scope of ViaQuest's duties, it is impossible to find what duty ViaQuest would have breached in regards to the medication administration. ViaQuest was not responsible for administering the medication to the residents, only the preparation and audit after the fact. ViaQuest[] argues in its motion, and the Court agrees that even if a discrepancy existed in the pill pack accounting, ViaQuest would not have discovered it in a fashion that would have prevented this unfortunate occurrence. CLE staff were responsible for the daily audit of the pills being given to residents. ViaQuest did not provide training for CLE after 2022, so they had no duty to make sure the CLE staff was properly trained on policy and procedure for documenting medication administration.

Plaintiff further alleges that ViaQuest failed to provide proper care as a nursing agency with regards to Mr. Ross's headaches and lack of treatment. It is undisputed that ViaQuest had a duty to be available to provide telephone services for CLE staff. Once the call was received, ViaQuest nurses could take that information and make decisions as to treatment or necessary steps to properly care for residents. Its [sic] undisputed that [n]o witness or pleading alleges that ViaQuest was contacted regarding these headaches or the possible need for further medical intervention. Therefore ViaQuest was not aware of any issues with Mr. Ross and breached no duty of care as to providing for his medical care.

In light of the facts surrounding Mr. Ross's death, even if taken in the light most favorable to the non-moving party, the Court cannot find the facts in the pleadings and evidence before it to find that ViaQuest shared in any culpability for Mr. Ross's death. The motion for summary judgment as it relates to Defendant ViaQuest is hereby GRANTED. Pursuant to Ohio Civil rule 54(B), this is a final appealable order and there is not just cause for delay.

{¶19} The trial court issued a final judgment entry granting summary judgment to ViaQuest on all claims on April 17, 2026. It is from this judgment that Ross appeals, asserting the following assignment of error for our review.[9]

Assignment of Error

> **The trial court erred in granting summary judgment in favor of Defendant-Appellee ViaQuest because the Court improperly weighed evidence and resolved disputed questions of material fact that are exclusively within the province of the jury.**

{¶20} Ross argues in his assignment of error that the trial court erred by granting summary judgment to ViaQuest. More specifically, he argues that the trial court improperly weighed evidence in this matter.

Standard of Review

{¶21} An appellate court reviews a trial court's decision on a motion for summary judgment *de novo*. *Birkmeier v. St. Rita's Med. Ctr*., 2018-Ohio-2343, ¶ 14 (3d Dist). Trial courts may grant a motion for summary judgment when "(1) no genuine issue as to any material fact remains to be litigated, (2) the moving party is entitled to judgment as a matter of law, and (3) it appears from the evidence that reasonable minds can come to but one conclusion and that conclusion is adverse to

[9] ViaQuest's co-defendant CLE also filed a motion for summary judgment in this case, but the trial court had not ruled upon the motion at the time ViaQuest was granted summary judgment. The trial court certified its judgment in favor of ViaQuest as a final order resolving all issues between Ross and ViaQuest, creating the appeal before us.

the party against whom the motion for summary judgment is made." *Hamilton v. Hector*, 117 Ohio App.3d 816, 819 (3d Dist. 1997).

{¶22} The party moving for summary judgment bears the burden of showing that there is no genuine issue of material fact and that it is entitled to judgment as a matter of law. *Dresher v. Burt*, 1996-Ohio-107. Additionally, "'upon appeal from summary judgment, the reviewing court should look at the record in the light most favorable to the party opposing the motion.'" *Hamilton*, quoting *Campbell v. Hosp. Motor Inns, Inc*., 24 Ohio St.3d 54, 58 (1986). Once the moving party satisfies its burden, the nonmoving party "may not rest upon the mere allegations or denials of the party's pleadings, but the party's response, by affidavit or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Civ.R. 56(E).

Analysis

{¶23} Many key facts are undisputed in this case. The psychiatric medications prescribed to Ross, including those that were implicated in his cause-of-death—clozapine and olanzapine—were prescribed to Ross by "Dr. Johnson" who had no affiliation with ViaQuest.[10] Ross was on the psychiatric medications for years. It is undisputed that ViaQuest employees did not administer clozapine or olanzapine to Ross on *any* occasion, let alone during the time period immediately

[10] Dr. Johnson was not named as a defendant in this lawsuit.

preceding his death. Ross does not make any allegations that the MAR prepared by ViaQuest had any errors; and, in fact, the MAR, by all accounts, contained the appropriate doses of clozapine and olanzapine as prescribed by Ross's doctor.

{¶24} The record also reflects that ViaQuest was not notified of any potential medication administration issues prior to Ross's death, and ViaQuest was not contacted regarding any of Ross's headaches. In fact, the record reflects that the last time any ViaQuest employee was in the Marseilles Galion home was on February 23, 2023, over three weeks prior to Ross's death.

{¶25} The trial court granted ViaQuest's summary judgment motion for multiple reasons including that ViaQuest could not have breached a duty regarding medication administration because ViaQuest was not responsible for administering the medication to Ross (or any other resident at Marseilles Galion). The trial court determined that even if there was a discrepancy in CLE's daily pill-pack accounting, ViaQuest would not have discovered it in a fashion that would have prevented Ross's death because CLE was responsible for the daily audit of the pills. The trial court determined that ViaQuest had no duty to train CLE staff during the relevant period prior to Ross's death. Finally, the trial court determined that ViaQuest could not have breached a duty of care regarding the headaches Ross complained of prior to his death because ViaQuest was never contacted, by any means, regarding Ross's headaches.

{¶26} Ross makes the following arguments on appeal in an attempt to undermine the trial court's determinations: 1) there were genuine issues of material fact with regard to whether ViaQuest's quarterly medication audits, if conducted properly, would have discovered and prevented the medication error that caused Ross's death; 2) the trial court erred in its determination that ViaQuest owed no duty to ensure adequate medication administration oversight and staff competency; 3) the trial court erred by determining that ViaQuest's unilateral cessation of staff training after 2022 extinguished any duty; 4) the trial court erred in determining that ViaQuest's duty as a licensed nursing agency was limited solely to reactive telephone consultation; and 5) the trial court erred in finding that ViaQuest did not have an affirmative duty to monitor, assess, and respond to Ross's deteriorating condition. We will address each of Ross's arguments in turn.

{¶27} Ross first contends that ViaQuest's quarterly medication audits, if conducted properly, would have prevented the "medication error" that caused Ross's death. To support his position, Ross argues that the record reflects that an *internal* CLE controlled-drug audit sheet for February 2023 showed that counts were potentially off related to *clonazepam*; however, that drug was not implicated in Ross's death. In fact, Ross acknowledges that clonazepam did not contribute to his death; nevertheless, he argues that the discrepancy should have triggered some action by ViaQuest. However, the only evidence in the record indicates that when ViaQuest's employee was in the home in February of 2023 and she did not find any

issues with the narcotics count or with the MAR at that time, particularly because any discrepancy related to clonazepam was on an internal CLE document.

{¶28} Further, Ross contends that a review of the clozapine blister pack that appears to be for April 2023, the month after Ross's death, showed that the pill slot for the 16th had potentially been opened, a pill pushed out, then the pill was replaced and the blister pack was sealed with tape. The pill in the blister pack had the same markings as the others, and the blister pack was initialed next to pill-slot 16 by someone. None of the other April pills in the blister pack had been opened or consumed since Ross was not alive in April of 2023. As there is no pill actively missing, and there is no indication that any of the April of 2023 medication was actually given to Ross, we do not see how this blister pack "discrepancy" creates a breach of duty, or results in any chain of causation, related to ViaQuest.

{¶29} In his second and third arguments, Ross contends that the trial court erred by determining that ViaQuest had no duty with regard to medication administration training of CLE employees. Ross supports his argument by pointing to the last written contract between the parties, signed August 6, 2021. The contract reads, in pertinent part, as follows:

> 2. Services
>
> A. ViaQuest shall deliver RN, Quality Assurance Review, Training, and Consultation Services to Agency;

> B. All services will be provided by ViaQuest utilizing licensed employees and/or contractors, as required by applicable state and federal laws.
>
> C. ViaQuest shall maintain documentation of all services furnished under this Agreement, subject to procedures agreed to by the parties which are consistent with ViaQuest's usual and customary methods of documentation and applicable state and federal laws.

{¶30} Ross argues that the contract between ViaQuest and CLE plainly called for "quality assurance review" and "training." ViaQuest responds by noting that multiple people testified that ViaQuest ceased its medication administration training at the end of 2021. ViaQuest provided an affidavit indicating that they did business with CLE in a number of residences and that each residence had its own unique requirements. ViaQuest indicated that its role with regard to the Marseilles Galion home was limited to reviewing physician's orders for the residents, completing the MAR, submitting the MAR to CLE, and being available if CLE had questions or concerns for a resident.

{¶31} Even if we assumed that there was a factual dispute related to whether ViaQuest was responsible for some training based on the conflicting language of the last known written contract itself and the testimony of ViaQuest employees, we do not find any such factual dispute is "material" in this matter. *Anderson v. Liberty Lobby, Inc*. 477 U.S. 242, 248 (1986) ("Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted.").

{¶32} We agree with the trial court that "CLE staff were responsible for the daily audit of the pills being given to residents." Ross does not show that there was any deficiency with ViaQuest's actions in this case, such as preparing a MAR that had the incorrect dosages of the medication. There is simply no evidence that the counts of either clozapine or olanzapine were off when ViaQuest was in the residence such that additional training, if it was ViaQuest's responsibility to do so, was required. Thus Ross's arguments are not well-taken.

{¶33} Finally, Ross argues that the trial court erred by determining that ViaQuest did not have an active, affirmative duty to check on Ross's deteriorating condition even though ViaQuest was indisputably never made aware of Ross's headaches. We disagree. The contract cited above indicates that ViaQuest was required to provide consultation services, and ViaQuest indicated it had a 24-hour hotline available for CLE to speak with a nurse. By all indications, ViaQuest was available and was simply never contacted. Therefore, like the trial court, we do not see how ViaQuest breached any duty here that caused Ross's death.

{¶34} In sum, we do not find that the trial court erred by granting summary judgment in favor of ViaQuest in this matter. Therefore, Ross's assignment of error is overruled.

Conclusion

{¶35} Having found no error prejudicial to Ross in the particulars assigned and argued, his assignment of error is overruled and the judgment of the trial court is affirmed.

Judgment Affirmed

MIILER, and WILLAMOWSKI, J. J., concur.

JUDGMENT ENTRY

For the reasons stated in the opinion of this Court, the assignment of error is overruled and it is the judgment and order of this Court that the judgment of the trial court is affirmed with costs assessed to Appellant for which judgment is hereby rendered. The cause is hereby remanded to the trial court for execution of the judgment for costs.

It is further ordered that the Clerk of this Court certify a copy of this Court's judgment entry and opinion to the trial court as the mandate prescribed by App.R. 27; and serve a copy of this Court's judgment entry and opinion on each party to the proceedings and note the date of service in the docket. See App.R. 30.

Juergen A. Waldick, Judge

Mark C. Miller, Judge

John R. Willamowski, Judge

DATED:
/jlm