

IN THE CIRCUIT COURT OF THE 15TH
JUDICIAL CIRCUIT, IN AND FOR PALM
BEACH COUNTY, FLORIDA

CASE NO.:

JAYLA CABRERA AS PERSONAL
REPRESENTATIVE OF THE ESTATE OF
MARGARITA CASTILLO,

Plaintiff,

vs.

HEARTLAND BOCA OPCO, LLC d/b/a
BOCA CIRCLE REHABILITATION
CENTER; EXCELSIOR CARE GROUP LLC,

Defendants.

COMPLAINT

COMES NOW the Plaintiff, JAYLA CABRERA AS PERSONAL REPRESENTATIVE OF THE ESTATE OF MARGARITA CASTILLO, by and through undersigned counsel, and sues the Defendants, HEARTLAND BOCA OPCO, LLC d/b/a BOCA CIRCLE REHABILITATION CENTER (hereinafter referred to as "LICENSEE") and EXCELSIOR CARE GROUP LLC (hereinafter referred to as "MANAGEMENT"), and alleges:

GENERAL JURISDICTIONAL ALLEGATIONS

1. This is a cause of action for damages, which exceeds Fifty Thousand Dollars (\$50,000.00), exclusive of costs, interest, and attorney's fees, and is being filed within the applicable statute of limitations.
2. All conditions precedent to the filing of this action, including compliance with the notice provisions of Chapter 400, have been met or waived.

3. This action is being brought by the Plaintiff for violations of Chapter 400 against LICENSEE and MANAGEMENT while MARGARITA CASTILLO (hereinafter referred to as "RESIDENT") was a resident at the Defendants' nursing home located in Palm Beach County, Florida (hereafter "the nursing home" or "the facility").

4. At all times material, RESIDENT was a resident of Florida.

5. At all times material, JAYLA CABRERA is, or is in the process of being, appointed as the Personal Representative of the Estate of RESIDENT and is the proper party to bring this action.

6. At all times material, LICENSEE, was a company doing business in the county in which the subject nursing home is located.

7. LICENSEE committed tortious acts against RESIDENT in the State of Florida. Each tortious act is specifically alleged in the subsequent counts. Accordingly, LICENSEE is subject to the jurisdiction of the courts of the State of Florida.

8. At all times material, MANAGEMENT, was a company doing business in the county in which the subject nursing home is located.

9. MANAGEMENT committed tortious acts against RESIDENT in the State of Florida. Each tortious act is specifically alleged in the subsequent counts. Accordingly, MANAGEMENT is subject to the jurisdiction of the courts of the State of Florida.

10. Venue is appropriate in this action as the events giving rise to the cause of action occurred in the county where the subject nursing home is located, the Defendant(s) operates and does business in the county where the subject nursing home is located, and the Plaintiff resides in the county where the subject nursing home is located.

11. At all times material hereto, the Defendant facility was subject to the provisions of Chapter 400 of Florida Statutes, Titles 10 and 59 of the Florida Administrative Code, and OBRA 1987, which set the standards for operating nursing homes such as this facility.

12. This Complaint is being filed within the applicable statute of limitations period.

13. The undersigned certifies a good faith basis for bringing this action.

ALLEGATIONS AGAINST LICENSEE

14. At all times material hereto, the Defendant, LICENSEE, was the licensee of the nursing home facility, which was authorized to do business in the State of Florida and to operate the subject nursing home and is subject to the provisions of Florida Statutes Chapter 400.

15. At all times material hereto, the Defendant, LICENSEE employed the nurses and caretakers at the facility and is therefore responsible for their tortious conduct.

16. At all times material hereto, the Defendant, LICENSEE, was operating the subject facility and/or had a non-delegable duty to ensure reasonable operation of the facility and reasonable care to residents, as the licensee of the facility, licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

17. At all times material hereto, the Defendant, LICENSEE, owed a duty to its residents to exercise reasonable care in its operation of the subject nursing home according to §400.023(3), Florida Statutes

ALLEGATIONS AGAINST MANAGEMENT

18. At all times material, MANAGEMENT, was a “management or consulting company” of the nursing home as defined under Chapter 400.023 of the Florida Statutes.

19. At all times material hereto the Defendant, MANAGEMENT, was in the business of owning, managing, and/or maintaining nursing and convalescent homes and related health care facilities, including the subject facility.

20. At all times material hereto, the Defendant, MANAGEMENT, was the management company for the subject facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

21. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the budget at LICENSEE.

22. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, staffing levels at LICENSEE.

23. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the hiring and firing of the administrator of LICENSEE.

24. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the policies and procedures at LICENSEE.

25. At all times material hereto, the Defendant, MANAGEMENT, performed under a contract or received a fee for the services performed for LICENSEE.

26. At all times material hereto, the Defendant, MANAGEMENT, was operating the Defendants' facility and/or had a non-delegable duty to ensure reasonable operation of the facility and reasonable care to residents, as the management company for the facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

27. At all times material hereto, MANAGEMENT owed a duty to its residents to exercise reasonable care in its operation of the subject nursing home according to §400.023(3), Florida Statutes.

FACTS GIVING RISE TO THIS CAUSE OF ACTION

28. RESIDENT was admitted to the Defendants' nursing home for care and supervision relating to ongoing medical conditions and cognitive changes.

29. At all times material, RESIDENT was at risk for preventable injuries including but not limited to skin breakdown, falls, wandering, infection, malnutrition, and dehydration.

30. During admission and at all times material, RESIDENT was vulnerable and unable to care for themselves and was dependent on facility staff for assistance in performing their activities of daily living.

31. RESIDENT required supervision and assistance with their day to day function from facility staff to remain safe and free from harm, abuse, and preventable injury.

32. Defendants owed a duty to provide the reasonable care, supervision, and assistance that RESIDENT needed while RESIDENT resided at their facility.

33. Despite this, Defendants by and through their staff, negligently failed to provide the required reasonable care, supervision, and assistance to RESIDENT.

34. As a result of these failures, RESIDENT suffered preventable injury.

35. Specifically, as a result of Defendants' negligence, RESIDENT suffered preventable injury, including but not limited to avoidable wounds, wound infections, and severe skin breakdown in the form of pressure ulcers.

36. The aforementioned injuries plagued RESIDENT until her death on February 22, 2025.

WRONGFUL DEATH DAMAGES

37. RESIDENT wrongfully died on or around February 22, 2025, as a direct and proximate result of the Defendant's negligence, more fully described above and below.

38. As a direct and proximate result of the negligence outlined above and below, the Estate of RESIDENT and the survivors of the Estate, is/are entitled to all damages recoverable for the wrongful death caused by the Defendant, as alleged above and below, including but not limited to:

- i. Any and all damages available under the wrongful death statute;
- ii. Medical bills and expenses;
- iii. Funeral expenses;
- iv. Loss of net accumulations;
- v. The survivor(s) have suffered mental pain and suffering, past and future, which will continue for the rest of their life, and they have suffered the loss of services, consortium, society, comfort and support of the decedent, and have incurred medical and funeral expenses as a result of the decedent's death, and have suffered the loss of the decedent's love and companionship.

SURVIVAL DAMAGES

39. Alternatively, if these injuries did not cause RESIDENT's death, the Estate of RESIDENT claims all damages recoverable under a survival action, including but not limited to the non-economic and economic damages of the decedent for bodily injury and resulting pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition, from the time of injury of RESIDENT to the time of their death. These survival damages occurred as a direct and proximate result of the negligence of the Defendants(s) outlined above and below.

COUNT I: **RESIDENT v. LICENSEE – WRONGFUL DEATH**

40. Plaintiff re-adopts and re-alleges paragraphs 1 through 38 and further alleges:

41. Defendant, LICENSEE, through its employees, agents and apparent agents were

below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

- i. Failing to prevent physical injury and abuse to the resident;
- ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
- iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
- iv. Failing to prevent skin breakdown, pressure ulcers and infection;
- v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
- vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
- vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
- viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
- ix. Failing to properly supervise at-risk residents;
- x. Failing to keep common areas clean of fall hazards;
- xi. Failing to document the resident's injuries;
- xii. Failing to inform family members of serious changes in condition;
- xiii. Failing to treat the resident for injuries and report abnormalities;
- xiv. Failing to provide appropriate hygiene;
- xv. Failing to keep the resident clean and to change diapers and linens;
- xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
- xvii. Failing to timely provide outside consultation with physicians and specialists;
- xviii. Failing to timely transfer the resident to a higher care facility;
- xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
- xx. Failing to follow physician's orders;
- xxi. Failing to provide appropriate nutrition and hydration to the resident;
- xxii. Failing to properly assess and prevent dehydration and malnutrition;
- xxiii. Failing to uphold rights to dignity of the resident;
- xxiv. Failing to follow state and federal regulations to protect nursing home residents;
- xxv. Failing to appropriately staff and train employees and agents;
- xxvi. Failing to provide appropriate budgeting for the subject facility;
- xxvii. Failing to provide appropriate policies and procedures to the subject facility;
- xxviii. Failing to provide medication when required; and
- xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

42. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, LICENSEE, while in the course and scope of their employment, agency and/or apparent agency.

43. As a direct and proximate result of said negligence, RESIDENT wrongfully died.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT and its survivors, demand judgment for damages against Defendant, LICENSEE, and further demand a trial by jury of all issues so triable.

COUNT II:
RESIDENT v. MANAGEMENT – WRONGFUL DEATH

44. Plaintiff re-adopts and re-alleges paragraphs 1 through 38 and further alleges:

45. Defendant, MANAGEMENT, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

- i. Failing to prevent physical injury and abuse to the resident;
- ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
- iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
- iv. Failing to prevent skin breakdown, pressure ulcers and infection;
- v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
- vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
- vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
- viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
- ix. Failing to properly supervise at-risk residents;
- x. Failing to keep common areas clean of fall hazards;
- xi. Failing to document the resident's injuries;
- xii. Failing to inform family members of serious changes in condition;
- xiii. Failing to treat the resident for injuries and report abnormalities;
- xiv. Failing to provide appropriate hygiene;
- xv. Failing to keep the resident clean and to change diapers and linens;
- xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
- xvii. Failing to timely provide outside consultation with physicians and specialists;
- xviii. Failing to timely transfer the resident to a higher care facility;

- xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
- xx. Failing to follow physician's orders;
- xxi. Failing to provide appropriate nutrition and hydration to the resident;
- xxii. Failing to properly assess and prevent dehydration and malnutrition;
- xxiii. Failing to uphold rights to dignity of the resident;
- xxiv. Failing to follow state and federal regulations to protect nursing home residents;
- xxv. Failing to appropriately staff and train employees and agents;
- xxvi. Failing to provide appropriate budgeting for the subject facility;
- xxvii. Failing to provide appropriate policies and procedures to the subject facility;
- xxviii. Failing to provide medication when required; and
- xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

46. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, MANAGEMENT, while in the course and scope of their employment, agency and/or apparent agency.

47. As a direct and proximate result of said negligence, RESIDENT wrongfully died.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT and its survivors, demand judgment for damages against Defendant, MANAGEMENT, and further demand a trial by jury of all issues so triable.

COUNT III:
RESIDENT v. LICENSEE – SURVIVAL CLAIM

48. Plaintiff re-adopts and re-alleges paragraphs 1 through 36 and 39 and further alleges:

49. Defendant, LICENSEE, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

- i. Failing to prevent physical injury and abuse to the resident;
- ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
- iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
- iv. Failing to prevent skin breakdown, pressure ulcers and infection;
- v. Failing to properly respond to skin breakdown, pressure ulcers and infection;

- vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
- vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
- viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
- ix. Failing to properly supervise at-risk residents;
- x. Failing to keep common areas clean of fall hazards;
- xi. Failing to document the resident's injuries;
- xii. Failing to inform family members of serious changes in condition;
- xiii. Failing to treat the resident for injuries and report abnormalities;
- xiv. Failing to provide appropriate hygiene;
- xv. Failing to keep the resident clean and to change diapers and linens;
- xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
- xvii. Failing to timely provide outside consultation with physicians and specialists;
- xviii. Failing to timely transfer the resident to a higher care facility;
- xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
- xx. Failing to follow physician's orders;
- xxi. Failing to provide appropriate nutrition and hydration to the resident;
- xxii. Failing to properly assess and prevent dehydration and malnutrition;
- xxiii. Failing to uphold rights to dignity of the resident;
- xxiv. Failing to follow state and federal regulations to protect nursing home residents;
- xxv. Failing to appropriately staff and train employees and agents;
- xxvi. Failing to provide appropriate budgeting for the subject facility;
- xxvii. Failing to provide appropriate policies and procedures to the subject facility;
- xxviii. Failing to provide medication when required; and
- xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

50. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, LICENSEE, while in the course and scope of their employment, agency and/or apparent agency.

51. As a direct and proximate result of the Defendant's deprivation of and infringement upon RESIDENT's Chapter 400 rights as alleged in this Complaint, which includes the above alleged negligence, RESIDENT suffered bodily injury and resulting pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of

hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT, demands judgment for damages against Defendant, LICENSEE, and further demands a trial by jury of all issues so triable.

COUNT IV:
RESIDENT v. MANAGEMENT – SURVIVAL CLAIM

52. Plaintiff re-adopts and re-alleges paragraphs 1 through 36 and 39 and further alleges:

53. Defendant, MANAGEMENT, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

- i. Failing to prevent physical injury and abuse to the resident;
- ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
- iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
- iv. Failing to prevent skin breakdown, pressure ulcers and infection;
- v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
- vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
- vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
- viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
- ix. Failing to properly supervise at-risk residents;
- x. Failing to keep common areas clean of fall hazards;
- xi. Failing to document the resident's injuries;
- xii. Failing to inform family members of serious changes in condition;
- xiii. Failing to treat the resident for injuries and report abnormalities;
- xiv. Failing to provide appropriate hygiene;
- xv. Failing to keep the resident clean and to change diapers and linens;
- xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
- xvii. Failing to timely provide outside consultation with physicians and specialists;
- xviii. Failing to timely transfer the resident to a higher care facility;
- xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
- xx. Failing to follow physician's orders;
- xxi. Failing to provide appropriate nutrition and hydration to the resident;
- xxii. Failing to properly assess and prevent dehydration and malnutrition;

- xxiii. Failing to uphold rights to dignity of the resident;
- xxiv. Failing to follow state and federal regulations to protect nursing home residents;
- xxv. Failing to appropriately staff and train employees and agents;
- xxvi. Failing to provide appropriate budgeting for the subject facility;
- xxvii. Failing to provide appropriate policies and procedures to the subject facility;
- xxviii. Failing to provide medication when required; and
- xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

54. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, MANAGEMENT, while in the course and scope of their employment, agency and/or apparent agency.

55. As a direct and proximate result of the Defendant's deprivation of and infringement upon RESIDENT's Chapter 400 rights as alleged in this Complaint, which includes the above alleged negligence, RESIDENT suffered bodily injury and resulting pain and suffering, disability disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT, demands judgment for damages against Defendant, MANAGEMENT, and further demands a trial by jury of all issues so triable.

DATED this 13th day of April 2026.

/s/ Dylan J. Hanson, Esq.

DYLAN J. HANSON, ESQ.

Florida Bar No.: 1032785

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