

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM LEXINGTON COUNTY  
Court of Common Pleas

Walton J. McLeod, IV, Circuit Court Judge

Appellate Case Number.: 2018-002236

Case No. 2016-CP-32-00950

**RECEIVED**  
AUG 14 2019  
SC Court of Appeals

Amy S. Davis, as Personal Representative of the Estate of  
Utricia Shealy, deceased, .....Respondent,

v.

Agape Nursing Rehabilitation Center, Inc., Agape Management Services, Inc., John Doe, Richard  
Roe Corporation, Jane Doe, and Mary Doe Corporation, ..... Defendants

Of which Agape Nursing Rehabilitation Center, Inc. and Agape Management Services,  
Inc., are the ..... Appellants.

**RECORD ON APPEAL**

Shaun C. Blake, S.C. Bar No. 76349  
Jenkins M. Mann, S.C. Bar No. 74894  
ROGERS LEWIS JACKSON MANN & QUINN, LLC  
PO Box 11803  
Columbia, SC 29211  
P: 803-256-1268  
F: 803-252-3653  
sblake@rogerslewis.com  
jmann@rogerslewis.com

ATTORNEYS FOR APPELLANTS

C. Caleb Connor, S.C. Bar 100517  
A. Keith McAlister, Jr., S.C. Bar No. 78213  
Kenneth L. Connor, S.C. Bar No. 100298  
CONNOR & CONNOR, LLC  
302 Park Avenue SE  
Aiken, South Carolina 29801  
P: 803-226-0543  
F: 800-480-9715  
Email: caleb@theconnorfir.com

ATTORNEYS FOR RESPONDENT

## **INDEX**

### **Judgements and Orders**

Filed copy of the Form 4 Judgment dated October 26, 2018.....00001

Filed copy of the Order denying Appellants' Motion for Judgment Notwithstanding the Verdict, or in the alternative, a Motion for a New Trial Absolute, or in the alternative, a Motion for a New Trial Nisi Remittitur .....00003

Filed copy of the Order denying Appellants' Motion for Leave to Deposit and Stay the Accrual of Interest and Execution Pending a Ruling on Post-Trial Motions and Any Appeal .....00020

### **Pleadings**

Filed copy of the original Summons and Complaint .....00027

Filed copy of the Second Amended Complaint .....00066

Filed copy of the Answer to the Second Amended Summons and Complaint .....00081

### **Transcripts**

Trial Transcript from proceedings the week of October 22, 2018.....00088

Deposition of Gregory Scott Middleton, as redacted, pp. 1-5, 14-15, 17-19, 29-35, 53-58, 79-80, and 90-91 .....00956

### **Exhibits**

Joint Exhibit 2, pp. LMC\_C&C\_443, 481 .....00983

Joint Exhibit 4, pp. 1, 3, 141, 321-329.....00985

Joint Exhibit 10 .....00997

Joint Exhibit 12 .....01019

Joint Exhibit 14 .....01037

Joint Exhibit 18 .....01039

Joint Exhibit 25 .....01043

Joint Exhibit 27 .....01060

|                            |       |
|----------------------------|-------|
| Plaintiff's Exhibit 2..... | 01063 |
| Plaintiff's Exhibit 3..... | 01088 |
| Plaintiff's Exhibit 4..... | 01135 |

**Motions and Memoranda**

|                                                                                                                                                                                                                                                          |       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| Filed Motion for leave to file Second Amended Summons and Complaint .....                                                                                                                                                                                | 01137 |
| Filed copy of Appellants' Motion for Judgment Notwithstanding the Verdict, or in the alternative, a Motion for a New Trial Absolute, or in the alternative, a Motion for a New Trial <i>Nisi Remittitur</i> .....                                        | 01163 |
| Filed copy of Respondent's Response in Opposition to Appellants' Motion for Judgment Notwithstanding the Verdict, or in the alternative, a Motion for a New Trial Absolute, or in the alternative, a Motion for a New Trial <i>Nisi Remittitur</i> ..... | 01183 |
| Filed copy of Appellants' Motion for Leave to Deposit and Stay the Accrual of Interest and Execution Pending a Ruling on Post-Trial Motions and Any Appeal .....                                                                                         | 01202 |
| Filed copy of Respondent's Response in Opposition to Appellants' Motion for Leave to Deposit and Stay the Accrual of Interest and Execution Pending a Ruling on Post-Trial Motions and Any Appeal .....                                                  | 01206 |

**Other Material Documents**

|                                                                                                                                                         |       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| Filed copy of Respondent's Offer of Judgment.....                                                                                                       | 01213 |
| Filed copy of Respondent's Amended Offer of Judgment .....                                                                                              | 01216 |
| Filed copy of the Verdict Form dated October 26, 2018 .....                                                                                             | 01219 |
| Filed copy of the Notice of Filing, together with enclosures, providing Lexington County with a copy of the Notice of Appeal and Proof of Service ..... | 01223 |

1 A. No.

2 Q. Thank you. I appreciate your time and patience  
3 with us.

4 RECROSS-EXAMINATION

5 BY MR. CONNOR:

6 Q. Now, ma'am, what do you not believe you  
7 breached the standard of care about?

8 A. I don't believe that there was any other  
9 intervention that could have been put in place.

10 Q. Right. But you've already acknowledged and  
11 admitted that you breached the standard of care as  
12 it relates to the failure to document the use of the  
13 Ativan on the MAR; correct?

14 A. On the MAR?

15 Q. Right. You've acknowledged that?

16 A. Yes.

17 Q. And we also know that we don't know, based on  
18 your note, anything about what happened to this  
19 patient between 5:30 and the time that she fell,  
20 except for she was left such that later she was  
21 discovered by you on the floor; correct?

22 A. No. She was brought to the nurses station for  
23 close monitoring.

24 Q. Right. And then she apparently didn't want to  
25 stay there, and then later you discovered her on the



1 floor either in a room, per the EMTs, or in the  
2 hallway, per your notes; correct?

3 A. Correct.

4 Q. And you don't have any specific recollection of  
5 this?

6 A. Correct.

7 Q. So, certainly, you've got two hours where we're  
8 not sure what happened to this patient except that  
9 we know that she ended up on the floor; correct?

10 A. Correct.

11 Q. All right. So there's a host of interventions  
12 that could have been put into place to ensure that  
13 that didn't happen; correct? For example, you could  
14 have put her in the line of sight of a nurse or  
15 aide; right?

16 A. She was in the line of sight of a nurse or  
17 aide.

18 Q. But not at the time she fell; right?

19 A. Correct.

20 Q. That's right. You found her on the floor, per  
21 your note; correct?

22 A. Uh-huh.

23 Q. So at some point, though she may have been, she  
24 didn't want to stay there. And at some point, she  
25 was out of the line of sight, because she was

1 discovered on the floor; correct?

2 A. Right.

3 Q. So there were nursing interventions that could  
4 have been put into place, including just putting her  
5 in a place where somebody could have kept an eye on  
6 her; right?

7 A. Correct.

8 Q. And, ma'am, you are a nurse; correct?

9 A. Yes.

10 Q. And you understand what the standard of care  
11 requires regarding documentation in a nursing home;  
12 correct?

13 A. Correct.

14 Q. And how do we know, if we can't tell the time  
15 that explains when this -- these entries were made,  
16 who actually made them? Why should we accept your  
17 signature in the same block but not the times?

18 A. Is that a question?

19 Q. Yes, ma'am. I mean, why should we accept that  
20 you're the author of this note but not that this  
21 time is accurate? You don't remember any of this,  
22 do you?

23 A. No.

24 Q. All right. Now, Mr. Blake asked you about the  
25 standard of care and went through your education.

1 You understand that nursing homes have an obligation  
2 under the law to keep records in an accurate and an  
3 appropriate fashion; correct?

4 A. Correct.

5 Q. And you testified repeatedly that you have  
6 significant concerns about what's going on here  
7 based on the inconsistencies in the charting, not  
8 only about the times, but about the information  
9 contained, as well as the facts about where this  
10 fall occurred; correct?

11 A. Correct.

12 Q. That's all the questions I have for you, ma'am.  
13 Thank you for your time.

14 THE COURT: You may step down.

15 MR. CONNOR: Oh, I'm sorry. I have one more  
16 question, Your Honor, if I may.

17 THE COURT: One question?

18 MR. CONNOR: Yes, Your Honor.

19 THE COURT: Very briefly, Counsel.

20 MR. CONNOR: Understood.

21 BY MR. CONNOR:

22 Q. Ma'am, looking at the ADL report that Mr. Blake  
23 asked you about and the summation that they all  
24 appear to be entered at once -- remember that?

25 A. Yes.

1 Q. You agree, having looked at that record, that  
2 there is no summation of care related to this  
3 patient, whether it be once a shift or any time  
4 after 2:20 PM; correct?

5 A. Right.

6 Q. All right. So regardless of when it was  
7 entered, never was there any care entered after  
8 2:20 PM; correct?

9 A. Correct.

10 Q. And she remained in the facility for five more  
11 hours; right?

12 A. Correct.

13 Q. Thank you.

14 THE COURT: Now you may really step down.  
15 Thank you.

16 Okay. Ladies and gentlemen, we kept you a  
17 little bit later today, but we had to get through  
18 these witnesses. Can y'all be ready to go at  
19 9:00 AM? I had you here at -- what's up?

20 JUROR: I'm sorry. I don't mean to interrupt,  
21 Your Honor. I just want to ask is there any way I  
22 can be dismissed as a juror from this, because I  
23 don't believe I can -- I need to talk to you in  
24 private after they leave so I don't prejudice the  
25 jury.

1           THE COURT: All right. Can y'all be here at  
2           8:45 in the morning, the idea being we'll start at  
3           9:00 AM sharp. Okay? Try to be in the jury room  
4           between 8:45 and 8:50. Please don't discuss the  
5           case with anyone tonight. I'll see you tomorrow  
6           morning bright and early. Have a good evening.  
7           Thank you.

8           JUROR: Would I be able to --

9           THE COURT: Stop. Stop. Wait.  
10          Lawyers, come up here.

11          (Sidebar conference.)

12          THE COURT: Okay.

13          JUROR: I'm waiting for them to close the door  
14          so they can't hear anything I'm saying.

15          THE COURT: All right.

16          JUROR: I don't believe I'm going to be able  
17          to --

18          THE COURT: Hold on. I want to talk with the  
19          lawyers. And here's the thing: I want you back  
20          tomorrow morning regardless.

21          JUROR: Okay. But I still --

22          THE COURT: We'll take this up first thing in  
23          the morning. What?

24          JUROR: If you'd like me to stay til  
25          afterwards, I'm fine.

1 THE COURT: I'm ready to get off the record.

2 JUROR: Of course.

3 THE COURT: So I'll see you tomorrow morning at  
4 8:45 AM. You be here and we'll talk it out.

5 JUROR: Sorry to --

6 THE COURT: It's all right. It's okay. I just  
7 don't want to get into a long thing right now.

8 JUROR: True.

9 THE COURT: Anything else for the record at  
10 this time?

11 MR. CONNOR: Nothing from the plaintiff, Your  
12 Honor.

13 MR. BLAKE: Not from the defendant.

14 THE COURT: Madam Court Reporter, let's go off  
15 the record.

16 (The following proceedings were held October  
17 24, 2018.)

18 THE COURT: Good morning, ladies and gentlemen.  
19 What I'd like to do is go ahead and get started.  
20 Our juror from yesterday has not shown up. I was  
21 clear about 8:45. I was actually clear to him when  
22 he passed me in the hallway yesterday. It's been 25  
23 minutes. We're already starting later than we  
24 wanted to. So I'm going to -- I presume I don't  
25 have any objections to go ahead and move in the

1 first alternate.

2 MR. CONNOR: None from the plaintiff, Your  
3 Honor.

4 MR. BLAKE: None from the defendant.

5 THE COURT: All right. So I'll inform the  
6 first alternate when they come in. The first  
7 alternate, again, was Jessica Anderson, Juror  
8 No. 80. So she's going to get called into the game  
9 today.

10 Anything before we bring the jury out?

11 MR. BLAKE: No, Your Honor.

12 MR. CONNOR: No, Your Honor.

13 THE COURT: All right. Let's get started.

14 (The jury enters the courtroom at 9:09 AM.)

15 THE COURT: Okay. Mr. Foreperson, ladies and  
16 gentlemen of the jury, I apologize for starting a  
17 little bit later than I thought we would today.  
18 There's some things out of our control. To the  
19 extent that you've been sitting back there for 25  
20 minutes, please understand you can blame me. It has  
21 nothing to do with anything that's going on in the  
22 courtroom, I can assure you.

23 So, Ms. Anderson.

24 JUROR ANDERSON: Yes?

25 THE COURT: All right. Congratulations, you're

1 in the game. Our first alternate is now being made  
2 a part of the jury.

3 We still have you, if needed.

4 But, Ms. Anderson, please understand that  
5 you're no longer an alternate, you're now a member  
6 of the jury panel.

7 All right. We left yesterday during the  
8 plaintiff's case. We're going to pick right back up  
9 where we left off.

10 Counsel?

11 MR. CONNOR: Yes, Your Honor. At this time,  
12 the plaintiff intends to publish for the jury the  
13 nursing home's fall prevention training video.

14 THE COURT: Very well.

15 MR. CONNOR: May we dim the lights?

16 (Brief pause in the proceedings.)

17 THE COURT: The nicer the equipment, the  
18 tougher it is to operate. Ladies and gentlemen, the  
19 courtroom just had the audiovisual suite upgraded  
20 about a month ago.

21 (Joint Exhibit No. 28 published for the jury  
22 and his Honor.)

23 MR. CONNOR: Your Honor, that's Joint  
24 Exhibit 28.

25 THE COURT: Thank you.



1 MR. CONNOR: Your Honor, at this time,  
2 Plaintiff calls Ellen Lewis.

3 THE COURT: Ms. Lewis, please come forward.

4 ELLEN LEWIS

5 being first duly sworn, testified as follows:

6 THE WITNESS: Yes.

7 THE CLERK: Have a seat and state your name  
8 name, please, ma'am.

9 THE WITNESS: Ellen Leanne Lewis.

10 DIRECT EXAMINATION

11 BY MR. CONNOR:

12 Q. And, Ms. Lewis, what is it that you do?

13 A. I'm a nurse practitioner.

14 Q. All right. And where do you reside?

15 A. Atlanta.

16 Q. Okay. And what is your profession? Apart from  
17 a nurse practitioner, do you have any other -- as  
18 far as your background --

19 A. To be a nurse practitioner, you have to be a  
20 registered nurse. So I -- and in Georgia, you have  
21 to maintain your nursing license as a registered  
22 nurse so that you can be a nurse practitioner.

23 Q. Understood. So you're both a certified nurse  
24 practitioner, as well as a registered nurse?

25 A. Yes.

1 Q. And how long have you been a nurse?

2 A. I've been a nurse since May of 1994.

3 Q. And have you remained actively licensed in  
4 Georgia since that time period?

5 A. Yes.

6 Q. And how long have you been a nurse  
7 practitioner?

8 A. Since 1998.

9 Q. And, also, have you remained actively licensed  
10 as a nurse practitioner in the state of Georgia  
11 since that time period?

12 A. I -- well, I graduated in -- I completed the  
13 program in December of '97. And in June of '98, I  
14 passed the certification test, so at that point I  
15 was a certified nurse practitioner.

16 Q. Okay. Thank you, ma'am.

17 Now, could you please provide the jury an  
18 explanation of the types of disciplines and the  
19 differences between those two practices?

20 A. Okay. As I stated earlier, you have to be a  
21 registered nurse first with a four-year degree  
22 before you can become a nurse practitioner. The  
23 difference between nursing, being a registered  
24 nurse, and a nurse practitioner, the nurse  
25 practitioner adds an additional piece where you can

1 do medical diagnoses.

2           You still have all of the nursing information  
3 because you're a registered nurse, but you're  
4 allowed to give the patient or resident medical  
5 diagnoses. We're allowed to order medications,  
6 order labs, X-rays. We examine the patient,  
7 communicate with families, communicate with the  
8 nursing staff, communicate with the various  
9 disciplines.

10 Q.   And as a nurse practitioner, are you required  
11 to be supervised by a physician?

12 A.   Yes. It's a collaborative role. In Georgia we  
13 do not have independent privileges. Some states do.  
14 But in Georgia, it hasn't been passed yet. So we  
15 work collaboratively with the physician, meaning  
16 they're not behind us the entire day while we're  
17 working, but we have an agreement with them that  
18 they are supervising us.

19 Q.   All right. And what is a gerontological nurse  
20 practitioner?

21 A.   That's a track a person can choose to study.  
22 There's midwife where you help -- you deliver  
23 babies; there's a nurse anesthetist where you give  
24 people medicine before surgery to put them to sleep.  
25 There's different tracks to be a nurse practitioner,

1       and I chose gerontology or geriatrics because I like  
2       working with age 65 and above.

3       Q.    And is there anything that's required as far as  
4       becoming certified in that specialty?

5       A.    Yes.  You have to specifically study to be a  
6       gerontological nurse practitioner, which is what I  
7       am.  You have to specifically study the age 65 and  
8       above, and then you have to take a specific national  
9       test which is specific to the gerontological nurse  
10      practitioner.

11      Q.    And is there a certification associated with  
12      that?

13      A.    Yes.

14      Q.    And do you hold that certification?

15      A.    Yes.

16      Q.    And how long have you held that?

17      A.    I've had that since May of 1998.

18      Q.    All right.  Now, if you could, please give the  
19      jury the benefit of your educational background.

20      A.    I started at Dekalb College in Georgia, which  
21      was a community college.  And I actually thought --  
22      I was new to Georgia, fairly new, and I thought that  
23      that was a four-year college.  I didn't know the  
24      colleges because I didn't grow up in Georgia.

25                So I went to the community college and then I

1 found out that it was a two-year program. I was  
2 doing my prerequisites for nursing and learned that  
3 I could transfer to another school so that I could  
4 obtain a four-year degree, which, ultimately,  
5 initially, was my goal. So I did that.

6 I was at Dekalb College and did my  
7 prerequisites for nursing and transferred to Emory.  
8 And then I completed the four-year program at Emory  
9 to be a registered nurse, and then I went back to  
10 study at Emory to be a nurse practitioner.

11 Q. And how did you fare academically?

12 A. I set a goal to do my very best. I said that I  
13 would be taking care of patients, residents, their  
14 lives would be in my hands, so I said I've got to  
15 learn as much as possible. So I said that I would  
16 do very well, and so I made sure that I did that.

17 Q. And did you graduate summa cum laude?

18 A. Yes.

19 Q. Now, ma'am, if you could, describe your present  
20 employment.

21 A. Okay. Well, right now, as I have for the last  
22 several years, I have quite a few positions. I work  
23 in four different nursing homes seeing residents. I  
24 work in two different psychiatric hospitals seeing  
25 patients. I also take calls on patients.

1 I do telepsych, which is something that's  
2 fairly new, where I see patients on the computer.  
3 We have areas in Georgia that are underserved that  
4 don't have enough healthcare providers, so they want  
5 to provide that service to the community.

6 And my clinic is in Augusta, Georgia, and I'm  
7 in Atlanta. I can't drive to Augusta every day, so  
8 we do it over the computer. And I really feel like  
9 I'm helping that area by doing that. I see the huge  
10 need. So I do the telepsych. Let's see. I believe  
11 that's it.

12 Q. And do you --

13 A. If I think of anything else, I'll let you know.  
14 But -- oh, and I've recently been hired to do  
15 medical visits at the hospital. And all of this is  
16 part-time, but it keeps me very busy.

17 Q. Yes, ma'am. All right. And do you work  
18 collaboratively with any physicians?

19 A. Yes, several.

20 Q. And who are those?

21 A. Dr. Medhi, M-E-D-H-I; Dr. Aflatoon,  
22 A-F-L-A-T-O-O-N; Dr. Brown. Those are some of them.

23 Q. And what sorts of specialties, generally, do  
24 those physicians hold?

25 A. I'm sorry. Also Dr. Kirson, K-I-R-S-O-N. They

1 are psychiatrists. And then, also, Dr. Kirson is  
2 the psychiatrist that is supervising me in the  
3 nursing home.

4 Q. Okay. And, if you could, just give us the  
5 benefit of your prior vocational history. What  
6 other sorts of things have you done?

7 A. When I first started as a nurse, I was in a  
8 geriatrics hospital, which was a free-standing,  
9 acute care geriatric hospital. They only took  
10 patients 65 and above, so that's where I learned  
11 that I liked working with the elderly patients. And  
12 so I worked there in a nursing-assistant-type  
13 position.

14 Since I was going to Emory's nursing school,  
15 they allowed me to work as a nursing assistant  
16 taking people to the bathroom, helping to feed  
17 people, helping with ambulation, monitoring  
18 patients, turning and repositioning, all of the  
19 nursing-assistant-type duties. So that was  
20 excellent training while I was in nursing school  
21 because I was getting additional time to learn  
22 everything -- it was reinforcing what I was  
23 learning.

24 And then they hired me after that to be a  
25 registered nurse at the geriatrics hospital. And I

1        stayed there while I was completing my master's to  
2        be a nurse practitioner. I stayed at the geriatric  
3        hospital, and then once I completed my master's, I  
4        continued on at the geriatric hospital because I  
5        really liked it and also took a job working with  
6        residents in nursing homes. And I did that for  
7        about six years. And then we were expanding our  
8        family and I had to kind of scale down. That was a  
9        full-time position.

10        And so then I worked still in nursing homes as  
11        a nurse practitioner and saw patients for  
12        physicians, and then just gradually added -- over  
13        the years, as the kids got older, I added more and  
14        more positions to what I do now.

15        Q. All right. Now, if you could, tell us a little  
16        bit about your experience in working with skilled  
17        nursing facilities like Agape West Columbia and the  
18        nature of your interaction and oversight with staff  
19        who provide care in those facilities.

20        A. Okay. I've been in nursing homes since --  
21        well, before 1998, because I did clinical in nursing  
22        homes with my gerontological program. But as far as  
23        working in nursing homes, I started in 1998 --  
24        January of '98. And I've been in nursing homes ever  
25        since. It seems like I've been in almost every



1 nursing home in Atlanta at some point because  
2 they -- sometimes I'd cover for maternity leave,  
3 different things.

4 So when I'm at the nursing homes, I talk with  
5 the nurses; I talk with families; I talk with  
6 residents; I go through charts; I see residents,  
7 order whatever they need, diagnose if they're having  
8 a problem. We try to catch problems early before  
9 the urinary tract infection develops into sepsis.  
10 So it's a pretty comprehensive role.

11 Q. Okay. And in your interactions with nurses in  
12 the nursing home and with the nurses aides, are you  
13 involved in teaching them standards of practice for  
14 them to apply in their own treatment of residents?

15 A. Yes. I do inservices with the nurses and  
16 nursing assistants in the nursing home. Sometimes  
17 I'll be asked to do one on a specific topic; other  
18 times I'll do one that I feel like I want to teach  
19 about.

20 Q. Okay. And do you also provide any hands-on  
21 training or training at the bedside?

22 A. Yes. That's always. When I'm in the room, if  
23 a nurse has a question -- for a long time I did  
24 wounds in a nursing home, so I would communicate  
25 with the nurses. Even the nursing assistants would

1 ask me questions and I would answer their questions.

2 Q. And do you instruct them on the appropriate  
3 ways in which to perform tasks?

4 A. Yes.

5 Q. What are some topics relevant to this case that  
6 you've offered inservice training on?

7 A. Dementia, falls and fall prevention, when to  
8 notify a physician or a nurse practitioner.

9 Q. Okay. And can you tell us whether or not the  
10 topics that you provided on also include compliance  
11 with applicable rules and regulations?

12 A. Yes.

13 Q. And that would include regulations like the  
14 OBRA rules?

15 A. Yes.

16 Q. Those are something you're very familiar with?

17 A. Yes.

18 Q. Okay. Now, Ms. Lewis, you mentioned -- or let  
19 me ask you this: Are you familiar with the nursing  
20 process?

21 A. Yes.

22 MR. CONNOR: Your Honor, may I approach the  
23 witness?

24 THE COURT: Sure.

25 BY MR. CONNOR:

1 Q. We've, at your request, prepared a diagram that  
2 I think Ms. Lewis would like to explain that  
3 process.

4 MR. CONNOR: Is it okay if I set it up here  
5 or --

6 THE COURT: That's fine, if you can fit it.  
7 BY MR. CONNOR:

8 Q. And, if you could, just walk us through the  
9 nursing process as if we were one of your students.

10 A. Okay. Well, it's ADPIE, A-D-P-I-E. And I  
11 don't know if I came up with that. I don't think --  
12 probably not. But that's -- when I was a nursing  
13 student, that's how I saw that you could remember  
14 ADPIE: Assess, diagnosis, plan, implement or  
15 intervention, and evaluate.

16 And this is an ongoing process. You can see  
17 how it's circular. You're constantly doing this.  
18 You might not always go in the exact order; you  
19 know, you may be stuck at a certain point for a  
20 while when you're trying to figure the patient out  
21 or the resident. But, assess, that's the first  
22 thing. And we do this all the time. We're looking  
23 at residents, patients, how are they doing.

24 We look at their physical characteristics, how  
25 they're acting, their affect, are they smiling, do

1       they look depressed, you know, just anything  
2       physical that we can see. And then, you know, we  
3       have the stethoscope where we can also do an  
4       assessment with our stethoscope to look at lungs and  
5       heart and abdomen.

6               And then diagnose. With nursing, this is a  
7       nursing diagnosis. This is -- for example,  
8       dehydration is a medical diagnosis. So in the care  
9       plan -- and this is all going to contribute to the  
10      care plan which is individualized for the resident.  
11      But with the diagnosis, the nursing diagnosis might  
12      be alteration and fluid deficit, but the medical  
13      diagnosis would be dehydration. And the nurses  
14      cannot give the medical diagnoses, but they can  
15      alteration and fluid deficit; the patient is not  
16      taking in enough fluids, for an example. And so  
17      then that's the nurse's diagnosis.

18             Once you come up with that, then you go to a  
19      plan. So what are we going to do to help this  
20      diagnosis? So offer eight ounces of fluid every  
21      four hours would be one of the interventions you  
22      could do, as an example. Monitor what the patient  
23      is taking in is another intervention you could do  
24      for that example.

25             And then implement is actually doing the

1 intervention, actually going to the resident and  
2 saying, I have water for you, would you please take  
3 it, and then sit there and wait for them to take it  
4 or, you know, depending on their cognitive status,  
5 if they're alert and oriented, then they can drink  
6 it and you can go back and check. But that is  
7 actually performing the intervention or implementing  
8 it.

9 And evaluate. Did the patient or resident take  
10 the water? How are we doing? Are they dehydrated?  
11 How are their labs? And then the nurse practitioner  
12 or doctor would order their labs to see how they're  
13 doing. Do they look dry? I mean, it's  
14 constantly -- all of this is constantly how we're  
15 thinking when we're looking at patients and  
16 residents.

17 Q. Okay. Thank you, ma'am. And those steps that  
18 you've described -- assessment, diagnosis, plan,  
19 intervene, evaluate -- are those things that you  
20 either do or oversee nurses do on a regular basis?

21 A. Yes.

22 Q. And then have you been continuously doing that  
23 and overseeing that since you've graduated from the  
24 nurse practitioner program?

25 A. Well, and actually since I was in the nursing

1 program as a nurse and then nurse practitioner.

2 Q. So even before 1994?

3 A. Right. It would have been when I was studying.  
4 Yes.

5 Q. All right. And if you could tell us, what's  
6 the purpose of this assessment?

7 A. It's a comprehensive way to look at a patient  
8 or a resident to see what's going on with them.  
9 It's a systematic way to evaluate.

10 Q. And is the goal to, in effect, provide  
11 appropriate treatment and reduce risks?

12 A. Yes. So, in other words, if the assessment  
13 isn't done properly, then it's going to mess up  
14 everything else because then you don't know what's  
15 going to be specific that you can put in place to  
16 help the patient or resident. So if you aren't  
17 doing one of these or several of these the correct  
18 way, then you'll have a problem.

19 Q. And we've heard testimony from several nurses  
20 in this case already that were actually treating  
21 this patient that they -- that assessment is  
22 foundational to an appropriate plan and appropriate  
23 interventions being in place.

24 A. Correct.

25 Q. Would you agree with that?

1 A. Yes.

2 Q. Now, ma'am, just so that the record is clear  
3 and because the law requires it, can you tell us  
4 whether, for at least three of the last five years,  
5 you've been engaged in the active practice of  
6 nursing, providing care to residents similar to Ms.  
7 Utricia Shealy?

8 A. Yes.

9 Q. And has that active practice of nursing  
10 regularly, including these different steps,  
11 assessing residents, developing plans of care,  
12 providing nursing care and interventions, and  
13 evaluating the efficacy or the effectiveness of  
14 those things?

15 A. Yes.

16 Q. Given your background, training, and education,  
17 as well as experience, are you familiar with the  
18 standards of care applicable to skilled nursing  
19 facilities, such as Agape Rehabilitation West  
20 Columbia, in the provision of nursing care to  
21 residents?

22 A. Yes.

23 Q. And in addition to those standards of practice,  
24 are you familiar with the state and federal laws  
25 that also apply?

1 A. Yes.

2 Q. Now, Ms. Lewis, you've been engaged as an  
3 expert witness in this case; correct?

4 A. Yes.

5 Q. And is that because the law requires that  
6 before a claim for malpractice can be brought in  
7 this state, that a plaintiff must provide an  
8 affidavit by an expert specifying at least one  
9 negligent act or omission claimed by the defendants  
10 based upon the available evidence at the time that  
11 the affidavit is filed?

12 A. Yes.

13 Q. And, ma'am, you've provided that affidavit in  
14 this case; right?

15 A. Yes.

16 Q. And you were engaged to do that and did so,  
17 again, as required by law, back in November of 2015;  
18 is that correct?

19 A. Yes.

20 Q. And, ma'am, are you -- isn't it true you've  
21 also been engaged because Plaintiffs have asserted a  
22 claim of professional negligence as part of their  
23 complaint in this case?

24 A. Yes.

25 Q. And are you aware that South Carolina mandates



1       that in order to prove a claim of professional  
2       negligence, that it must be established through  
3       expert testimony?

4       A.    Yes.

5       Q.    Now, you are being compensated for your time;  
6       correct?

7       A.    Yes.

8       Q.    And is that normal for expert testimony?  
9       People don't come up here and do this for free, do  
10      they?

11      A.    No.

12      Q.    How are you being reimbursed and compensated,  
13      if you can walk us through that process?

14      A.    When I look at records, I charge 145 an hour,  
15      which is probably actually lower than most experts.  
16      I've been 145 an hour since the year 2000. And for  
17      deposition testimony, it's 175 per hour, and for  
18      trial testimony, it's 195 per hour.

19      Q.    Okay. And are those rates -- you mentioned  
20      that they were low. Is that your understanding  
21      based upon the market that you provide these  
22      services within?

23      A.    Yes. And I've seen various testimonies of  
24      other nurses and some nurses who have two-year  
25      degrees or four-year degrees and they charge, you

1 know, much more.

2 Q. Sure. Rates range from \$100 an hour to \$1,000  
3 an hour, depending on the expert; fair?

4 A. That is correct. Yes.

5 Q. Can you tell us whether your compensation is  
6 dependent upon the outcome of the case?

7 A. No.

8 Q. And you've been retained in the past to provide  
9 opinions for our firm; correct?

10 A. Yes.

11 Q. And you've done that, again, because the law in  
12 the states in which our firm operates require that  
13 testimony of professional negligence be proven by an  
14 expert; correct?

15 A. Correct. If the case continues as far as -- if  
16 it continues to go and doesn't settle, then they  
17 need the person to testify. Yes.

18 Q. Sure. And you've also been retained by defense  
19 lawyers to provide standard of care opinions in  
20 defense of nursing homes as well; correct?

21 A. Yes.

22 Q. And, commonly, in fact, in most instances,  
23 aren't nursing homes also offering counter-availing  
24 defense experts?

25 A. Yes.

1 Q. Sure. Now, are your opinions in any way  
2 dependent upon who retains you?

3 A. No.

4 Q. Would your opinions in this case --

5 MR. BLAKE: At some point he's got to stop  
6 leading and calling for legal conclusions and having  
7 her testify to things without laying foundation and  
8 are, certainly, outside the scope. He can ask her  
9 questions, she can answer then, but he can't testify  
10 for her and have her yes for the next hour.

11 THE COURT: Okay.

12 MR. CONNOR: Your Honor, we have to lay some  
13 foundation --

14 THE COURT: You can lay foundation, but try not  
15 to lead her as much.

16 MR. CONNOR: Understood.

17 THE COURT: She can answer your questions, but  
18 not respond to your statements.

19 BY MR. CONNOR:

20 Q. Can you tell us whether your opinions would  
21 differ in this case depending on who engaged you?

22 A. No. I would look at the records and give my  
23 opinions on what I found.

24 Q. All right. And in what states have you been  
25 qualified to provide expert testimony in?

1       A.     Several.  Florida, Pennsylvania, Tennessee,  
2       Arkansas, Kentucky, Louisiana, Mississippi, Alabama.  
3       I believe I've had a case before in South Carolina.  
4       I think it was in West Virginia also.  Oh, and  
5       Georgia.  I'm sorry.

6       Q.     Have you ever been disqualified as an expert?

7       A.     No.

8       Q.     Now, Ms. Lewis, what were you asked to do in  
9       this case?

10      A.     I was asked to look at the records and give my  
11      opinions.

12      Q.     Okay.  And what sorts of records have you  
13      reviewed in preparing to offer those opinions?

14      A.     Deposition testimony, medical records from the  
15      hospital before the nursing home stay and then the  
16      hospital after.  And then, also, Ms. Shealy went to  
17      an extended care facility after.  I've looked at  
18      surveys, policies and procedures, the training  
19      video.  I saw that before.

20      Q.     Have you reviewed any inservice records?

21      A.     Yes.

22      Q.     Have you reviewed any training records?

23      A.     Yes.

24      Q.     ADL records?

25      A.     Yes.

1 Q. Have you reviewed any job descriptions?

2 A. Yes. And there was also some job description  
3 information in the deposition testimony.

4 Q. Okay. And you mention testimony -- deposition  
5 testimony. Do you recall who all you reviewed?

6 A. Yes. I looked at Ebonie McDaniel, who was a  
7 nurse, and then Ms. Vaughn, who is a nurse.

8 Q. And did you also have the opportunity to review  
9 the DON, Scott Smith's, deposition?

10 A. I didn't look at that. No.

11 Q. Okay. And it's my understanding you've  
12 reviewed policies and procedures. Did you mention  
13 that?

14 A. Yes.

15 Q. Now, prior to this case, can you tell us  
16 whether you performed similar assessments in  
17 connection with your professional responsibilities?

18 A. Yes. I do it all the time. I don't want  
19 patients to fall when I'm taking care of them or if  
20 I'm in charge of them. So I do it all the time.

21 Q. When you say you do it all the time, does that  
22 mean you review the types of records that you've  
23 described to determine whether or not there's been a  
24 violation of the standard of care?

25 A. Oh, I'm sorry. I thought you meant do I do

1       this when I'm working, you know, making sure  
2       patients are safe. I'm sorry.

3       Q.     That's okay. So, professionally, when you're  
4       actually providing nursing care, you are looking at  
5       the same sorts of information, whether it be  
6       statements by nurses about an event or documentation  
7       generated within a nursing home to make an  
8       assessment as to whether or not the standard of care  
9       was met and whether or not interventions or  
10      improvements could be made?

11     A.     That's correct.

12     Q.     And those types of materials that you've  
13     described that you've relied upon in forming your  
14     opinions here, are those the types of materials that  
15     experts, such as yourself, reasonably rely upon in  
16     forming professional opinions?

17     A.     Yes.

18           MR. CONNOR: Your Honor, at this time, I'd like  
19     to tender the witness as an expert in the following  
20     areas of nursing: The nursing process, including  
21     the steps of assessment, diagnosis, plan, intervene,  
22     and evaluate; the nursing process as it relates to  
23     the care of gerontological patients; nursing care of  
24     elderly patients and residents with confusion and  
25     dementia and who are at risk for falls; the

1 provision of nursing care in nursing and  
2 rehabilitation facilities, such as the one at issue  
3 in this case; the standard of care for nursing  
4 homes, including that of -- that -- the standards to  
5 licensed and unlicensed professionals in their care  
6 of elderly patients, including those at risk for  
7 falls; the standards for nursing documentation, as  
8 well as the rules, regulations, and statutes  
9 applicable to nurses in their care and treatment of  
10 residents within nursing homes.

11 MR. BLAKE: Without objection.

12 THE COURT: All right. I won't be able to  
13 repeat all that --

14 MR. CONNOR: Sure.

15 THE COURT: But, ladies and gentlemen of the  
16 jury, normally a person cannot can give opinion  
17 testimony. When a person testifies, they must  
18 testify as to what they saw, heard, or smelled, or  
19 something of that nature.

20 However, there is an exception with someone who  
21 is qualified because of education or experience.  
22 They're permitted to give their opinion in certain  
23 areas if the Court qualifies them in that way. This  
24 witness shall be qualified, in the area of the  
25 nursing process and gerontological patients and

1 everything that the lawyer just said in front of  
2 you, to give her opinion in that area.

3 That does not mean that you must accept their  
4 opinion, but it is evidence for you to use in any  
5 way you see fit.

6 BY MR. CONNOR:

7 Q. Now, Ms. Lewis, can you tell us whether you  
8 hold any professional nursing opinions in this case  
9 as to the defendant's nursing and non-licensed  
10 staff?

11 A. Yes.

12 Q. And what are those?

13 A. Well, in my opinion, when Ms. Shealy came to  
14 the nursing home, Agape, she was a high fall risk.  
15 She just had surgery, she was elderly, she had  
16 dementia, which would -- she would have confusion,  
17 would have some agitation. She was unsteady with  
18 her gait, so she could not ambulate independently.

19 Also, she was a high fall risk and, in my  
20 opinion, the nursing home did not treat her  
21 adequately and appropriately because they did not  
22 put reasonable measures in place to keep her safe.  
23 She was there a very short time. And when a  
24 resident is new to the facility, especially when  
25 they have dementia, they do get confused.



1           And Ms. Shealy also had a history of  
2           sundowning, which means right around when the sun  
3           goes down, you can see a change with the resident or  
4           patient who have -- the ones who have confusion.  
5           They -- it's called sundowning, where the confusion  
6           is worse. And so, in my opinion, they did not keep  
7           Ms. Shealy safe like they should have.

8           Q.    And, in your opinion, did that rise to the  
9           level of negligence?

10          A.    Yes.

11          Q.    Now, can you tell us whether you hold any  
12                opinions about whether you believe the applicable  
13                standards of care in this case were breached by the  
14                defendants?

15          A.    They were breached, yes.

16          Q.    And can you tell us whether you hold any  
17                opinions about whether the conduct of Agape,  
18                including its licensed and non-licensed staff,  
19                violated the defendants' own policies and  
20                procedures?

21          A.    They did, yes. They did violate them.

22          Q.    And can you tell us whether you hold any  
23                opinions about whether the conduct of Agape's  
24                nursing and non-licensed staff violated applicable  
25                state and federal laws, regulations, and codes?

1 A. They did, yes.

2 Q. Now, Ms. Lewis, if you could, you've provided a  
3 summary of your opinions in this case via that  
4 affidavit that was originally filed before this  
5 complaint could be brought; correct?

6 A. Yes.

7 Q. And in that affidavit, you identified several  
8 failures on the part of the nursing home. Could you  
9 walk us through those?

10 A. Yes. Let me just go to the document. Failed  
11 to provide a safe environment for Ms. Shealy free of  
12 accident hazards, failed to provide adequate and  
13 appropriate care plans, failed to provide care plan  
14 interventions that were specific to Ms. Shealy,  
15 failed to provide accurate and consistent admission  
16 assessments of Ms. Shealy, failed to properly train  
17 the caregivers regarding the care and safety of  
18 dementia residents.

19 Q. And it's my understanding, ma'am, you've also  
20 been deposed in this case. Correct?

21 A. Yes.

22 Q. And in that deposition you offered additional  
23 failures having reviewed testimony of witnesses as  
24 well as other materials that have been produced by  
25 the defendants; correct?

1 A. Yes.

2 Q. And did -- those failures that you've just  
3 identified, were they confirmed by your continued  
4 review of the materials?

5 A. Yes, they were confirmed. Oh, and also failed  
6 to adequately and appropriately document the care  
7 provided to Ms. Shealy.

8 Q. All right. Now, what I'd like for you to do is  
9 sort of walk us through the factual basis of each  
10 one of those opinions, starting with your opinion  
11 about a lack of appropriate assessments. And, if  
12 you'd like -- as we go through this, if there's  
13 certain medical records that you would like us to  
14 put on the screen, we're positioned to do that.  
15 Okay?

16 A. Okay.

17 MR. BLAKE: Quick issue, Your Honor.

18 THE COURT: Yes, sir.

19 MR. BLAKE: May we approach?

20 THE COURT: Sure.

21 (Sidebar conference.)

22 THE COURT: We're going to take a very short  
23 break, ladies and gentlemen. Go back to your jury  
24 room, please do not discuss the case, and we'll have  
25 you right back out as soon as possible.

1 (The jury exits the courtroom at 9:54 AM.)

2 THE COURT: Counsel for the defendant has asked  
3 that he be allowed to see to ensure that the  
4 expert's file has not changed since the file you, in  
5 theory, have. Correct?

6 MR. CONNOR: Well, it's certainly changed, Your  
7 Honor, because Defense dumped a bunch of documents  
8 on us in the last week. So she has more materials  
9 that have been reviewed. I'm sure there are things  
10 like -- there's additional materials that --

11 THE COURT: Well, let me just -- assuming she's  
12 only got what you provided, you just want to know if  
13 there's anything new that you never had the  
14 opportunity to look at; right?

15 MR. BLAKE: Specifically, Your Honor, from here  
16 I can see that she had handwritten notes on a pad  
17 that she's looking at. I'm not concerned about what  
18 documents that are my documents; I'm concerned what  
19 other documents the witness is using to refresh her  
20 recollection of her opinions while she's testifying.  
21 I think under 612 I'm allowed to look at them while  
22 she's testifying.

23 THE COURT: All right. Counsel, let him see  
24 the notes, I guess.

25 MR. CONNOR: Sure.

1 MR. BLAKE: May I approach?

2 THE COURT: Yeah, sure. I mean, do you need a  
3 copy or --

4 MR. BLAKE: I may not if it's --

5 THE COURT: Yeah.

6 MR. BLAKE: Thank you.

7 THE COURT: Anything else before we bring the  
8 jury back?

9 MR. BLAKE: No, sir.

10 MR. CONNOR: Joint Exhibits 29, 30, 31, and 32  
11 in evidence.

12 THE COURT: Let's get the jury, please.

13 (The jury enters the courtroom at 10:22 AM.)

14 THE COURT: All right. Mr. Foreman, ladies and  
15 gentlemen of the jury, I appreciate your patience.  
16 I decided just to go ahead and make it our  
17 midmorning break, so we took a little bit longer  
18 than I intended. But that was on me.

19 So I have -- in order to help things run a  
20 little smoother today, I am ordering lunch for you  
21 today. So when we take our next break, in theory,  
22 lunch will be waiting for you in the jury room.  
23 We'll see if it all comes together, but that's the  
24 plan. So we'll just pick up right where we left  
25 off.

1 Counsel?

2 MR. CONNOR: Yes, Your Honor. Just for the  
3 record's sake, during the break we did reach some  
4 agreements on some exhibits that I'd like to go  
5 ahead and move in, since I'll be referencing them  
6 with Ms. Lewis.

7 THE COURT: All right.

8 MR. CONNOR: The first is Joint 29, these are  
9 the 42 CFR 483, the federal regulations applicable  
10 to skilled nursing facilities; Joint 30, which is  
11 the South Carolina Code 44-81-10 et seq. This is  
12 the South Carolina Bill of Rights for long-term-care  
13 residents. Joint 31 is the Nurse Practice Act. It  
14 is South Carolina Code 40-33-1 et seq. And the --  
15 Joint 32 are the South Carolina DHEC regulations for  
16 nursing homes. And these are for the applicable  
17 year in which this resident was a resident at the  
18 skilled nursing facility.

19 THE COURT: All right.

20 (Joint Exhibit Nos. 29, 30, 31, 32 admitted  
21 into evidence.)

22 BY MR. CONNOR:

23 Q. And, Ms. Lewis, I can't recall where we were  
24 when we stopped, but let me just ask you this: If  
25 you could, give the jury the benefit of sort of an

1 overview of Ms. Shealy's medical history up until  
2 the point of her admission at the nursing home.

3 A. Ms. Shealy had fallen at home. She was out in  
4 the garden and she had fallen and broken her left  
5 hip. And so the family took her to the hospital and  
6 she had surgery on her left hip. She had some  
7 problems with the anesthesia, as elderly people do  
8 sometimes, with post-op confusion, they said --  
9 sometimes anesthesia can -- if you have dementia, it  
10 can move it forward some, and sometimes the patients  
11 don't come back from that.

12 But she had had some post-op confusion. She  
13 started therapy at the hospital, like they do,  
14 usually, after surgery, to get her stronger. And  
15 the goal was for her to go to the skilled nursing  
16 facility, Agape, have therapy, physical therapy,  
17 occupational therapy. And I think she also had  
18 speech therapy, but I'm not 100 percent sure.

19 But she had the physical therapy and  
20 occupational; therapy so that she could become  
21 stronger so that she could go back home. That's  
22 always our goal when we have patients or residents  
23 like that. We want them to be as functional as  
24 possible, as independent as possible. So --

25 Q. Let me ask you this, ma'am: In the hospital,

1 after the first fall, did you see any fall  
2 interventions being taken place by the hospital?

3 A. Yes.

4 Q. And what were some of those?

5 A. I noted that the physical therapist, after the  
6 therapy, took Ms. Shealy back to the room, put her  
7 in a recliner -- we also call them geri chairs, it's  
8 a large recliner -- put the chair alarm on the  
9 patient. The daughter was at the bedside and  
10 then -- and she also noted that all the things that  
11 she would need, like telephone or water or whatever,  
12 were within reach. And that was noted several times  
13 in the hospital records.

14 Q. Okay. And then tell us about her admission to  
15 the nursing home on July 1st. Just walk us through  
16 that.

17 A. Okay. She came to the nursing home on July  
18 1st, 2014. The admission notes said -- or the face  
19 sheet said -- it was in the afternoon sometime. And  
20 she was having some confusion that day, some  
21 agitation, and they gave her at Ativan, which is  
22 antianxiety medication. And the family was there,  
23 they visited and they stayed until around midnight,  
24 is what the note said. The family was there very  
25 late.



1           And then the next morning, it sounded like she  
2           had her therapy, which is typically what we do when  
3           they're at the nursing home, is the therapists come  
4           in. Usually they're -- sometimes that first day,  
5           they'll go by and introduce, and then they start the  
6           therapy pretty quick. So she had quite a bit of  
7           therapy.

8           The therapist noted that -- let me just go to  
9           that record. The therapist noted that before --  
10          this is the initial assessment, that Ms. Shealy did  
11          not ambulate with an assisted device; she used a  
12          shower chair. The daughter told the therapist that  
13          she was having cognitive difficulties prior to the  
14          hip fracture. And that would be expected with the  
15          dementia.

16          Ms. Shealy was unable to dress herself, but  
17          when the daughters put her in the shower, she was  
18          able to dress herself after that. This July 2nd,  
19          2014, before the fall, the therapist also noted that  
20          Ms. Shealy was unable to state her full name, she  
21          had unintelligible speech -- so they couldn't  
22          understand what she was saying -- difficult to  
23          follow the patient's speech; patient was unable to  
24          follow directions, tearful during the eval. There  
25          were also some hallucinations.

1           It said: During the eval, she said she was  
2           seeing children outside the window. And that would  
3           also be expected with the dementia, a change in an  
4           environment, you do see things like that sometimes.  
5           The standing balance was poor. Decreased functional  
6           endurance, decreased functional independence with  
7           basic activities of daily living, decreased  
8           orientation, meaning she didn't know -- you know,  
9           alert and oriented times four is person, place,  
10          situation, and time. So she wasn't aware of all  
11          that.

12                 Would benefit from skilled occupational therapy  
13          to return to highest level of function. That's  
14          always our goal, like I said. Patient is currently  
15          dependent with functional transfers. That means for  
16          her to get up, she needed assistance. So she was  
17          depending on someone else to get up, for help.

18                 Very tearful. Another entry about seeing the  
19          children outside the window. Unable to follow  
20          directions. Had difficulty putting her glasses on  
21          her face. Severe dementia with hallucinations,  
22          combativeness, extremely prone to fall, no safety  
23          awareness. That means she doesn't have any idea, as  
24          far as any decisions she makes about her safety,  
25          should she get up -- you know, some people know they

1 can't get up by the themselves; she didn't.

2 Cognition. I talked earlier about the alert  
3 and oriented times four. She was only times one.  
4 But remember earlier, she couldn't even say her  
5 name. Very confused. Has difficulty processing and  
6 following instructions. Safety awareness: None.  
7 She doesn't have any. Needs constant supervision.

8 Q. What does that mean?

9 A. Someone has to have their eyes on her, in the  
10 very least, all the time, given her condition.  
11 These are the therapists that are working in the  
12 skilled nursing facility. This is their assessment.

13 Q. And I'll represent to you, ma'am, that the  
14 evidence in this case is that the therapists were  
15 employed by the nursing home at this time; later  
16 they were spun off into a separate corporation, but  
17 they were employees. So that knowledge would have  
18 been within the realm of those folks working in the  
19 nursing home; correct?

20 A. Yes.

21 Q. And, ma'am, did you see the physician's note  
22 about this patient and how he described her fall  
23 risk?

24 A. Yes. Very high fall risk. And the doctor  
25 talked about the Ativan. Ativan is on the Beers

1 list. It is one of the medications that -- we'll  
2 use it with the elderly, but we have to be very  
3 cautious because it can contribute to falls.

4 Q. So walk us through that day up until the fall.

5 A. Okay. Oh, here's the time. 10:00 till 4:00 in  
6 the afternoon when she was admitted.

7 Q. That was on the 1st?

8 A. Okay. So after the therapy in the morning, we  
9 have a note at 3:22 PM by Ebonie that says that  
10 Ms. Shealy had fallen and was transferred to the  
11 hospital. So Ebonie, I don't know how she was able  
12 to predict that at 3:22 PM, but she was. So that's  
13 not accurate. But that's --

14 Q. And I'm not asking your opinions about that at  
15 this point. We're going to talk about that. But  
16 you would agree that this is -- that entry, that  
17 there's no way that that would be humanly possible  
18 given that the fall occurred four hours later?

19 A. That's correct. That is totally unacceptable.  
20 And there was some information about -- and I saw it  
21 in one of the depositions, where there were names of  
22 people who had gone --

23 MR. BLAKE: Objection, Your Honor. This has  
24 been dealt with, previously -- where the witness is  
25 going has been dealt with and ruled on by you.

1 MR. CONNOR: She's not --

2 THE COURT: Real quick, guys.

3 (Sidebar conference.)

4 BY MR. CONNOR:

5 Q. Let's talk about this 3:22 PM note that is  
6 apparently documenting a fall that happens four  
7 hours later. And, if you could, just walk us  
8 through this information, at least as far as what  
9 you find relevant to your opinions.

10 A. Okay. Let me just see if I have my notes here.  
11 All right. At the top we have -- it's an ER note.  
12 And I learned from the deposition testimony that the  
13 nurses were required -- if the patient was sent to  
14 the hospital, that they were supposed to do this  
15 note. And it has Ms. Shealy's name at the top, has  
16 her allergies, her vital signs. And it would appear  
17 that these were the vital signs taken after the  
18 fall. And then what prompted the ER transfer -- and  
19 there's a description of -- the nurse gave of what  
20 prompted the ER transfer.

21 Q. Okay. And this is a -- one of the nurses that  
22 you relied upon in forming your opinions as to the  
23 neglect of the defendants?

24 A. Well, I didn't have the deposition testimony  
25 initially when I was forming my opinions, but it

1 added to my opinions after.

2 Q. Okay. All right. And rather than walk us  
3 through the actual note, what I'd like you to do is  
4 just briefly describe for us your understanding of  
5 what happened up to the point of the fall and then  
6 after, just so we can kind of get an overview of her  
7 course that you intend on offering opinions about.

8 A. Okay. Well, the note says that Ms. Shealy fell  
9 to the floor in the hallway by the PT room and they  
10 called the doctor. The doctor said send the  
11 resident to the emergency room.

12 Q. And did she ultimately go to the hospital?

13 A. Yes.

14 Q. All right. Walk us through that course just  
15 briefly -- that's what I'm looking for you to do --  
16 just to give them an overview of what happened with  
17 this patient, not a specific record at this point.

18 A. Oh, okay. She went to the hospital and she was  
19 diagnosed with a right hip fracture.

20 Q. Okay. So she fractured the other hip that she  
21 originally was hospitalized in the facility for  
22 rehabilitation for?

23 A. Correct.

24 Q. Okay.

25 A. And then she had the surgery for the right hip.

1 And then they gave her a little therapy like they do  
2 at the hospital, and then she went to the extended  
3 care facility.

4 Q. Okay. So let me ask you this: Obviously this  
5 is about a fall; correct?

6 A. Yes.

7 Q. Okay. And the jury has seen the fall training  
8 offered. I think you were here for the publication  
9 of one of the videos. We've talked about other  
10 materials that the facility allegedly offered to its  
11 staff. Understanding or having reviewed those  
12 materials, having reviewed the video, do you have  
13 any opinion as to whether or not the nurses and  
14 aides responsible for caring for this resident  
15 should have understood the damages associated with  
16 the fall such as the one that Ms. Utricia Shealy  
17 sustained?

18 A. Yes. They should have been aware that when a  
19 resident falls, that it can cause a lot problems.  
20 Sometimes the residents die after a fall.

21 Q. Sure. And that's something that's well-known  
22 within the nursing profession, particularly those  
23 who are responsible and in charge of caring for  
24 geriatric patients; correct?

25 A. Yes.

1 Q. Now, do falls and fractures such as this, in  
2 your experience as a nurse practitioner as well as a  
3 nurse, can they cause pain or do they cause pain?

4 A. Yes.

5 Q. And you mentioned that they often lead to other  
6 complications up to and including death. Sort of  
7 walk us through how that works.

8 A. Okay. Well, after someone breaks their hip and  
9 if they have the dementia, it can cause the dementia  
10 to progress or get worse, and so then that causes  
11 other problems. Sometimes then they don't want to  
12 eat or they forget how to eat or, you know, it  
13 causes a lot more problems. Also, they have to have  
14 the anesthesia. They have to undergo the anesthesia  
15 which -- I mentioned earlier how that can cause the  
16 dementia to progress --

17 Q. And is -- that impact of that anesthesia, is  
18 there a name for that?

19 A. The anesthesia effect. Yes.

20 Q. And tell us what that is in elderly patients.

21 A. It's basically just how the elderly patient  
22 will tolerate the effects off the anesthesia. And,  
23 you know, they'll look at that before they do the  
24 surgery. You know, if they're a candidate, they'll  
25 review that to see, you know, if they can tolerate



1       that.

2       Q.     And this anesthesia effect, given your  
3       experience as a nurse practitioner, is that  
4       something that can often accelerate or advance  
5       someone's dementia rapidly?

6       A.     Yes.

7       Q.     And in your opinion, did it appear that       Ms.  
8       Shealy suffered from an adverse anesthesia effect,  
9       both after her first and as well as after her second  
10      surgeries?

11      A.     Yes.

12      Q.     And do you hold that opinion within a  
13      reasonable degree of nursing certainty?

14      A.     Yes.

15      Q.     Now, ma'am, do falls, apart from the impact on  
16      their cognitive status, have any impact on their  
17      mobility?

18      A.     Yes.

19      Q.     Tell us about that.

20      A.     It's going to make them weaker. She already  
21      had a hard time standing up, as we could tell from  
22      the fact that she fell. So it's going to make them  
23      weaker. They can have a fear of falling, so they  
24      might not want to get up. Even with assistance,  
25      they'll hesitate. And it can just impact their

1 activities of daily living. They're in a lot of  
2 pain, sometimes they have depression.

3 Q. Counsel for the defense has suggested that  
4 because this patient was able to ambulate more after  
5 the second surgery in rehab than after the first,  
6 that somehow she must have been better off with two  
7 broken hips. What do you say to that?

8 A. I don't agree. I don't think it was a good  
9 idea that she had two broken hips.

10 Q. That's certainly not any goal that you've ever  
11 had for a patient.

12 A. No. And also, the physical therapist had  
13 charted in the extended care stay after she left the  
14 hospital from her second hip fracture and went to  
15 Lexington Medical -- it was an extended care -- for  
16 more therapy, they charted that her confusion was so  
17 bad that it was impeding her progress; she couldn't  
18 participate in therapy. It's documented in the  
19 chart. And they said -- they discharged her from  
20 therapy and discharged her to long-term care and  
21 restorative, which is kind of the end of -- the  
22 therapy is done and, you know, we're just going to  
23 do a little restorative.

24 Q. And as a consequence of that, this patient was  
25 never in a position to go back home, which was the

1 goal at Agape Rehab; correct?

2 A. That is correct. Initially, that was the goal,  
3 yes.

4 Q. Now, in your opinion, just generally, what was  
5 the consequences as far as harm suffered to Ms.  
6 Shealy as a result of this fall on July 2nd?

7 A. Well, transfer trauma. Now Ms. Shealy who was  
8 in a new environment had to go to another new  
9 environment. So transfer trauma is what we call it.  
10 It's the -- you know, the problems that are created  
11 when you move someone from one surrounding to  
12 another that they're unfamiliar with. She didn't  
13 even have time to get settled in at the new place  
14 and then she had to go back out. So what other  
15 complications? Pain, dignity. You know, that's not  
16 dignified to fall and break your other hip.  
17 Decreased mobility, meaning she -- now she has pain  
18 on both sides, she's had surgery on both sides, so  
19 she's in a lot of pain.

20 Q. She also obviously had to undergo surgery to  
21 repair that; correct?

22 A. Yes. So everything that goes along with a big  
23 surgery like that.

24 Q. Okay. And in your opinion, ma'am, those  
25 damages that she sustained, were they the proximate

1       cause or the natural consequences of the conduct of  
2       the defendants that you find at issue?

3       A.    Yes.

4       Q.    And do you hold that opinion within a  
5       reasonable degree of nursing certainty?

6       A.    Yes.

7       Q.    Now, given the hazards associated with a fall,  
8       particularly in an elderly patient who has already  
9       sustained one surgery and gone through the trauma of  
10      that repair, can you tell us whether patients  
11      admitted to a facility for rehabilitation, like  
12      Utricia Shealy when she came into the facility at  
13      Agape, required protection from a second fall event?

14      A.    Yes. Yes. We would be very cautious with  
15      somebody like Ms. Shealy. We'd be worried. She'd  
16      already fallen and broken her hip; she's wobbly.  
17      Her gait -- they assessed her gait, apparently, and  
18      she had a problem with her gait. But then they also  
19      checked that it was normal, which was conflicting.  
20      So, yes, we'd be very worried about a resident like  
21      that.

22      Q.    And can you tell us whether steps need to be  
23      taken along each step of this nursing process to be  
24      sure that she be protected from a subsequent fall?

25      A.    Right. So you would definitely have to make

1       sure you're doing all these steps and continuously.

2       Q.     Okay.

3       A.     And also, with the evaluation, with the Ativan  
4       after she received it, they didn't monitor her after  
5       the Ativan, which can contribute to falls. And  
6       there's a physician, it's on the physician order  
7       form, that says: Agitation. Notify the doctor if  
8       other interventions are unsuccessful.

9             They talk about the things they should do, and  
10       then if that doesn't work, you call the doctor. And  
11       they didn't do that.

12       Q.     Okay. Let's talk then about your breaches in  
13       the standard of care that you found in this case,  
14       starting, obviously, the first, that being the  
15       failure to provide a safe environment. So tell us  
16       about that.

17       A.     Well, they -- Ms. Shealy came into the facility  
18       and she was a high fall risk. And she was given the  
19       Ativan; she was having the confusion. She didn't  
20       respond to the Ativan. She should have calmed down  
21       a little bit, and she did not. So when she did not  
22       calm down from the Ativan, they should have called  
23       the doctor. It says right there on the order:  
24       Notify the doctor if other interventions are  
25       unsuccessful with agitation.

1 Q. Okay. Tell us the Bates page of that page.

2 A. It says Agape Records 3 at the bottom.

3 Q. Okay. We'll put that up.

4 All right. So you're looking at the  
5 physician's orders here; is that correct?

6 A. Yes.

7 Q. And this is part of Joint Exhibit 4, for the  
8 jury's benefit. And, if you could, point to where  
9 you're are talking about. Is that under agitation?

10 A. Yes. It's kind of in the middle of the page.  
11 It says agitation; it says standing orders.

12 Q. Okay. And what does that mean?

13 A. These are in the chart and these are there for  
14 the resident. They're standing; they're current.

15 Q. All right. So under agitation, you're supposed  
16 to do assessment for pain or distress in the face of  
17 those symptoms; correct?

18 A. Yes.

19 Q. What does that entail?

20 A. That would mean that you look at the resident,  
21 and you talk with the resident and you see what is  
22 causing the resident or patient to be agitated.

23 Q. And you should be doing that not only along the  
24 day, but any time you see a change in the patient's  
25 condition or a lack of response to an intervention

1       that you're providing?

2       A.     Correct.

3       Q.     And, in your opinion, that did not happen in  
4       the appropriate times in this case; is that correct?

5       A.     That is correct. And at one point they did  
6       assess for it, but then they didn't do anything --  
7       when the Ativan didn't work, they didn't do anything  
8       after that.

9       Q.     Okay. Are you talking about this notation here  
10      on the -- this is Agape 141 by Ms. McDaniel.  
11      There's a notation where she says that the patient  
12      was given Ativan, but that she remained agitated,  
13      confused, and combative.

14      A.     Yes.

15      Q.     So she's assessed symptoms, but done nothing in  
16      response; is that correct?

17      A.     That is correct.

18      Q.     Okay. How about the next step under agitation?  
19      It says: Toileting the resident. How does a lack of  
20      providing basic services such as toileting result in  
21      or contribute to agitation?

22      A.     Well, sometimes when patients have dementia and  
23      confusion, they can't put it all together that they  
24      have to go to the bathroom. They may feel a little  
25      uncomfortable, a little antsy. They will try to get

1 up, so -- and they might not even be able to say I  
2 have to go to the bathroom. So then you would be  
3 proactive and take them to the bathroom to make  
4 sure. And then you rule out that that's one of the  
5 things contributing to the problem.

6 Q. I want you to assume that the documents in this  
7 case reflect no ADL care of this resident past 2:20  
8 in the afternoon. If this fall occurred at 7:20,  
9 would you agree that from 2:20 to 7:25 that,  
10 certainly, that's a long time for a resident not to  
11 have to be toileted?

12 A. Correct; to not be toileted or if -- I believe  
13 she had a brief on -- or have her brief checked or  
14 adult diaper.

15 Q. Okay. Along those lines, I want you to assume  
16 that the testimony in this courtroom is, is that  
17 when the family showed up at the hospital, that  
18 their mother was complaining of the need to have to  
19 urinate and her brief was so saturated that it was  
20 full. Does that sound like a resident who had been  
21 properly toileted?

22 A. No. It sounds like she had that brief on for a  
23 long time.

24 Q. All right. And then number 4: Notify the M.D.  
25 if interventions are unsuccessful. Do you have an



1 opinion about whether or not in this particular case  
2 that occurred?

3 A. No. I think you skipped number 3, provide calm  
4 environment.

5 Q. Sure. Did you find any issue with their  
6 failure to provide a calm environment in this case?

7 A. Well, I think they tried. They put her by the  
8 nurses station. You know, I don't know how calm  
9 that was. But they did try to do that. But they  
10 did not notify the doctor that the agitation, the  
11 combativeness, was continuing.

12 Q. All right. And it does reflect that they did  
13 move her to the nurses station, but it also  
14 indicates that, at some point, she did not want to  
15 remain in that area. Did you see that?

16 A. Yes.

17 Q. And I want you to assume that the testimony in  
18 this courtroom by Ms. McDaniel is that two and a  
19 half hours later, this resident was found on the  
20 floor after having experienced an unwitnessed fall,  
21 and that she didn't know how long she'd been there  
22 or how long it was from the time that she was moved  
23 to the nurses station to the time that she no longer  
24 wanted to remain in that area and where she went.  
25 Okay?

1 A. Yes.

2 Q. Now, I understand you hold opinions relating to  
3 failures to assess this patient. Can you walk us  
4 through those. And, again, if there's certain  
5 records that you'd like me to display on the screen,  
6 just let me know and I'm happy to do that.

7 A. Okay.

8 Q. In addition, obviously, to what you've already  
9 testified to.

10 A. Okay. If we can use Agape 126.

11 Q. Okay. And this is, again, part of Joint  
12 Exhibit 4, and we've already looked at this with  
13 some witnesses. Tell me about this assessment and  
14 the criticisms that you had that you thought were a  
15 breach of the standard of care.

16 A. Well, it's conflicting information. Under  
17 Section C, pain, it says: No pain reported. And  
18 then it says: Type of pain, stabbing, and that it  
19 was daily. So that's conflicting.

20 Q. Okay.

21 A. And if they're -- I understand -- I read the  
22 deposition testimony of one of the nurses and she  
23 was trying to explain it. But if there was more  
24 information -- it just doesn't make any sense to say  
25 no pain and then there is pain.

1 Q. All right. What other types of assessments did  
2 you see breached the standard of care?

3 A. Agape 130.

4 Q. Which section?

5 A. It's under the admission assessment.

6 Q. Okay. This is the fall risk assessment. Which  
7 portion of this did you have problems with?

8 A. Under gait and balance, it has: Gait and  
9 balance normal, and then balance problems while  
10 standing, balance problems while walking, decreased  
11 muscular coordination.

12 Q. And, again, those inherently conflict; correct?

13 A. Yes.

14 Q. And we've already heard nursing testimony about  
15 that.

16 Okay. Anything else, just as examples?

17 A. They didn't check off that she uses the  
18 wheelchair on the required use of assistive devices.

19 Q. Okay. Where is that?

20 A. That was right there with gait. It's all the  
21 way -- if you see where the yellow is highlighted --

22 Q. Right here?

23 A. Yeah, to the right. And under problem with the  
24 assessment was with the Ativan, like I talked about  
25 before where they gave her the Ativan and they did

1 not adequately and appropriately follow up and  
2 document Ms. Shealy's condition.

3 Q. In fact, we have no notation at all for the two  
4 hours after this medication was provided; correct?

5 A. That is correct.

6 Q. And would that breach the standard of care?

7 A. Yes.

8 Q. And is that particularly true when you're  
9 dealing with a demented resident who has all these  
10 symptoms that they described?

11 A. Yes.

12 Q. Now, is it my understanding, based off the  
13 testimony that you've previously given in your  
14 deposition, as well as your affidavit, that you also  
15 have criticisms relating to the care plans that were  
16 prepared in this case?

17 A. Yes. And, I'm sorry, I have another document  
18 for assessment.

19 Q. Okay.

20 A. It's 139.

21 Q. Okay. What is this?

22 A. This is a nurse's note, July 2nd, 2014,  
23 8:07 PM.

24 Q. Okay. And this would have been after the fall;  
25 correct?

1 A. Right, because she fell around 7:25 PM.

2 Q. Okay.

3 A. And alert and oriented times one, patient has  
4 had no complaints today.

5 Q. Clearly we know that's not consistent with the  
6 other information we've seen; correct?

7 A. That is correct. So, you know, again, I have a  
8 huge question about this -- about the assessment.  
9 They're saying she had no complaints. And she had  
10 already fallen about 40 minutes before that, so that  
11 doesn't make sense.

12 Q. Sure. And she had been crying in the PT room,  
13 I think you told us about that, and expressed other  
14 problems as well.

15 A. That is correct. And then --

16 Q. How about the showing no signs or symptoms of  
17 distress? Does that tell us anything about whether  
18 an appropriate assessment of this patient is  
19 occurring? This is 40 minutes after her fall.

20 A. Yeah. That's correct too. And it's the same  
21 nurse who was documenting the combative behavior and  
22 the agitated behavior and the same nurse who gave  
23 her the Ativan. So that doesn't make any sense. No  
24 signs of -- no S&S, signs and symptoms, of distress.

25 Q. Yet, they're giving her an antianxiety

1 medication?

2 A. Correct.

3 Q. Let me ask you this: Did you see anywhere in  
4 the chart for this patient, over her 27 hours in the  
5 facility, ever where she would have been in this  
6 condition, no complaints?

7 A. No.

8 Q. Out of the bed, no signs or symptoms of  
9 distress, oriented to the call light?

10 A. No. Because the day before, she was agitated;  
11 she was having problems; they had to give her the  
12 Ativan. The family was there and -- I can't  
13 remember if the family was there and they left and  
14 they called them back. I'm pretty sure they called  
15 them back and then the family stayed till midnight  
16 because of the situation.

17 Q. So in that instance, when this patient was  
18 having problems, the nursing home actually called  
19 the family back in an effort to try to deal with the  
20 situation; is that correct?

21 A. Correct.

22 Q. Is there anything that you've reviewed that  
23 would suggest that this family, had they known that  
24 she was having continued problems after the Ativan  
25 was administered at 5:30, to come back and try to

1 assist with their mother?

2 A. On July 2nd? The --

3 MR. BLAKE: Objection, Your Honor; calls for  
4 speculation about what the family would do. That's  
5 not within the scope of this expert's ability.

6 BY MR. CONNOR:

7 Q. Well, ma'am, have you reviewed the records?

8 A. Yes.

9 Q. Do they reflect that the family is very  
10 involved?

11 A. Yes.

12 Q. Do they reflect that they were there throughout  
13 both days of admission?

14 A. Yes.

15 Q. So is there anything about that record that  
16 would suggest that they would not be available if  
17 called upon?

18 A. No, there's nothing that suggests that. And,  
19 you know, if you call them and they say, no, I  
20 can't, I'm at work or what have you, then, you know,  
21 you tried. You're a nurse and you tried to do that.  
22 And then you would go to another intervention.

23 Q. Okay. Thank you. Anything else about  
24 assessments before we move to planning?

25 A. I think that's it.

1 Q. Okay. So tell us your opinions about this  
2 facility's failure to adequately care-plan for this  
3 patient.

4 A. If you look at Agape 315, I believe. Yes, 315.

5 Q. Okay. Tell us what this document is.

6 A. This is the care plan. This is the interim  
7 care plan. That's what they put in place when a  
8 resident is first admitted to the nursing home. You  
9 don't really have time to do a full care plan, but  
10 you want to assess for their immediate needs.

11 Q. Okay.

12 A. And they identified the at risk for falls  
13 related to history of falls, weakness, and the other  
14 reasons. And this is what drives the care; this is  
15 what says Ms. Shealy needs to be done; this is what  
16 we need to do with Ms. Shealy to keep her safe.

17 Q. Okay. So what about this did you find  
18 deficient?

19 A. It says: Resident will not have a fall with  
20 injury. While they did not meet their goal --

21 Q. Okay. Well, certainly, that goal was not  
22 satisfied, was it?

23 A. No.

24 Q. What else?

25 A. The fall risk score is -- it looks like there



1 is a 15 and then there's a 7 written over. You  
2 know, everyday life, we do that all the time where  
3 we write over, but in a medical chart, you are not  
4 allowed to do that. You have to draw a line through  
5 it, you write error, and put your initials, and then  
6 you would write what it is.

7 So they wrote over that, and you're not  
8 supposed to. If you look at -- above, how they  
9 crossed out the 17, that's how you're supposed to do  
10 it.

11 Q. And I'll represent to you that there's been  
12 open -- or testimony in this court by the nurse  
13 Javan Vaughn that she did not make that modification  
14 to the record and has no idea who did.

15 A. Okay.

16 Q. Does that concern you?

17 A. Yes. Yes.

18 Q. And is that why there's a standard on how  
19 you're supposed to document?

20 A. Yes.

21 Q. Okay. Anything else about this care plan that  
22 you find deficient?

23 A. Okay. Call bell in reach and answered  
24 promptly. If you look over all the way to the  
25 right, all these are checked off.

1 Q. Uh-huh.

2 A. Assess resident's risk for falls upon admit and  
3 PRN. You know, maybe they should add accurately  
4 assess to their care plan, because it was all over  
5 the place.

6 Q. And you've told us about that; correct?

7 A. Yes.

8 Q. You've got multiple criticisms about how they  
9 assessed patients, both upon admission and then  
10 subsequently as needed given changes in her  
11 condition are not -- not responding appropriately to  
12 medications?

13 A. Correct.

14 Q. All right.

15 A. And then monitor/document resident for risk  
16 behavior in compliance with education and  
17 interventions. And that's what we talked about with  
18 the interventions, what you do, for example, to keep  
19 them safe. And it says monitor/document. So --

20 Q. And we've seen deficiencies in both of those  
21 areas, including the fact that you've got a resident  
22 found on the floor who had been there for an unknown  
23 duration?

24 A. Correct.

25 Q. And then documentation, I think that speaks for

1       itself. I think the jury has had the benefit of  
2       those errors.

3       A.    Okay. And then medications as ordered, fall  
4       preventions as ordered --

5       Q.    And what fall preventions, if any, did you see  
6       that the nurses sought to have the doctor implement  
7       here?

8       A.    They had a star outside the door for the  
9       Falling Star program.

10      Q.    All right. And did this fall occur within this  
11      resident's room?

12      A.    No.

13      Q.    And there's been testimony by Ms. Vaughn that  
14      the only benefit of that program is that star placed  
15      on the placard on their door. So how does that help  
16      when residents -- are they always confined to their  
17      rooms?

18      A.    No.

19      Q.    And particularly with a new resident, who the  
20      staff would be unfamiliar with, would you agree that  
21      that would be a completely ineffective intervention?

22      A.    Correct. To just put a star outside the door,  
23      Ms. Shealy needed much more than that.

24      Q.    Okay. And then again, as far as the ordered  
25      preventions, did you see any evidence that a nurse

1       ever requested any sort of fall prevention  
2       intervention be ordered by a physician in this case?

3       A.    No.

4       Q.    And what are some of the examples of  
5       interventions that nurses have the discretion to  
6       either implement or request a doctor to put in an  
7       order for?

8       A.    Well, there's numerous interventions one can  
9       put in place to keep a patient safe, to prevent them  
10      from falling. And some of them don't require a  
11      physician's order. The nursing home staff could  
12      have talked with the physical therapist and/or the  
13      occupational therapist and discussed the condition.  
14      And maybe they did and they didn't document it and  
15      they didn't follow through.

16     Q.    Okay.

17     A.    But that's certainly one of the things that  
18      they could have done. They could have asked the  
19      doctor for an alarm.

20     Q.    Okay.

21     A.    A lot of facilities are going to  
22      restraint-free, which, in some instances, they  
23      consider an alarm on your chair could be a  
24      restraint. This -- according to everything I've  
25      read, this facility was not restraint-free.

1 Q. Sure. Actually, they had a policy, an Agape  
2 Senior restraint assessment, that was provided and  
3 afforded nursing staff the opportunity to utilize  
4 all these various restraints available to them.

5 A. Correct. And see on there, you can see the  
6 alarm is indicated, so, you know, in certain  
7 instances an alarm can be a restraint, but at the  
8 same time we want to keep the patient safe.

9 Q. Is that particularly true for a new patient  
10 with dementia who is disoriented, confused,  
11 combative, and on antianxiety medications?

12 A. Well, we want to keep everybody safe,  
13 obviously. But with Ms. Shealy's condition, she was  
14 placed in a higher fall risk category, so it was --  
15 she really had a good chance of falling without  
16 appropriate interventions. And so to not put in  
17 appropriate interventions is a failure and to have,  
18 you know, a star on the door -- I mean, really, what  
19 did they do for this patient?

20 They gave her some Ativan and then they didn't  
21 monitor her after. They had a star on her door.  
22 They placed her by the nurses station, but then she  
23 wandered off, they said. And then somehow she got  
24 up and she fell. So there was very little done to  
25 keep her safe.

1 Q. I know we've gotten off on your criticisms  
2 related to the specific interventions. Let's focus  
3 back on the care plan. Is there anything else, at  
4 least as it relates to the plan that this facility  
5 had in place, that you find that they were negligent  
6 over?

7 A. Here's another one they checked off: The  
8 monitor for the tolerance for the activity being  
9 done. And she was -- the activity she was doing,  
10 she was at the nurses station in the wheelchair, and  
11 she didn't tolerate it and she kind of wandered off  
12 in the wheelchair. So that wasn't done.

13 Bed in low position. There was some  
14 information that the bed was broken, so they  
15 couldn't put the bed in a low position. And I  
16 understand she fell in the hallway, but that was  
17 just another error. Educate resident and family of  
18 fall precautions, use of fall-prevention devices,  
19 risk and benefits of treatment. Well, the family  
20 wasn't given that opportunity because they weren't  
21 requested to come back in.

22 Q. Okay. And we know education in demented  
23 residents -- we've already heard from staff at the  
24 nursing home -- is ineffective because they can't  
25 comprehend or appreciate what -- one, they have no

1 safety awareness; two, they don't even understand  
2 what you're saying.

3 A. Correct. And, particularly, Ms. Shealy. It's  
4 charted she did not have any safety awareness.

5 Q. Anything else about the care plan, the interim  
6 care plan, or the plans of care, if any of those, in  
7 the record that you have criticisms of, or does that  
8 summarize your findings?

9 A. I'm sorry. Say that again.

10 Q. Sure. Is there anything else about the plan  
11 put into place by the nursing home that you are  
12 critical of?

13 A. No. That was it.

14 Q. Now, we've talked some, obviously, about  
15 interventions with respect to this patient. Do you  
16 hold the opinions -- well, I think you've already  
17 explained some of your opinions about failures to  
18 put in appropriate interventions. But do you have  
19 any others that you'd like to bring to the attention  
20 of this jury?

21 A. You mean other things they could have done to  
22 keep Ms. Shealy safe?

23 Q. Yes, ma'am.

24 A. Okay. Like I talked about, when the Ativan  
25 didn't work, call the doctor. And it's clearly an

1 order in their chart. They could have put a lap  
2 buddy -- they could have talked with the physical  
3 therapist or the occupational therapist and put a  
4 lap buddy, which is like kind of a soft pillow that  
5 forms and it clips into the wheelchair and it -- and  
6 Ms. Shealy also had a problem with sitting up.

7 There's some documentation about her posture  
8 when she was sitting up. So that would also help  
9 her sit up better, so they could have used that.  
10 And then if they put that in place and she doesn't  
11 like it -- you know, some patients take them and  
12 throw them across the floor -- well, then you try  
13 another intervention. That's what the whole nursing  
14 process is about. So that was an option they could  
15 have tried but they did not.

16 A safety belt. They could have tried a safety  
17 belt, which is really what it is. It's just like a  
18 little seatbelt while she's in the wheelchair just  
19 to remind her not to get up or if you see them  
20 trying to, you know, struggle to get up, you go to  
21 them and see what they need --

22 Q. And did we see an example of that safety belt  
23 in that training video with that gentleman in the  
24 wheelchair?

25 A. Yes. And it's also in the recommendations when



1       they did their safety meeting. It was one of the  
2       recommendations that they could try.

3       Q.     Okay.

4       A.     Again, the fact that this place was not a  
5       restraint-free facility. Increased monitoring. You  
6       know, well, how often? Well, that's up to the  
7       nurses' judgment. You have the resident in front of  
8       you. You know, if you think this resident is going  
9       to get up and fall -- I've seen nurses and I've done  
10      it myself where I take the resident around with me  
11      while I'm taking care of other patients and have  
12      them, you know, sitting right outside the room, you  
13      know, keeping an eye on them. You chart at the  
14      nurses station with the resident sitting right there  
15      in the wheelchair. I mean, you do whatever you can  
16      to keep the patient safe. You don't want them to  
17      fall, so increase monitoring.

18      Q.     Is there a rule or a nursing adage that relates  
19      to keeping residents in a line of sight who are at  
20      risk for falls? What does that mean, line of sight?

21      A.     You have your eyes on them.

22      Q.     And how is it -- what are ways that nursing  
23      staff can ensure that a resident remain in a line of  
24      sight, but at the same time still allow them to do  
25      their jobs?

1       A.    Well, like the -- what I just mentioned, you  
2       know, while you're charting at the nurses station or  
3       going around passing out your medicine.  You know, a  
4       lot nursing homes will have the nurses station here  
5       and it's -- a lot of times it's the same residents  
6       all the time in their certain place.  They're right  
7       there in front of you.

8       Q.    Okay.

9       A.    And, also, you don't let the patient --  
10      considering dignity and respect and privacy and  
11      what's going to make the resident happy.  But if a  
12      resident is a high fall risk, you would not want  
13      them back in their room by themselves.

14     Q.    Sure.  And are there other options as far as  
15     sort of communal settings and dayrooms and things  
16     like that that allow nurses to still do their job  
17     but keep their an eye on patients at risk for falls?

18     A.    Yes.

19     Q.    Tell us about that.

20     A.    Well, you know, bingo, various activities.  
21     They'll have performers come to the nursing home.  
22     They'll have socials -- little socials, they'll  
23     have, you know, a dance where, you know, the ones  
24     that are ambulatory that can get up and dance -- you  
25     know, just various activities.

1 Q. And those group activities, do they afford --  
2 they're not just for the entertainment of the  
3 residents; correct?

4 A. Correct.

5 Q. They actually afford nursing staff and aides an  
6 opportunity to keep their eye on residents in a  
7 group setting.

8 A. Correct. And then the ones who would be the  
9 high fall risk, you know, I've seen where the  
10 nursing assistant is sitting right there in the  
11 group with that person.

12 Q. Did you see any efforts here by this facility,  
13 other than moving her to the nursing station and  
14 then, at some point, allowing her to wander away or  
15 them themselves leaving, that suggest that the  
16 intervention that they attempted was effective?

17 A. It was not effective, no.

18 Q. Sure.

19 A. Some other things are a pommel cushion --

20 Q. What is that?

21 A. -- which is a special cushion to prevent the  
22 falls. It's a special cushion that goes in the  
23 wheelchair. It's a deep-seated cushion. So if I  
24 had one in my chair, it would be harder for me to  
25 get up. And so that's another -- that's a very

1 effective intervention, or it can be.

2 We talked about the group setting; we talked  
3 about calling the family; we talked about ongoing  
4 assessment. Educate the CNAs. And this was also in  
5 the information at the safety meeting that they had.  
6 You know, let the CNAs know, hey, we have a new  
7 person, they're a high fall risk, and give them all  
8 the details, accurate details, so that they can keep  
9 an eye on the patient and they know what to do.

10 Hipsters are just the hip pads so that if they  
11 do fall, it should soften the blow. Nonskid socks  
12 and shoes. That wasn't in the care plan and it  
13 should have been. And I believe that's -- there are  
14 more. There are numerous ones, but those are just  
15 some of the ones that I thought were specific to Ms.  
16 Shealy.

17 Q. Okay.

18 A. That could have been done and weren't.

19 Q. All right. And do you have any opinion as to  
20 whether or not, had appropriate interventions been  
21 taken, this fall could have been prevented?

22 A. Yes.

23 Q. And what is that?

24 A. In my opinion, it could have been prevented.

25 Q. And do you hold that opinion within a

1 reasonable degree of nursing certainty?

2 A. Yes.

3 Q. Now, ma'am, it's my understanding you also have  
4 criticisms related to the documentation at this  
5 facility. Is that correct?

6 A. Yes.

7 Q. And we've heard about some of those examples.  
8 Are there others where you find the recordkeeping of  
9 this nursing home to be in violation of the standard  
10 of care?

11 A. Yes.

12 Q. Tell us about those others, if we haven't  
13 talked about them yet.

14 A. Let's see. On the face sheet, it's Agape 1 --

15 Q. Okay. And this is of Exhibit 4 again.

16 A. -- up at the top. Admit: July 1st, 2014 at  
17 3:50 -- so about ten till 4:00 -- discharged at  
18 6:30 PM. So this -- so they discharged her and then  
19 she came back and fell and then she went back out  
20 again. So that's -- that doesn't make any sense.

21 Q. Now, ma'am, we've heard some attempt to  
22 explain -- and I'm sure we will hear some more  
23 attempt to explain -- how all these records are  
24 just -- why they're all wrong.

25 Is a facility -- I mean, do they have an

1 obligation to ensure that the records reflect the  
2 actual care provided?

3 A. Yes, they do. I know some of this might sound  
4 nit-picky, but this is a legal document. The chart  
5 should reflect the care that was provided. And  
6 there's a federal regulation that says that  
7 documents have to be accurate, reproducible, readily  
8 accessible, and it has to meet the -- that criteria.  
9 And this does not. And we're not just talking about  
10 one error; we're talking numerous errors in a very  
11 short time.

12 Q. Yeah. We're talking about one day; correct?

13 A. Correct.

14 Q. We've got multiple errors we've seen in the ER  
15 note. We've talked about the time entry at 3:22,  
16 four hours before the fall; the face sheet. The  
17 entry from the evening before at 11:30, tell us  
18 about that.

19 A. Is that it up there?

20 Q. Oh, no, ma'am. I'm sorry.

21 A. If you could, put it up.

22 Q. Sure. We've talked about some of the facts in  
23 this case and the reference to the family staying  
24 after midnight. What time is this note?

25 A. 11:30 PM.

1 Q. And, again, that's another example of the  
2 inconsistencies; correct?

3 A. Yes. They -- the family was there, the note  
4 says, until after midnight, and it's charted at  
5 11:30. And then it also has a different time for  
6 the Ativan on there. It says it was given at  
7 8:00 PM.

8 Q. Okay.

9 A. And I thought it was given at 5:30 or 5:25.

10 Q. This is from the night before.

11 A. Oh, yeah. Okay. I'm sorry. Yes.

12 Q. And then you've also talked about the note at  
13 8:07; correct?

14 A. Yes.

15 Q. Where everything looked good, but the resident  
16 had been discharged from the -- I mean, had the fall  
17 and had been discharged from the facility by that  
18 time.

19 A. That is correct.

20 Q. And, ma'am, I want you to assume that, apart  
21 from the testimony of Javan Vaughn, that Ebonie  
22 McDaniel expressed that she was very concerned about  
23 the information contained in those records. Having  
24 reviewed her deposition transcript, did you also see  
25 where she testified to that?

1 A. Yes.

2 Q. As it relates to the Ativan, have you reviewed  
3 the MAR?

4 A. Yes.

5 Q. And do you have any criticisms about whether  
6 appropriate documentation relates to that  
7 medication?

8 A. They charted that -- or they put in the record  
9 about the Ativan the night before, but they did not  
10 put in the medication administration record about  
11 the Ativan on July 2nd at 5:30, and it should have  
12 been there. I mean, that's very important. When  
13 you're passing out medications, you want the records  
14 to be accurate.

15 Q. And did you read the testimony of Ms. McDaniel  
16 acknowledging that her failure to document in the  
17 MAR that very powerful medication that, obviously,  
18 was impacting this patient's safety abilities was a  
19 breach in the standard of care?

20 A. Yes.

21 Q. And do you have any opinion as to whether or  
22 not these documentation errors in part contributed  
23 to the injuries that this patient suffered?

24 A. Probably not documenting the Ativan just by  
25 itself, but by not documenting it -- if she had



1        stayed there longer at the facility and then a nurse  
2        comes behind and sees, oh, well, she didn't have any  
3        of her stand-by Ativan, I'll give her a dose, and  
4        that should be caught when she goes to the narcotic  
5        log when she's signing out the Ativan; it should be  
6        caught. But, you know, it's possible that she --  
7        the nurse would overlook it, so then that could  
8        cause an error.

9                But in the whole -- in looking at this in a  
10       whole, not charting that Ativan by itself, because  
11       then she left the facility about three hours  
12       later --

13       Q.     Sure.

14       A.     -- is not -- I don't think that solely  
15       contributed to the harm. But all these errors  
16       contributed.

17       Q.     Do all these errors related to assessment, to  
18       interventions, to planning, do they help form any  
19       opinion that you might have about whether or not  
20       these nurses and aides were properly trained?

21       A.     It seems like they weren't because the way they  
22       charted, the way they put entries in the charts,  
23       scratched through, wrote over, that was not how  
24       we're taught in nursing school; you know, the  
25       failure with the nursing process, you know, it just

1 appeared to me that they were not properly trained,  
2 or if they were trained, they just didn't do it.

3 Q. So either they were callus to the consequences  
4 of this patient's rights or just simply not  
5 appropriately trained?

6 A. Correct.

7 Q. And do you hold that opinion within a  
8 reasonable degree of nursing certainty?

9 A. Yes.

10 Q. And is it your opinion that as a consequence of  
11 that failure to appropriately train this staff, that  
12 Ms. Shealy suffered harm?

13 A. Yes.

14 Q. Now shifting gears, ma'am, describe to the jury  
15 what an avoidable fall is versus an unavoidable  
16 fall.

17 A. An avoidable fall would be one that reasonable  
18 measures are not put in place. And then, you know,  
19 if you don't give the person the opportunity to  
20 avoid it and then the fall happens, well, that was  
21 avoidable.

22 Unavoidable is when you have reasonable  
23 measures put in place and they fall anyway. So you  
24 try, you -- and we have to do more than just try.  
25 Like I said, we have to do this nursing process;

1       it's ongoing. But that would be the difference  
2       between avoidable and unavoidable.

3       Q.    And what's required by law, as it relates to  
4       documenting measures in place, before you can define  
5       an event as an unavoidable injury?

6       A.    Well, you have to have the documented  
7       interventions in place.

8       Q.    And in this case, do you have any opinion as to  
9       whether or not this fall was avoidable or  
10      unavoidable?

11      A.    I do have an opinion, yes.

12      Q.    And what is that?

13      A.    It was avoidable.

14      Q.    Now, ma'am, let's turn to the -- I'd like to  
15      shift gears and focus on the policies and procedures  
16      for a moment. The jury has not had the benefit of  
17      these, so I'd like to go through some of them with  
18      you and get your opinions.

19            The first is -- these are Joint Exhibit 20.  
20      Okay? First, let's look at 20B which relates to the  
21      admission of the facility. And, again, this is 20B  
22      and it's a policy related to admissions of the  
23      facility. And, ma'am, if you could read for me,  
24      what is the policy of this facility related to  
25      admissions?

1       A.    Our facility will admit only those residents  
2       whose medical and nursing care needs can be met.

3       Q.    And you reviewed this policy in forming your  
4       opinions?

5       A.    Yes.

6       Q.    And do you have an opinion as to whether or not  
7       this policy was breached?

8       A.    Oh, wait. I need to correct my statement. I  
9       was supplied these after my affidavit and my  
10      deposition. I was given the policies and procedures  
11      after, so they supported my opinions.

12      Q.    Okay. And do you have an opinion as to whether  
13      or not this policy was breached?

14      A.    Yes, it was breached.

15      Q.    Okay. Thank you.

16            Okay. Next let's look at the policy 20E  
17      relating to the facility care plans. And this is  
18      their preliminary care plan like the one that we've  
19      already looked at. Okay? This is 20E. And, ma'am,  
20      this policy requires that a preliminary plan of care  
21      to meet the resident's immediate needs shall be  
22      developed for each resident within 24 hours of  
23      admission. Ma'am, have you reviewed this policy in  
24      forming your opinions today?

25      A.    Yes.

1 Q. And do you have any opinion as to whether or  
2 not that policy was satisfied?

3 A. It did not. They did have a care plan, but it  
4 wasn't the one they needed to meet the resident's  
5 immediate needs.

6 Q. Yes, ma'am. Thank you.

7 All right. The next policy I want to look at  
8 is the facility's policy on charting. It's 20G.  
9 And you've reviewed this policy prior to testifying  
10 today; correct?

11 A. Yes.

12 Q. This policy reads: All services provided to  
13 the resident or changes in the resident's medical or  
14 mental condition shall be documented in the  
15 resident's medical record. Have I read that  
16 properly?

17 A. Yes.

18 Q. And do you have an opinion as to whether or not  
19 this policy was breached or violated by the  
20 defendants in this case?

21 A. Yes, it was breached.

22 Q. Now looking down at number 2, it indicates that  
23 entries may only be recorded in the resident's  
24 clinical record by licensed professionals and that  
25 they must be done in accordance with state and

1 federal policy.

2 Do you have any opinion as to whether or not  
3 that provision of this policy was breached?

4 A. Well, yes. It appears that other people  
5 were -- went back in the chart and changed entries.

6 Q. Okay. And, in addition, I think you already  
7 testified that the records did not comply with state  
8 and federal laws relating to documentation; is  
9 that correct?

10 A. Correct.

11 Q. Number 5 indicates that -- I'm sorry. Number  
12 1, I skipped: All observations, medication  
13 administrations, services must be documented in the  
14 resident's clinical record. Do we have any  
15 indication that there were a host of -- there's been  
16 testimony that toileting episodes that were provided  
17 by staff weren't documented.

18 Do you have any opinion as to whether or not  
19 this policy would require that those, as services  
20 provided by the facility, be documented in the  
21 resident's records?

22 A. Yes. The toileting is an activity of daily  
23 living and that should be in the chart.

24 Q. Okay. Number 6 identifies documentation of  
25 procedures and treatments with care-specific details

1       that include date and time the procedure was  
2       provided, the name and title of who provided the  
3       care, an assessment of any unusual findings obtained  
4       during the procedure, how the treatment was  
5       tolerated, whether the resident refused, whether  
6       there was physician, family, or staff notification,  
7       and the signature of the individual documenting.

8               Is it fair to assume, based off the testimony  
9       that you've previously given, that you also contend  
10      that provision was violated?

11     A.    Yes.  There were a lot of omissions; entries  
12     weren't made properly; there wasn't follow-up.  Yes.

13     Q.    And just for the jury's benefit, because they  
14     will have these regulations available for them to  
15     review, each one of these policies references  
16     various provisions of the federal law that the  
17     facility is required to comply with that go directly  
18     with these policies.  And y'all will be able to  
19     correlate those with the policies to make your own  
20     determination.

21            Next let's look at Exhibit 20H regarding  
22     charting errors or omissions.  This policy requires  
23     accurate medical records being maintained by the  
24     facility.  Do you see that?

25     A.    Yes.

1 Q. And, in your opinion, was that policy breached?

2 A. Yes.

3 Q. The next deals with administering medications,  
4 20I. This policy requires that medication shall be  
5 administered in a safe and timely manner and as  
6 prescribed. Reading further, under section 12,  
7 which is on the second page, it reads: The  
8 individual administering the medication must initial  
9 the resident MAR on an appropriate line after giving  
10 each medication and before administering the next.

11 Number 15 indicates that if a drug is withheld,  
12 refused, or given at a time other than scheduled,  
13 the individual administering the medication shall  
14 initial it and circle the MAR space provided for the  
15 drug and dose.

16 Number 16 says: As required for or indicated  
17 for a medication, the individual administering the  
18 medication will record in the resident's medical  
19 record the date and time it was administered, the  
20 dosage, the route, the injection site, if  
21 applicable, any complaints or symptoms, the achieved  
22 result, and the signature.

23 Ma'am, you've reviewed this policy; correct?

24 A. Yes.

25 Q. And, in your opinion, given the conduct of the



1 defendants at issue in this case, do you contend  
2 this policy has been violated?

3 A. Yes, it was violated. And that talks about  
4 like with the -- the MAR, which is the medication  
5 administration record, where they did not write down  
6 that they gave the Ativan, and they should have.

7 Q. Okay. Let's look at 20J which deals  
8 specifically with the medication administration.  
9 Again, this is the policy of the facility. It says:  
10 The facility shall maintain a medication record to  
11 document all medications administered. Have I read  
12 that appropriately?

13 A. Yes.

14 Q. And it says: Administration of medication must  
15 be documented immediately after it is given. Have I  
16 read that correctly?

17 A. Yes.

18 Q. And, in your opinion, that policy was breached?

19 A. Yes. It wasn't documented at all, that one  
20 dose. Yes.

21 Q. And she only got two doses the entire time she  
22 was there; correct?

23 A. Correct.

24 Q. So half the time, they failed to follow policy?

25 A. Correct.

1 Q. Now, ma'am, let's look at 20K, the facility's  
2 PRN orders. This policy requires that PRN orders  
3 shall be given as little as possible and they must  
4 clarify the circumstances for offering or giving the  
5 medication. Have I read that appropriately?

6 A. Yes.

7 Q. When PRN orders are implemented, nursing staff  
8 must monitor the use of such medication including  
9 the following: The nature and the problem and  
10 whether it persists, whether additional evaluation  
11 is needed, and whether the medication can be  
12 discontinued entirely because the problem has  
13 resolved. Ma'am, do you have any opinion as to  
14 whether or not this policy was violated?

15 A. Yes, it was violated.

16 Q. Next is the facility's accident and incident  
17 policy, which is 20M. Our facility shall provide a  
18 safe and secure environment for staff and its  
19 residents. Therefore, all incidents occurring at  
20 the facility or premises of the facility while  
21 performing their job shall be reported. Ma'am, did  
22 this facility provide a safe and secure environment  
23 for this resident?

24 A. No.

25 Q. Consequently, is it your opinion that this

1 policy was violated?

2 A. Yes.

3 Q. Next is the nursing services policy, procedure,  
4 and manual, 20-O. This policy states: Services  
5 provided to residents will be performed in  
6 accordance with current applicable standards of  
7 clinical practice. Ma'am, in your opinion, was that  
8 policy breached?

9 A. Yes, it was breached.

10 Q. Okay. The next is the staffing policy; it's  
11 20P. This policy requires our facility provide  
12 adequate staff to meet the needed care and services  
13 of our resident population. Our facility maintains  
14 adequate staffing on each shift to ensure that our  
15 residents' needs and services are met. Licensed  
16 registered nurses and licensed nursing staff are  
17 available to provide and monitor the delivery of  
18 resident care and services.

19 Ma'am, in your opinion, were those policies met  
20 in this case?

21 A. In my opinion, they were not met.

22 Q. The next is resident rights, 20T. Employees  
23 shall treat all residents with kindness, respect,  
24 and dignity.

25 Do you have any opinion as to whether or not

1 Ms. Shealy received -- or had her dignity violated  
2 in this case?

3 A. In my opinion, her dignity was violated.

4 Q. And would that breach this resident's rights  
5 provision?

6 A. Yes.

7 Q. Next is on safety and supervision, 20V. The  
8 policy reads: Our facility strives to make the  
9 environment as free from accident hazards as  
10 possible. Residents' safety and supervision and  
11 assistance to prevent accidents are facility-wide  
12 priorities.

13 Ma'am, do you have any opinion as to whether or  
14 not this policy was breached?

15 A. Yes, it was breached.

16 Q. Under this resident-oriented approach to  
17 safety, you see this notation: Our  
18 resident-oriented approach to safety addresses  
19 safety and accident hazards for individual  
20 residents. Do you believe that happened in this  
21 case?

22 A. No.

23 Q. Do you believe this patient's safety in  
24 accident hazards were met?

25 A. No, they were not met.

1 Q. Staff shall use various sources to identify  
2 risk factors for residents including the information  
3 obtained from the medical history, physical exam,  
4 observation of the resident, and the MDS. You've  
5 already talked about criticisms related to their  
6 assessment of this patient; correct?

7 A. That is correct.

8 Q. Our interdisciplinary care team shall analyze  
9 information obtained from assessments and  
10 observations to identify specific accident hazards  
11 or risks for the resident and the care team shall  
12 target interventions to reduce potentials for  
13 accidents.

14 Let me ask you about that. In that safety  
15 meeting that Ms. Henderson conducted and the  
16 materials that were provided to the resident, there  
17 was this new safety committee assessment form that  
18 they indicated would be, at least in their facility  
19 where she was forwarding this information from for  
20 consideration here, an assessment of every patient  
21 within 24 hours of their stay to determine what  
22 specific individualized needs that patient may have  
23 to keep them safe.

24 This is an Agape Senior document available to  
25 the defendants in this particular instance. Did you

1 see any such form in this patient's chart?

2 A. No.

3 Q. Next policy is 20Y, the facility's managing  
4 falls and fall risk policy. This policy indicates:  
5 Based on previous evaluations, current data, the  
6 staff will identify interventions related to the  
7 resident's specific risks and causes, try to prevent  
8 the resident from falling, and try to minimize  
9 complications from falling.

10 Ma'am, did you see any evidence that that  
11 occurred in this case to the point required by this  
12 policy?

13 A. It did not occur.

14 Q. Next is the policy on assessing falls and their  
15 causes. This is 28A and, I know the jury will be  
16 glad to hear, the last one. This policy requires  
17 that -- it offers guidelines for assessing a  
18 resident after a fall and to assist staff in  
19 identifying the cause of the fall. And if you look  
20 under the section preparation, if I can find it, it  
21 indicates that the review of the resident's care  
22 plan to assess any special needs of the resident,  
23 identify the resident's current medication, active  
24 medications, assemble equipment and supplies as  
25 needed.

1           Again, we've talked about this, but under  
2           general guidelines, this facility has identified the  
3           heightened risk of falls including the risk of death  
4           and that many residents fall -- they must be  
5           assessed in a timely manner for potential causes of  
6           falls, and environmental issues should be addressed  
7           properly.

8           Are these things that put the facility on  
9           notice of the hazards associated with falls, in  
10          addition to the other various training documents  
11          that you've seen?

12         A.    Correct. That should have put them on notice.

13         Q.    Next, having reviewed all of those policies,  
14         ma'am, do you have an opinion as to whether or not,  
15         when you look at them as a whole -- the nature of  
16         the defendant's conduct, how would you describe it?

17         A.    Reckless. It goes beyond careless. Reckless,  
18         not being concerned for the patient's well-being,  
19         egregious.

20         Q.    Have you seen -- have -- one-day admission, to  
21         have that many violations, is that something that  
22         factors into your opinion that this case is reckless  
23         or outrageous?

24         A.    To have that many problems with the chart, to  
25         happen in such a short amount of time, and the lack

1 of intervention provided to Ms. Shealy, the whole  
2 notion that they should have known what would have  
3 happened, if they don't put reasonable measures in  
4 place to keep her safe, all of that makes it  
5 egregious, reckless.

6 Q. Now, ma'am, I'd like to turn now to the  
7 applicable federal regulations that you have  
8 indicated and that all of the witnesses so far have  
9 indicated are applicable to this particular  
10 facility. And I'm going to ask you about some  
11 specific provisions. The first that I want to talk  
12 about, and most importantly that we'll go through as  
13 far as displaying on the screen, are those  
14 regulations that pertain to federal rules. There  
15 are also corresponding state rules, and I'll make  
16 reference to those, but I'm not going to display  
17 them, just for the interest of time.

18 So, ma'am, if you could, just describe  
19 generally what the OBRA regulations are and how they  
20 apply in nursing home settings.

21 A. All right. These were created in the 1980s by  
22 the government. It was a way for the government to  
23 have the care provided in skilled nursing facilities  
24 regulated. Since the government pays with the  
25 Medicare, Medicaid, then any facility that accepts



1 Medicare or Medicaid dollars has to abide by these  
2 regulations. And it's an attempt to improve the  
3 care in nursing homes or skilled nursing facilities.

4 Q. And is it your understanding that these rules  
5 and regulations are in place in part to ensure the  
6 safety and well-being of the residents who are  
7 within these skilled nursing facilities?

8 A. Correct.

9 Q. And, ma'am, just for the jury's benefit, what  
10 is the federal agency that regulates nursing homes  
11 that do accept those federal funds?

12 A. CMS.

13 Q. Sure. And does South Carolina have a similar  
14 set of regulations that also applies to nursing  
15 homes?

16 A. Yes.

17 Q. And those have been marked as Joint Exhibit 32,  
18 for the jury's benefit as well, and those are the  
19 DHEC regulation 61-17, standards for licensed  
20 nursing homes.

21 And I do want to ask you about some of these  
22 specific provisions starting with 42 CFR 483.18.  
23 Now, ma'am, this statute defines abuse, does it not?

24 A. Yes.

25 Q. And per the statute, the resident has the right

1 to be free from verbal, sexual, physical, and mental  
2 abuse, as well as corporal punishment and  
3 involuntary seclusion.

4 A. Correct.

5 Q. Have I read that appropriately?

6 A. Yes.

7 Q. Both this statute as well as the corresponding  
8 state statutes also define neglect; are you aware of  
9 that?

10 A. Yes.

11 Q. For example, in the DHEC regulations at  
12 61-17-101, neglect is defined as the failure or  
13 omission of a direct-care staff member or  
14 direct-care volunteer to provide the care, goods, or  
15 services necessary to maintain the health and safety  
16 of a resident, including but not limited to food,  
17 clothing, medicine, shelter, supervision, and  
18 medical services. It may be repeated conduct or a  
19 single incident that has produced or could result in  
20 a physical or psychological harm or substantial risk  
21 of death. And noncompliance alone with the  
22 standards has not been defined to constitute  
23 neglect; it requires -- the reason why you're here  
24 today -- professional expert testimony.

25 Let me ask you this, ma'am: Again, this is

1 just an example of how many of these things mirror.  
2 I'm not going to go through and highlight every  
3 single one of them. But both the federal  
4 regulations as well as the state regulations  
5 prohibit abuse and neglect in nursing homes;  
6 correct?

7 A. Yes.

8 Q. And, in your opinion, understanding the  
9 definition of abuse and neglect, do you believe that  
10 this resident was either abused or neglected?

11 A. Yes.

12 Q. Now, 42 CFR 483.15(a) requires that a nursing  
13 home preserve residents' dignity; correct?

14 A. Correct.

15 Q. And do you have an opinion as to whether or not  
16 this resident's dignity was preserved, as required  
17 by the statute?

18 A. Yes, I have an opinion. It was not preserved.

19 Q. Now I'll represent there's a similar statute,  
20 South Carolina regulation 67-100-1(c) that requires  
21 that treatment and services be rendered in a caring  
22 and humane manner and effectively and safely in  
23 accordance with orders from a physician or other  
24 legally authorized healthcare provider.

25 In your opinion, would that corresponding

1 provision also have been violated?

2 A. Yes.

3 Q. 42 CFR 483.15(h) requires that the facility  
4 provide a clean, safe, and comfortable, and homelike  
5 environment allowing a resident to use his or her  
6 personal belongings to the extent possible. In your  
7 opinion here, was Ms. Shealy provided a safe  
8 environment?

9 A. No.

10 Q. 43 CFR 483.20 requires an appropriate  
11 assessment; correct?

12 A. Yes.

13 Q. And that assessment triggers the need for a  
14 care plan; correct?

15 A. Correct.

16 Q. And given your testimony already, do you have  
17 any opinion -- at least as far as the basis for your  
18 opinion, do you have any opinions as to whether or  
19 not this federal provision was also violated?

20 A. Yes. It was violated.

21 Q. Okay. Section 20(g) requires, does it not,  
22 that assessments must accurately reflect the  
23 resident's status; correct?

24 A. Yes.

25 Q. We've heard some attempts by the defendant to

1 say, so what, we got the number wrong, but the  
2 ultimate number shows she was at risk for falls.

3 Ma'am, do the details matter?

4 A. Yes.

5 Q. And do the federal regulations require that  
6 they be accurate?

7 A. Yes.

8 Q. Do you have an opinion as to whether or not, as  
9 it relates to the assessments in this case, whether  
10 that provision of federal government and any  
11 corresponding state statute also requiring  
12 appropriate assessments was violated?

13 A. Yes. It was violated.

14 Q. Now, 483.25 covers quality of care. That's a  
15 regulation that you're very familiar with; correct?

16 A. Yes.

17 Q. For example, 25483 -- I'm sorry. 43 CFR 483.25  
18 requires that the facility must ensure that the  
19 resident's abilities and his and her activities of  
20 daily living not diminish unless the circumstances  
21 of the resident's clinical condition demonstrate  
22 that the decline was unavoidable.

23 Do you have any opinion as to whether or not  
24 that provision of federal law, particularly (a)(1),  
25 was violated?

1 A. Yes, it was violated.

2 Q. Now I'll represent that there's a corresponding  
3 South Carolina regulation 67-17-011 -- 1001(g) that  
4 requires that the provision of care and treatment  
5 services be rendered at resident's center and  
6 resident-directed to the fullest extent possible.

7 Do you have any opinion as to whether, in this  
8 particular case, Ms. Shealy's care was  
9 resident-centered such that that statute would have  
10 been satisfied?

11 A. It was not satisfied.

12 Q. Now, 42 483.25(f) requires, based upon a  
13 comprehensive assessment of the resident, that the  
14 facility must ensure that a resident who displays  
15 mental or psychological adjustments or difficulties  
16 receive appropriate treatment to correct the  
17 assessed problem.

18 Do you have any opinion as to whether or not  
19 this patient received the appropriate support and  
20 treatments to ensure that her mental and  
21 psychological status be maintained?

22 A. I have an opinion, and they did not follow that  
23 guideline.

24 Q. And when you say guideline, these are actually  
25 federal mandates; correct? /

1 A. Correct.

2 Q. They are minimum standards that the facility  
3 must comply with or they're subject to a host of  
4 different penalties; correct?

5 A. Correct.

6 Q. And, ma'am, you've reviewed the survey history  
7 of this facility?

8 A. Yes.

9 Q. And you know that prior to this incident, this  
10 facility had been repeatedly violated for many of  
11 these same violations that you find in this case;  
12 correct?

13 A. Correct.

14 Q. Now, (h) deals specifically with accidents.  
15 This provision requires, does it not, that the  
16 facility ensure that the resident's environment  
17 remain as hazard-free as possible and that each  
18 resident receive adequate supervision as well as  
19 assistance devices to prevent accidents.

20 A. Pardon me?

21 Q. You're familiar with that provision?

22 A. Yes.

23 Q. And do you have any opinion as to whether or  
24 not that provision of federal law and the  
25 corresponding state requirements was satisfied?

1 A. It was not satisfied.

2 Q. All right. Just another example of a South  
3 Carolina reg that I'd like to bring to the attention  
4 of the jury, South Carolina reg 67-17-1303. And,  
5 again, just a couple examples, the state  
6 regulations, like the federal, have requirements  
7 specific to both medication orders as well as  
8 administering medication; correct?

9 A. Correct.

10 Q. And under this provision, for example, 1303,  
11 under administration of medications, this act  
12 requires, does it not, that medication be  
13 administered in accordance with state practice acts  
14 and shall include, but not be limited to, properly  
15 recording on the MAR -- excuse me. Promptly  
16 recording on the MAR as it's administered, the date,  
17 time, dose given, mode of administration, and  
18 identification of the person administering the  
19 medication.

20 A. They should have followed that and they did  
21 not.

22 Q. And is that consistent with the standard of  
23 care as well?

24 A. Well, that helps to define the standard of  
25 care, and they were not consistent with the standard



1 of care.

2 Q. Sure. Now, ma'am, 42 CFR 483.30 has to do with  
3 nursing services. You're familiar with that  
4 provision?

5 A. Yes.

6 Q. And this provision of federal law requires that  
7 the facility must have sufficient nursing staff to  
8 provide nursing-related services to attain or  
9 maintain the highest practical physical, mental, and  
10 psychosocial well-being of each resident as  
11 determined by their assessment and plan of care.

12 Ma'am, do you have any opinion as to whether or  
13 not this facility provided sufficient nursing,  
14 whether it be in competency or number, to meet this  
15 requirement?

16 A. Yes, I have an opinion, and they did not.

17 Q. Now, this number is not just -- this provision  
18 does not just say you need a specific number of  
19 nursing staff; correct?

20 A. Correct.

21 Q. It requires sufficiency both in number as well  
22 as in competency; correct?

23 A. Correct.

24 Q. And it doesn't matter how many nurses you have,  
25 if they're not competent to get the job done and

1 provide care -- appropriate care for your patients,  
2 that's a violation of the statute; correct?

3 A. Correct.

4 Q. And, in your opinion, was that violated here?

5 A. Yes. In my opinion, it was violated.

6 Q. South Carolina has a similar requirement,  
7 section 600, again, of Exhibit 32, on staff and  
8 training. And this also requires that appropriate  
9 staff members in numbers and training shall be  
10 provided to perform those duties that result in  
11 compliance with regulations to suit the needs and  
12 conditions of the resident; correct?

13 A. Yes.

14 Q. And to meet the demands of the facility as they  
15 may arise; correct?

16 A. Correct.

17 Q. In your opinion, was this provision of South  
18 Carolina law violated in this particular case?

19 A. Yes, it was violated.

20 Q. And have we seen evidence of untrained staff  
21 over and over and over again in this chart?

22 A. Yes.

23 Q. 604 requires direct-care staff provide nursing  
24 and nursing-related services to attain and maintain  
25 the highest practical physical, mental, and

1 psychosocial health of the resident. That would be  
2 consistent with the federal law; correct?

3 A. Correct.

4 Q. And you've already told us that, in your  
5 opinion, that was violated. So is it fair, I don't  
6 want to assume, but that you, too, would hold that  
7 opinion as to this provision as well?

8 A. Correct.

9 Q. 607 deals specifically with training and what's  
10 required, including that the staff members receive  
11 and be provided the necessary training to perform  
12 their duties for which they're responsible. In your  
13 opinion, was that provision violated?

14 A. Yes.

15 Q. Now, ma'am, 42 CFR 483 addresses the  
16 administration of the facility. Are you familiar  
17 with that provision?

18 A. Yes.

19 Q. And that provision requires that a facility  
20 must be administered in a manner that enables its  
21 use and resources effectively and efficiently to  
22 attain and maintain the highest practical, physical,  
23 mental, and psychosocial well-being of each  
24 resident.

25 Now, ma'am, often, facilities will contract

1 with a management company; correct?

2 A. Correct.

3 Q. But their obligation to administer the facility  
4 in a fashion that is in accordance with this rule  
5 does not -- is not skirted when they do that, is it?

6 A. Correct, it is not.

7 Q. They're still required to meet them?

8 A. Correct.

9 Q. And, in your opinion, based off what you've  
10 seen in this case, was this facility administered in  
11 a fashion that maintained and attained the highest  
12 practical social, physical, mental, and psychosocial  
13 well-being of Ms. Shealy?

14 A. It was not.

15 Q. And, in your opinion, having reviewed the  
16 surveys on this case, as well as the quality  
17 five-star information available about this facility,  
18 does this appear to be a systemic problem at this  
19 facility during and around the period of Ms.  
20 Shealy's residence?

21 A. Yes.

22 Q. So it impacted multiple residents; correct?

23 A. Yes. Given that they had a one-star and given  
24 the survey results, then, yes, it would impact more  
25 than just Ms. Shealy.

1 Q. Now, South Carolina regulation 801 -- 67-17-801  
2 requires set standards for resident records;  
3 correct?

4 A. Yes.

5 Q. And how those are being -- to be maintained in  
6 a legible and complete and authenticable way, dated  
7 promptly by the individual identified by name, and  
8 et cetera. It's -- I'm going to let the jury read  
9 this, of course. But there's pages and pages  
10 related to how resident records are to be  
11 maintained; correct?

12 A. Correct.

13 Q. And there's corresponding federal rules that  
14 also require, as you've already mentioned,  
15 documentation be maintained within a facility;  
16 correct?

17 A. Correct.

18 Q. In your opinion -- or do you have an opinion as  
19 to whether or not those various provisions that  
20 relate to documentation were violated in this  
21 particular case?

22 A. Yes, they were violated.

23 Q. Now, in addition to those both state and  
24 federal rules that relate to the oversight of  
25 nursing homes by the state and federal regulators,

1 South Carolina also has a bill of rights for  
2 residents of long-term care facilities; correct?

3 A. Yes.

4 Q. And this is common in many states, including  
5 Georgia; right?

6 A. Yes.

7 Q. And you've seen it in many of the other states  
8 where you've provided expert services as well;  
9 correct?

10 A. Correct.

11 Q. And facilities also, like this one we've  
12 already looked at, have policies that are supposed  
13 to enforce these rights as well; correct?

14 A. That is correct.

15 Q. And you've reviewed this prior to today; fair?

16 A. Yes.

17 Q. And rather than going through all of this, do  
18 you have any opinion as to whether or not this  
19 patient's rights were violated in any fashion?

20 A. Yes, they were violated.

21 Q. Would that include the provision of ensuring  
22 that a resident be free from mental and physical  
23 abuse?

24 A. Correct.

25 Q. That each resident receive -- must be treated

1 with respect and dignity and ensured privacy during  
2 treatment and when receiving personal care?

3 A. Correct.

4 Q. Lastly, ma'am, as it relates to these  
5 regulations, the bill of rights is Joint 30. South  
6 Carolina has an adult protection -- or a Nurse  
7 Practice Act. Are you familiar with that?

8 A. Yes.

9 Q. And this is Joint Exhibit 31. And this sets  
10 forth the standards of practice required for nurses,  
11 correct, the Nurse Practice Act?

12 A. Correct, yes, for nurses.

13 Q. And included in here is the nursing process.  
14 The various steps have been codified in law,  
15 including developing -- or following these different  
16 steps, appropriate assessments, diagnoses, plans,  
17 intervene, and evaluate?

18 A. Correct.

19 Q. And, again, these are laws that are very common  
20 in a multitude of states; correct?

21 A. Correct.

22 Q. And you've reviewed this as well as those in  
23 the past and you're required to conform your  
24 behavior as a practicing nurse consistent with the  
25 standards for nurses in your particular -- where you

1 practice; correct?

2 A. Correct.

3 Q. And rather than go through this, do you have an  
4 opinion as to whether or not provisions of this  
5 Nurse Practice Act relating to appropriate  
6 assessments, diagnoses, planning, and interventions,  
7 as well as documentation were met in this case?

8 A. They were not met.

9 Q. Ma'am, based upon your specialized knowledge,  
10 education, experience, and review of all of the  
11 evidence that's been available to you to the acts or  
12 omissions and violations of state law on the part of  
13 Agape and those responsible for its operation cause  
14 Ms. Shealy injury, pain, and physical and mental  
15 decline?

16 A. Yes.

17 Q. And do you hold that opinion within a  
18 reasonable degree of nursing certainty?

19 A. Yes.

20 Q. And apart from those violations of the standard  
21 of care, coupled with these violations of both  
22 policies as well as federal law, how would you  
23 characterize the conduct of Agape Nursing Home in  
24 its one day of treating this patient?

25 A. Way below the standard of care. I mean, the



1 things that Ms. Shealy needed were basic things.  
2 That's what she needed was basic care, and it wasn't  
3 provided. It's egregious and reckless.

4 Q. That's all the questions I have, ma'am. Thank  
5 you for your time.

6 THE COURT: Cross-examination?

7 MR. BLAKE: Your Honor, would it make sense so  
8 I can take five minutes to get the documents ready  
9 at the stand? I have some I'll need to show, and I  
10 don't want to have some of the problems we had  
11 yesterday with documents getting out of order. I'm  
12 going to have to pull quite a few out of that Joint  
13 Exhibit box.

14 THE COURT: All right. Real quick -- approach  
15 real quick, please.

16 (Sidebar conference.)

17 THE COURT: Ladies and gentlemen, we're going  
18 to take a very short break here to allow counsel to  
19 set up. We'll have you go back to your jury room  
20 for a very short break and we'll get you back out  
21 here as soon as possible. Please don't discuss the  
22 case. Thank you.

23 (The jury exits the courtroom at 12:02 PM.)

24 THE COURT: We're going to go ahead and do  
25 lunch at this time, but we have a few things to note

1       for the record. We just had a bench conference  
2       where we discussed some objections regarding  
3       cross-examination.

4             In fact, Mr. Blake, I'll let you go ahead and  
5       let you just say what you perceive are the things  
6       you discussed; that way Mr. Connor can hear you say  
7       it and not me.

8             MR. BLAKE: Thank you, Your Honor. What we  
9       discussed -- I raised a concern on the record that  
10      we tried to work pretrial to balance the need to go  
11      into the Lexington Extended Care record itself. The  
12      discussion was if the door got open through this  
13      expert as it relates to causation and damages, we  
14      would re-evaluate.

15            We had another bench conference to re-evaluate  
16      where we were before cross began, and I raised my  
17      concern that based on the narrative description of  
18      the course of pain and suffering and sort of the  
19      life outcome that Ms. Shealy suffered following July  
20      2nd, that it sounded to me like testimony that the  
21      jury is going to interpret as saying because she  
22      fell at our facility on July 2nd, then she was  
23      unable to participate in therapy, trapped in  
24      Lexington Medical Extended Medical Care where her  
25      life was terrible, then she died three years or so

1 later.

2 What I was proposing to do was, one, address  
3 the hospital records that follow the fall and the  
4 ortho records on -- hospital records in particular  
5 that I'm concerned about are the ones that are  
6 immediately after the fall, such as the ER note, and  
7 then I'd like to go to the ortho records including  
8 an entry -- it's either from Dedmond or La Posta on  
9 the 8th, which talk about her improvement.

10 And then I talked about then going to the fact  
11 she had a fall on the 12th, which would be in the  
12 extended care records, and then talking about  
13 Dedmond's records where he says, I'm saying she  
14 needs therapy, Medicare is ignoring it, and then a  
15 subsequent record where Dedmond says, if they don't  
16 grant this lady her therapy, she's going to end up  
17 wheelchairbound and then -- and then basically show  
18 that there's some type of intervening causation in  
19 the course of debilitation that she had following  
20 the fall.

21 What I understand Your Honor is willing to be  
22 is that I'm not going to the Lexington Medical  
23 Center Extended Care records and I am able to go  
24 into the ortho records and the hospital records for  
25 which they're seeking economic damages. So that

1 would include the hospital records immediately  
2 following the fall, July 2nd, July 3rd, those  
3 records, and the ortho records and Dr. Dedmond's  
4 records.

5 THE COURT: Okay.

6 MR. MCALISTER: The ortho records are different  
7 than Dr. Dedmond's.

8 MR. CONNOR: Plaintiff vehemently objects to,  
9 one, any reference to any subsequent fall as it has  
10 no relevance whatsoever to any issue in this case.  
11 Subsequent malpractice, if any, is required to be  
12 proven by professional negligence. The defendants  
13 have no expert to offer any causal link between any  
14 malpractice that may have happened subsequently that  
15 caused any injury or contributed to any injury  
16 suffered by this patient.

17 If his intention is to talk about any  
18 subsequent falls whether in any of those records  
19 that he's describing, we vehemently object. We  
20 think they're unduly prejudicial. They have no  
21 relevance to the issues at hand.

22 The fact that this woman suffered a decline  
23 post-hip fracture is well within the ambit of their  
24 knowledge. That's what their own literature, their  
25 training, and their policy say happens. And we've

1 not made a claim for the hundreds of thousands of  
2 dollars of bills that were incurred after she left  
3 this facility, although we believe we have a right  
4 to do that if they at all open the door to these  
5 issues.

6 And we would seek to do that if they do fall  
7 astray. But so long as his limit -- his  
8 cross-examination is limited to her course in the  
9 hospital and the fact that she is documented as  
10 somehow improving, better off than she was before  
11 she got there, then I have no objection to him  
12 inquiring of that fact with our witness.

13 MR. BLAKE: And what about Dedmond's  
14 communications about the PT, that she was unable to  
15 participate, to probe the witness' testimony on why  
16 she was unable to participate in the PT as she  
17 discussed?

18 MR. CONNOR: Sure. If it is as he described,  
19 some result of some Medicare payment denial, that's  
20 one thing. But I think she testified that it was a  
21 consequence of her inability to participate in that.  
22 And if she wants to show the records to contradict  
23 him, then she's certainly willing and should have  
24 the opportunity to do that.

25 THE COURT: All right.

1 MR. BLAKE: Thank you for noting that.

2 (Juror Brian Worley enters the courtroom.)

3 THE COURT: All right, folks. We're going  
4 to -- well, actually, no.

5 Mr. Worley.

6 JUROR WORLEY: Yes, sir, Your Honor.

7 THE COURT: Good afternoon. Come up a little  
8 closer. Okay. What happened? I told you yesterday  
9 I wanted you here at -- needed you here at 8:45 this  
10 morning. So why weren't you here?

11 JUROR WORLEY: Despite our conversation  
12 yesterday, it was not because I'm trying to get out  
13 of my civic duty. I feel a certain way about this  
14 case. And I kind of wanted to talk to you, and I'm  
15 glad that they're here, about how I felt about it  
16 but also trying to look at the way -- the way that  
17 things are done. And maybe because of what my  
18 feelings are wouldn't make me good to make a  
19 decision because I already have a set decision about  
20 what I think happened in this situation. It's my  
21 personal opinion.

22 THE COURT: Right.

23 JUROR WORLEY: I'm just one juror.

24 THE COURT: Well, that was the discussion we  
25 were supposed to have at 8:45 this morning.

1 JUROR WORLEY: I couldn't get there. My car --  
2 something happened with the car.

3 THE COURT: What happened?

4 JUROR WORLEY: I have a radiator leak in my  
5 hose. It's a Jaguar, 2008. The radiator hose, it's  
6 got a hole in it or something stupid. Something  
7 happened. They want \$135 for the part. I was  
8 actually going to be making the money to make that  
9 before I got called to jury duty, but I had to come  
10 do this.

11 So now that I'm here -- I usually make almost  
12 \$100 a day -- I'm losing out and I couldn't get it  
13 done. But I still came, knowing what my situation  
14 was. So I keep bottles of water, like antifreeze.  
15 I keep it in my trunk. It leaked out over  
16 everything and it was just ticking me off about new,  
17 excuse my language, cars. They all are computerized  
18 now. So if you drop your phone in the water, it  
19 ain't going to work.

20 I just found out, unfortunately, the same thing  
21 with the Jag, because of the computer components,  
22 because they're in the trunk, it's a foreign car,  
23 it's not up top, when the water hit it, it just  
24 jacked everything up; it was not working.

25 My brother's car is down. I'm estranged from

1 my family. I don't really talk or mess with  
2 anybody. And I couldn't get a ride up here and I  
3 wasn't about to spend Uber money or something to get  
4 up here when I don't have it. I need money as it  
5 is. But that's -- I wasn't trying to get out of  
6 this. I really had a point to make, but I don't  
7 want to mess up your situation.

8 THE COURT: Well, do you have a cell phone?

9 JUROR WORLEY: Yes.

10 THE COURT: Do you have a jury card that shows  
11 your information and the phone number for the  
12 clerk's office?

13 JUROR WORLEY: I called them. I left a message  
14 this morning at 8:05 this morning.

15 THE COURT: You did?

16 JUROR WORLEY: Yes, sir. I swear on my kids.

17 THE CLERK: That number, though, is not to  
18 leave messages. Nobody checks it.

19 JUROR WORLEY: Then why does it beep and say  
20 [demonstrating]?

21 THE CLERK: Nobody checks it. That was just to  
22 get the recording.

23 JUROR WORLEY: So check it and you'll see my  
24 name on it.

25 THE COURT: Hey, just don't --



1 JUROR WORLEY: I'm not -- you're right.

2 THE COURT: Don't respond that way to her.

3 JUROR WORLEY: I feel like you're accusing me  
4 of lying.

5 THE COURT: I'm trying to gather why you  
6 weren't here and what you did.

7 JUROR WORLEY: Yeah. Let me calm down.

8 THE COURT: I'm doing what I'm supposed to do.

9 JUROR WORLEY: You're right. Let me take a  
10 step back, sir. I do respect your position and --

11 THE COURT: Yeah. So you say you called in.  
12 You've told me you left a voicemail. And I think  
13 what she was saying is that line doesn't take  
14 voicemails. Is that correct, Madam Clerk?

15 THE CLERK: They're not supposed to leave  
16 messages on it because nobody checks it.

17 THE COURT: Okay.

18 THE CLERK: But I'll check it now.

19 THE COURT: That's fine.

20 JUROR WORLEY: It does.

21 THE COURT: Hey, we're going to check it out.  
22 Okay? The fact that you called, that helps me a  
23 little bit because, I mean, the fact is, we were  
24 supposed to get started today at a certain time, and  
25 I waited a while until you got here -- or until you

1 did not show up, that is. So I had to use the  
2 alternate juror.

3 And I understand, you know, making money every  
4 day is an important thing. But that was one of the  
5 questions I asked in jury qualification: Is there  
6 someone who, because of some sort of undue or  
7 extreme hardship, couldn't really serve this week,  
8 to disclose that. I don't remember if you told me  
9 you couldn't survive or you couldn't, you know, pay  
10 the rent or fix the car if --

11 JUROR WORLEY: May I speak freely now?

12 THE COURT: Yeah, you can speak.

13 JUROR WORLEY: I didn't believe it was going to  
14 be a factor at the time. I was pretty sure that the  
15 car wasn't going to give me any problems at the  
16 time. It was just like I don't know why God put me  
17 in this situation. I know you're very religious  
18 down here. I'm assuming I'm here for a reason,  
19 something He wants to do, because that's how things  
20 go in life, whether it's just coincidence -- maybe  
21 there's no such thing as coincidence.

22 I'm here for a reason. And despite what we're  
23 talking about, it's not me trying to get out of  
24 this. I have something to say about this case that  
25 I believe in my heart. And because of that, if I'm

1       wrong or right --

2               THE COURT: Well, the jury is not here. You  
3       can -- well, actually, you've already been removed  
4       as a juror anyway. So --

5               JUROR WORLEY: So can I just say my piece? Is  
6       this not going on record or is it --

7               THE COURT: Sir? We're on the record right  
8       now.

9               JUROR WORLEY: Good. I love it.

10              THE COURT: So, anyways, what I'm trying to  
11       tell you is I've already removed you from the jury  
12       panel because you weren't here. So I had to make  
13       the appointment of the alternate because we have to  
14       do that --

15              JUROR WORLEY: And in my eyes, sir --

16              THE COURT: At the time -- at the time --

17              JUROR WORLEY: I don't mean to cut you off.  
18       But what I thought about in hindsight, what I should  
19       have said was, please make me an alternate and let  
20       somebody else make the decision about this man's  
21       life and her mother, because I feel a certain type  
22       of way. And things are not going a certain way, and  
23       I didn't think I could make that decision honestly  
24       and unobjectively. And that's why. But that's what  
25       I should have said. I didn't think about it until

1 afterwards. I should have said dismiss me; just  
2 make me an alternate. I would still have sat until  
3 afterwards to see how this turns out. So, like,  
4 make me an alternate and let somebody else do it, is  
5 what I should have said.

6 THE COURT: Okay. Well, that's not really how  
7 it works.

8 JUROR WORLEY: Yeah. It's too late now.

9 THE COURT: So, I mean, I can't just give you  
10 the rest of the week off.

11 JUROR WORLEY: I'm not asking for the week off.  
12 I would like to actually come here and see how this  
13 ends up, but I don't want to make a decision -- and  
14 now I know I'm not -- on what's happening in this  
15 case. That's all I want is -- I don't want to be  
16 the one responsible for making a decision because I  
17 have certain things that I'm feeling.

18 THE COURT: Did you get a ride here from the  
19 County?

20 JUROR WORLEY: Yes, sir.

21 THE COURT: Okay.

22 JUROR WORLEY: You're not going to let me tell  
23 you what I feel either, are you?

24 THE COURT: Well, I mean, it's irrelevant now.  
25 You're off the panel. You know? I mean, you had --

1 at 8:45 this morning --

2 JUROR WORLEY: I know what happened in this  
3 case.

4 THE COURT: -- I wanted to know. But I had to  
5 go ahead and make the decision. So however you  
6 felt --

7 JUROR WORLEY: Doesn't really matter.

8 THE COURT: -- of why you couldn't serve on the  
9 jury doesn't really matter now because you're off.

10 JUROR WORLEY: But I'm probably --

11 THE COURT: With that said -- huh?

12 JUROR WORLEY: I'm probably right.

13 THE COURT: You're probably right?

14 JUROR WORLEY: They need to re-examine that  
15 nurse that was up there. They need to ask her some  
16 more questions. I think the --

17 THE COURT: Please stop. You're not helping  
18 yourself. Okay?

19 JUROR WORLEY: I'm not trying to help myself,  
20 sir. I'm trying to help these people, or him if  
21 he's not at fault, because I'm supposed to believe  
22 that he's innocent until proven --

23 THE COURT: Okay. Okay.

24 JUROR WORLEY: Yeah. I'm turning it into a big  
25 speech. You're right. Let me just shut up.

1           THE COURT: I think what I'll do is, you're  
2 going to sit up here the rest of the day for sure,  
3 okay, or you have another option. You can go sit  
4 down in plea court if you want. But you're either  
5 going to sit in this courtroom or the third-floor  
6 courtroom and watch people get sentenced, one or the  
7 other. Who do you live with?

8           JUROR WORLEY: Unfortunately, because of how  
9 life been treating me and my mouth, my mother.

10          THE COURT: Okay. Does your mama have a car?

11          JUROR WORLEY: No.

12          THE COURT: Your mama doesn't have a car?

13          JUROR WORLEY: A car?

14          THE COURT: Yeah.

15          JUROR WORLEY: No.

16          THE COURT: Okay. So your only mode of  
17 transportation for you and your mother is the car  
18 that's currently out of comission?

19          JUROR WORLEY: Right, because brother's isn't  
20 working and I'm estranged from my family, again,  
21 because of my mouth. I don't know when to shut up.  
22 And I'm being honest about that. If I would shut  
23 up, I wouldn't be here right now.

24          THE COURT: Well, you're going to sit in court  
25 the rest of the week and you're going to keep your

1 mouth closed --

2 JUROR WORLEY: I understand that.

3 THE COURT: -- and not make any comments.

4 JUROR WORLEY: I tried to do that before. I  
5 didn't say anything until you said -- and I  
6 forgot -- I admit I forgot. It's still on the  
7 record. Once you started saying, okay, you can go,  
8 I thought it wasn't recording no more. Maybe I  
9 could say, Your Honor, I want to tell you what I  
10 want to tell you without it being on the record.  
11 But it was still on record. I didn't know that.  
12 That's the only reason I did it when I did it.

13 THE COURT: Thank you.

14 DEPUTY XANTHAKIS: Yes, Your Honor?

15 THE COURT: The sheriff's department is not a  
16 taxi service.

17 DEPUTY XANTHAKIS: True. But if the Court  
18 directs us to do it, we can take care of the  
19 problem.

20 THE COURT: But I'd like the sheriff to be  
21 upfront and let me know if that's a problem. I  
22 don't want it -- I mean, really, it needs to be  
23 something that's just not a big deal at all, because  
24 if it's not, I'll just --

25 DEPUTY XANTHAKIS: Due to our manpower this

1 week, sir, we're short-handed.

2 THE COURT: All right. I'm not going to put it  
3 on the sheriff's department.

4 How far do you live from the courthouse?

5 JUROR WORLEY: About 20 miles, Your Honor. It  
6 took me about 30 minutes to get here. This is so  
7 going wrong; not about me, I don't care about me;  
8 it's this case. I just feel --

9 THE COURT: I'd like you to stop talking about  
10 the lawsuit now. Thank you, sir.

11 Sheriff, will it be a problem to get him home  
12 today at the end of the day?

13 DEPUTY XANTHAKIS: No, sir, it will not be a  
14 problem.

15 THE COURT: Is Judge Griffith still holding  
16 court?

17 DEPUTY XANTHAKIS: Yes, sir, he is.

18 THE COURT: Okay. And who is the deputy down  
19 there?

20 DEPUTY XANTHAKIS: It would be Deputy Taylor.

21 THE COURT: Okay. Please advise Deputy Taylor  
22 that Mr. Worley will be joining him until the end of  
23 the day.

24 DEPUTY XANTHAKIS: Yes, sir. I sure will.

25 THE COURT: So you've had the opportunity to



1 look at some civil court. Now you get to look at  
2 another courtroom for a while. There will be more  
3 than one matter coming, so it may be a little more  
4 interesting for you.

5 JUROR WORLEY: It's quite an interesting  
6 opportunity.

7 THE COURT: You'll be -- what?

8 JUROR WORLEY: It's quite an interesting  
9 opportunity. I did not mean to mess up your whole  
10 process, I really didn't.

11 THE COURT: Okay. So --

12 JUROR WORLEY: So I apologize. And I'm an  
13 idiot.

14 THE COURT: Okay. So, anyway, please let the  
15 sheriffs know that --

16 DEPUTY XANTHAKIS: I will, sir.

17 THE COURT: -- he'll come down to plea court.  
18 You understand that, Mr. Worley?

19 JUROR WORLEY: Yes, Your Honor.

20 THE COURT: All right. So you're going to  
21 watch plea court for the rest of the day. I'm not  
22 going to require the Sheriff's Office to pick him  
23 up. I'd like you to call the clerk's office -- is  
24 there somebody he can call and just check in?

25 THE CLERK: Yes, sir. I can give him the

1           number.

2           THE COURT:   Okay.   Call the clerk's office  
3           tomorrow.   If your car happens to get fixed  
4           tomorrow, I'd like you to come in on Friday.   Fair  
5           enough?

6           JUROR WORLEY:   Yes, Your Honor.   I'm sorry for  
7           the delay.

8           THE COURT:   All right.   The sheriff will take  
9           you down to the right courtroom.

10          JUROR WORLEY:   Can I ask one question?   After  
11          the case is settled, am I allowed to talk about it  
12          or no?   Because I still have something I want to say  
13          and you're not listening to me.   And I have  
14          something I want to say, so I will say it, but after  
15          I'm allowed legally to say it, without anybody's  
16          names or anything --

17          THE COURT:   I'm going to ask you not to discuss  
18          the case with anyone until the end of the week,  
19          until this case is done.   After that -- you know.

20          DEPUTY XANTHAKIS:   Thank you, Your Honor.

21          THE COURT:   Off the record, please.

22          (Luncheon recess 12:37 PM - 1:19 PM.)

23          THE COURT:   All right.

24          MR. BLAKE:   Your Honor, we had one other thing  
25          that came up just with these ortho records.

1 THE COURT: Okay.

2 MR. BLAKE: Before we send the evidence back,  
3 we're going to redact out some of the ortho bills,  
4 some of these ortho treatments, since I'm not going  
5 into stuff that we just talked about me not getting  
6 into, some of these ortho treatments for subsequent  
7 falls that are in the ortho bills, rather than renew  
8 this argument again about the damages that are being  
9 sought and the cause of them --

10 THE COURT: So they're already in, is what  
11 you're saying?

12 MR. BLAKE: Yeah. They're in the current  
13 evidence, so they're wanting to redact out the ortho  
14 bills where she's being X-rayed and checked out for  
15 subsequent falls and --

16 THE COURT: Okay. So, in other words, you'll  
17 adjust the bills to ensure there's no --

18 MR. CONNOR: Correct. It's not from a fall.  
19 She had a CNA actually accidentally step on her ankle,  
20 and there's an X-ray for that that's included in  
21 here. There are subsequent X-rays of her hips and  
22 pelvic region as follow-up orders. For example, on  
23 Dr. Dedmond's orders, there's orders for subsequent  
24 imaging --

25 MR. BLAKE: If it's related to that, it doesn't

1       need to be redacted.

2               MR. CONNOR:  -- so we'll have to sort of sort  
3       that through.  It's clear there's this X-ray of the  
4       ankle.

5               THE COURT:  Well, at the end of today, y'all  
6       can hang around and start doing some of that.

7               MR. CONNOR:  Right.

8               MR. BLAKE:  Yes, Your Honor.

9               THE COURT:  All right.  Everybody here?

10              MR. BLAKE:  Yes, Your Honor.

11              THE COURT:  All right.  Let's bring the jury  
12      in, please.

13              (The jury enters the courtroom at 1:21 PM.)

14              THE COURT:  Okay.  Mr. Foreman, ladies and  
15      gentlemen of the jury, I wasn't able to get you back  
16      before lunch.  I had an unrelated matter,  
17      case-specific, that I had to deal with that took  
18      more time than I thought it would.  So that's why we  
19      went ahead and just broke for lunch.  I appreciate  
20      your patience.  So we're going to begin our  
21      afternoon testimony, and we're beginning with  
22      cross-examination of the plaintiff's expert by  
23      Mr. Blake.

24              MR. BLAKE:  Thank you, Your Honor.

25

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

CROSS-EXAMINATION

BY MR. BLAKE:

Q. Ms. Lewis, good afternoon.

A. Good afternoon.

Q. Let's start, if we can, with your understanding of the condition that Ms. Shealy was in prior to her fall on June 22nd, 2014. June 22nd, 2014, that's when she fell and broke her hip the first time; correct?

A. Correct.

Q. Tell me, was she having difficulty ambulating prior to June 22nd, 2014?

A. Well, apparently she was, because she fell. So, yes.

Q. Okay. Do you know whether or not she needed assistive devices to help her ambulate prior to June 22nd, 2014?

A. The daughter had reported to the physical therapist, when the physical therapist at Agape was asking her the history, because you always want to know how the patient was doing before, and the daughter said that she didn't use a wheelchair or a walker and that they'd help her get in the shower. So they would help her.

1 Q. Well, she needed to use a cane when she was  
2 walking though, didn't she?

3 A. I didn't see that in the record.

4 Q. You didn't see that in the hospital records?

5 A. No.

6 Q. Okay. Did you see the comments in the hospital  
7 records where the family told the hospital that she  
8 probably needed to be using a walker due to the  
9 difficulty that she was having ambulating prior to  
10 her first fall?

11 A. Okay. And, yes, they did use a walker at Agape  
12 in physical therapy, so that would make sense.

13 Q. Okay. So I'm going to show you the record  
14 here. This is from the stipulated Lexington Medical  
15 Center records. The note actually begins on page  
16 99, so I'll show that. Let's see if that helps jog  
17 your memory. I'm terrible with these things and  
18 their zoom focus. Should I try to back it out a  
19 little bit maybe?

20 MR. CONNOR: Try the wheel on top.

21 MR. BLAKE: Thank you, Mr. Connor.

22 BY MR. BLAKE:

23 Q. Okay. So that's the record. And it picks up  
24 here following Mr. -- Dr. McIntosh. If you look  
25 here at the bottom, you see a progress note. Do you

1 recall who Dr. Dedmond is, Barnaby Dedmond?

2 A. Oh, that's the doctor at the hospital.

3 Q. And he's an orthopedic doctor; correct?

4 A. Yes.

5 Q. And he's getting -- you'd call this a -- this  
6 objective, this is sort of a history and physical,  
7 isn't it?

8 A. Subjective is what the patient says or what the  
9 family says.

10 Q. Thank you. So if you want to flip to the next  
11 page, which is Bates number -- actually, that is 99,  
12 so the first one is 98.

13 Page 99, he says: Family reports that she  
14 sometimes uses a cane but does not get around well  
15 and probably should have been using a walker. Did I  
16 read that right?

17 A. Yes.

18 Q. Okay. Is that consistent or does that refresh  
19 your recollection as to what her ambulatory  
20 condition was prior to the fall?

21 A. Yes.

22 Q. Okay. How about her mentation prior to her  
23 first fall? Tell us about the status of dementia.

24 A. She was having some confusion and she needed  
25 assistance. So she definitely had the diagnosis of

1 dementia.

2 Q. And you don't disagree that was the appropriate  
3 diagnosis, do you?

4 A. No. I agree with that.

5 Q. Do you recall if later she was ultimately  
6 diagnosed with Alzheimer's?

7 A. Well -- yes. And dementia is kind of the  
8 blanket term. And specifically, you know, a doctor  
9 gave her the diagnosis of Alzheimer's.

10 Q. And do you recall that she received some  
11 neurological testing while she was inside the  
12 hospital following her first fall?

13 A. What are you referring to?

14 Q. Images of her brain that shows changes in the  
15 white matter in her brain. Do you recall the  
16 hospital's test results in those issues?

17 A. I'd have to look at it again.

18 Q. Okay. Let me pull that out. I'm trying to get  
19 myself organized. Here we go.

20 So I'm going to show you what has already been  
21 entered into evidence from the same hospital record.  
22 Okay? And this is from LMC C&C 41, carries over to  
23 42. If you look down at the laboratory studies,  
24 read that for me and let me know if that refreshes  
25 your recollection. And I can make it more zoomed



1 in, if that would help.

2 A. The patient's brain MRI on September 2013  
3 showed periventricular white matter changes. Head  
4 CT on June 22nd, 2014, showed left frontoparietal  
5 scalp hematoma.

6 Q. So back in 2013, she had a brain MRI that  
7 showed periventricular white matter changes. Can  
8 you explain what that means to the jury?

9 A. That can be significant for dementia.

10 Q. Okay. And you think it was in her case?

11 A. I'd have to look at the MRI report to see what  
12 the impression was and what the doctor interpreted  
13 that to be. That's just saying it showed  
14 periventricular white matter changes. How much, you  
15 know, what was his assessment of it, you know, that  
16 doesn't say right there.

17 Q. So following a normal course of dementia, does  
18 it degrade over time?

19 A. Well, see, with dementia, like I said, that's a  
20 blanket term. Alzheimer's dementia does -- it is a  
21 progressive disease and it does progress over time.  
22 And other dementias do progress, I guess, is  
23 reserved, as far as from, you know, dementia from a  
24 stroke.

25 Q. Okay. And you can't give us any more

1 information about this particular patient's dementia  
2 progression and as it relates to these brain studies  
3 on the MRI because you don't have the brain studies,  
4 do you?

5 A. No, I don't. But she did have dementia and it  
6 definitely worsened after the second fall. It's  
7 charted in the record.

8 Q. Right. But I'm saying you can't link that to a  
9 progressive disease process or say it's due to a  
10 fall because you don't have the MRI scans and the  
11 physician impression of those MRI scans to show you  
12 whether or not whatever her dementia was it  
13 progressed because of a fall or a normal disease  
14 process that she had prior to June 22nd, 2014; isn't  
15 that correct?

16 A. No, that's not correct. Without -- they don't  
17 always diagnose the dementia with lab studies such  
18 as that. You certainly can use them. A lot of  
19 times they'll just diagnose it with -- based on the  
20 clinical symptoms. And we know for a fact there's  
21 research out there that says that a patient's  
22 dementia or cognitive status will decline and can  
23 decline after trauma, such as having surgery, the  
24 effects of the anesthesia, and it was such a short  
25 time frame that, yes, a patient can decline slowly.

1 But dementia is a slow, progressive illness. It's  
2 over years. Sometimes people are diagnosed pretty  
3 early, in their late 50s and early 60s and, you  
4 know, they're 80 years old; they're still alive with  
5 dementia.

6 Q. So she suffered acute encephalopathy following  
7 her first fall in the hospital; right?

8 A. Right.

9 Q. And you don't contend that she was back at her  
10 baseline pre-June 22nd, 2014 level of dementia by  
11 July 1st, do you?

12 A. No, because her baseline before was at home in  
13 the yard doing her yard work and getting assistance  
14 with ADL. So there probably was some progression of  
15 the dementia, as there was also after the second  
16 fall and having to have the second surgery.

17 Q. Correct. And that acute encephalopathy had not  
18 resolved by the time she was admitted to Agape  
19 Nursing & Rehab Center; isn't that right?

20 A. I would say for the most part it was resolving.  
21 They called it acute, which means it comes on  
22 quickly. And had it not resolved almost to her  
23 baseline, then they probably would have kept her at  
24 the hospital longer.

25 Q. So you're familiar with the fact that she was

1 hallucinating at Agape; correct?

2 A. There was the one entry, yes, of the  
3 hallucinating, seeing the children outside. Yes.

4 Q. And the first night -- and, again, I know you  
5 weren't here, so you didn't get the benefit of the  
6 family's testimony during trial. But the first  
7 night, she was so inconsolable and saying such  
8 things that her family had to come back and stay  
9 with her until approximately midnight to help calm  
10 her. Are you saying that that's her normal baseline  
11 before June 22nd, 2014?

12 A. No. There's a lot of things to take into  
13 consideration when you have an elderly patient who  
14 has had a fall, who has had surgery; they've been at  
15 the hospital; now they're at a new place, new  
16 environment. They have to get used to it, new  
17 faces. They're already confused; they have some  
18 confusion on top of that, so there's -- it's --  
19 there's a lot of things you have to take into  
20 consideration.

21 Q. I agree. And that's why you can't say, to a  
22 reasonable degree of nursing certainty, that her  
23 acute encephalopathy was resolved by the time she  
24 was admitted to Agape; correct?

25 A. I would say that it was resolving given the

1 fact that she had been discharged from the hospital.  
2 They had taken a look at her and decided that it was  
3 from, they called it, post-op confusion from the  
4 anesthesia.

5 And, you know, the tearfulness, the crying, you  
6 know, residents will do that when they're new in a  
7 facility. You know, that behavior can be there.

8 Q. So let's go back to that record. So I  
9 understood what you just testified is that perhaps  
10 the level of hysteria that she explained at Agape  
11 and the level of disorientation was because she was  
12 in a new facility.

13 But isn't it true that after a week in the  
14 hospital, she doesn't even know where she is or why  
15 she's there?

16 A. May I see the date of that document?

17 Q. It is June 30th, 2014, the day before she came  
18 to Agape.

19 A. Okay. And, yes, dementia does wax and wane.  
20 You can see a resident in the morning -- I mean,  
21 it's not a consistent showing of always confusion.  
22 It waxes and wanes. It gets better and gets a  
23 little bit worse even in the course of a day and,  
24 like I talked about, with the sundowning where  
25 there's increased confusion, people get agitated as

1 the sun's going down.

2 Q. Right. But she's not sundowning during this  
3 visit, right, because it happens at 10:27 in the  
4 morning; right?

5 A. Correct. That wouldn't typically be the time  
6 of sundowning.

7 Q. You would expect, with her course of  
8 sundowning, she actually was worse than what's  
9 described in this note come 5:30 in the afternoon;  
10 true?

11 A. There were times, yes, where it sounded like  
12 she was worse. Yes.

13 Q. Now, when she came to Agape, you agree that she  
14 was assessed by a nurse named Donna Shafer; isn't  
15 that right?

16 A. Yes.

17 Q. And Donna Shafer had the benefit of Lexington's  
18 discharge records; true?

19 A. She should have. Yes.

20 Q. Right. And those are -- well, they're in  
21 Agape's records, aren't they?

22 A. Yes.

23 Q. And those are typical tools used by nurses to  
24 get an understanding of someone who is new in their  
25 building; correct?

1 A. That is correct.

2 Q. But based on that information, Donna Shafer  
3 documented in her assessment the problems that this  
4 patient has with dementia, didn't she?

5 A. If you'll show me the document, I can answer  
6 that.

7 Q. You don't recall the initial nurse's  
8 assessment?

9 A. I do, yes.

10 Q. Okay. And you don't recall whether or not, in  
11 your review of these records, they were evaluating  
12 her mentation upon admission?

13 A. Yes. I remember Ebonie McDaniel's assessment  
14 and I remember seeing Donna Shafer on -- signed on  
15 some of the notes also.

16 Q. Okay. Well -- and Ebonie McDaniel, those  
17 assessments -- I'll just let you know those  
18 assessments that Ebonie McDaniel made were on the  
19 2nd. Donna Shafer was the nurse that did the  
20 initial assessment on July 1st, and that's the  
21 assessment I'm talking about. When she first came  
22 to a building, she was assessed by a nurse; correct?

23 A. Yes. I would like to look at it. I don't have  
24 it in front of me, so I would like to look at it.

25 Q. You don't have it in your notebooks?

1 A. No.

2 Q. Did you not think that was an important  
3 document?

4 A. It's not that I didn't think it was important.  
5 I just didn't make a copy of it. I have important  
6 documents that I didn't copy.

7 Q. Okay. I'll let have you a chance to look at  
8 it. I want to keep this moving so that we don't  
9 waste the Court's time. Well, you've testified  
10 about there being inadequacy of assessments that  
11 were performed. You did look through all the  
12 assessments that were performed by Agape, didn't  
13 you?

14 A. Yes.

15 Q. And those included an initial assessment by  
16 Donna Shafer; correct?

17 A. Yes.

18 Q. MDS assessment and an initial care plan  
19 assessment, both done by Javan Vaughn, another  
20 nurse; correct?

21 A. Yes.

22 Q. And she was then assessed that evening by a  
23 CNA; isn't that correct?

24 A. Which CNA are you talking about?

25 Q. Ashley Holland.



1 A. I remember that name. Yes.

2 Q. And then the next morning, Ebonie McDaniel saw  
3 her and assessed her again, correct, another nurse?

4 A. Yes.

5 Q. And then she was assessed by another CNA named  
6 Shander Murray; correct?

7 A. Yes.

8 Q. And she was assessed in the morning by a  
9 Dr. Margalit; correct?

10 A. Yes.

11 Q. And then she was assessed by a physical  
12 therapist; correct?

13 A. Yes.

14 Q. And then she was assessed by an occupational  
15 therapist; is that correct?

16 A. Yes.

17 Q. And Ebonie McDaniel didn't assess her one time,  
18 did she? She assessed her multiple times, didn't  
19 she?

20 A. Yes.

21 Q. And she was assessed by another nurse after she  
22 had the fall in the afternoon; isn't that right?

23 A. Yes. I never said that she wasn't assessed. I  
24 was critical of the inaccuracy of the assessments.

25 Q. Okay. And the inaccuracy, you're referring

1 to -- and I want to make sure I have those, that on  
2 one assessment, no problem with gait and balance is  
3 checked, and then right below that, there are three  
4 gait and balance problems checked. That's one  
5 problem you have with the assessments; correct?

6 A. Correct.

7 Q. Okay. And what else? What are the other  
8 problems with the assessments?

9 A. About the pain; saying no pain and then  
10 describing pain.

11 Q. Well, let's pause there. And I'll let you  
12 finish your answer, but let's pause there and cover  
13 that one. So it says no pain reported, doesn't it?

14 A. Correct.

15 Q. Now, do you know whether or not she was able to  
16 communicate pain at that point, given her mentation?

17 A. It's possible she wasn't able to report it.

18 Q. Okay. And then it says that she has daily  
19 stabbing pain; correct?

20 A. Correct.

21 Q. And those two aren't inconsistent. I cannot be  
22 reporting pain at this moment, but have daily  
23 stabbing pain; isn't that true?

24 A. That is true. However, the way this document  
25 is, it's -- it's no pain reported or pain reported.

1 And they said no pain reported and then they went on  
2 to describe pain. So I understand what you're  
3 saying --

4 Q. Sure.

5 A. -- but the way the document is, it's either  
6 pain or no pain.

7 Q. Well, ma'am, do you know how that document got  
8 generated onto a piece of paper?

9 A. No. I couldn't tell you the exact specifics.

10 Q. Are you familiar with the AHT document  
11 management system that certain healthcare providers  
12 use?

13 A. No.

14 Q. So you're not familiar with the electronic  
15 process whereby data was entered into Ms. Shealy's  
16 record; correct?

17 A. I am familiar with the various electronic  
18 medical records, just not this one specifically.

19 Q. I understand.

20 A. You know, I don't know the AHT process and all  
21 that. But, you know, I shouldn't have to; I should  
22 just be able to read the document.

23 Q. Well, I agree. And you don't know then whether  
24 or not whenever any of the treating personnel are  
25 answering questions within that user interface,

1       whether they're organized and lined up the way  
2       they're printed off on that report, do you?

3       A.     Can you repeat that?

4       Q.     Sure.  Whenever somebody is entering data into  
5       an electronic database in the electronic health  
6       record, they answer questions that are generated by  
7       that module; isn't that right?

8       A.     Yes.

9       Q.     And you don't know, because you're not familiar  
10      with AHT, whether or not the questions line up the  
11      way they are generated -- the responses are  
12      generated on that printed report; correct?

13      A.     Right.  I don't know.  But, you know,  
14      regardless of how they do it, it still should be  
15      accurate.

16      Q.     Sure.

17      A.     It should reflect how the patient is.

18      Q.     But you agree with me that those two aren't  
19      necessarily inconsistent, that she can have not been  
20      reporting pain that day, but yet she can still have  
21      daily stabbing pain.  Correct?  Those are two  
22      different questions.

23      A.     The way I look at this, it says:  Section C,  
24      pain.  It says no pain reported.  And it's  
25      conflicting because it's stabbing and daily.

1 Q. Okay. Well, ma'am, again, you're not an expert  
2 on that documenting system; correct?

3 A. Not that one specifically, no.

4 Q. Right. And --

5 A. I don't have to be to look at these records.

6 Q. And you're an expert. As an expert, you're  
7 only relying on documents that you reviewed in this  
8 case; true?

9 A. And also my education, training, and  
10 experience.

11 Q. But in terms of what people did in this case,  
12 you're relying upon the records you reviewed; right?

13 A. Correct.

14 Q. Any other sources? I saw you hesitate. I'm  
15 not trying to put words in your mouth. But are  
16 there any other sources you've relied upon to  
17 determine what people have done in connection with  
18 the care of Ms. Shealy?

19 A. The deposition testimony.

20 Q. Anywhere else?

21 A. I believe that's it.

22 Q. Okay. And so as an expert who has to rely upon  
23 that, your opinions that are based upon those  
24 documents are only as good as your understanding of  
25 those documents; isn't that right?

1 A. Correct. But there -- it's only as good also  
2 as far as how good the documentation is.

3 Q. Okay.

4 A. We rely on this information to be accurate.

5 Q. Certainly. Certainly. So other assessment  
6 problems -- we talked about gait, balance; we talked  
7 about pain. What else?

8 A. The failure for the -- to check the required  
9 use of assisted devices.

10 Q. Let's pause there then. You don't contend that  
11 she was not, in fact, provided a wheelchair, do you?

12 A. It said she had the wheelchair.

13 Q. Right. Again, if you were here for the  
14 testimony, you would have benefited from hearing the  
15 family talking about the wheelchair. I mean, you  
16 have no dispute that she was provided a wheelchair  
17 throughout her stay at Agape; correct?

18 A. Correct.

19 Q. Okay. Any other problems with the assessment?

20 A. Are you talking about the initial assessment or  
21 ongoing?

22 Q. I'm going through all the assessments with  
23 which you claim there's -- that you have a problem.

24 A. I had a problem with the assessment whenever  
25 Ms. Shealy did not respond to the dose of the Ativan

1 on July 2nd. There wasn't a follow-up as far as  
2 after they assessed her.

3 I have a problem with the assessment July 2nd,  
4 2014 at 8:07 where no complaints today, no and  
5 symptoms of distress.

6 Q. And, again, I know you haven't had the benefit  
7 of being here in the courtroom. But have you had  
8 any conversations with anybody about how that  
9 completed box with the timestamp gets entered on  
10 those records?

11 A. No.

12 Q. Okay. You talked about one earlier where  
13 Ebonie, the nurse, documented a fall in an ER  
14 transfer four hours before it even happened; right?

15 A. Yes.

16 Q. At least that's what that looks like, based on  
17 that completed box. But you don't really believe  
18 that that's when the record was created, do you?

19 A. No. I believe -- what it appears to me is that  
20 the records were fudged somehow, because how else  
21 can you explain it?

22 Q. Again, it could be an error in the  
23 documentation system, can't it?

24 A. If there's an error in the documentation  
25 system, then that should have been caught by the

1 people who are monitoring that system. And there's  
2 several, several errors like that.

3 Q. We agree that there's timestamp problems on the  
4 record. I'm saying that because there's timestamp  
5 problems when you print a document out of an  
6 electronic records system, that doesn't mean someone  
7 has fudged something, does it?

8 A. I think it's very possible. You know, how in  
9 the world does the time get changed to July 2nd,  
10 2014 at 8:07?

11 Q. Well, to fudge something, you can presume, at  
12 least, there's a benefit to it. Tell me this: What  
13 would be the benefit to Agape if they're fudging  
14 records to saying that she fell and went to the  
15 hospital at 3:37 when the note itself has a timeline  
16 that's four hours later?

17 A. It doesn't make sense.

18 Q. It makes no sense that any nurse would fudge a  
19 medical record in such a fashion, does it?

20 A. Well, the nurse said that she didn't fudge it  
21 and then we had the other information that said the  
22 people -- the nurse didn't recall that those other  
23 people were nurses who had gone back into the  
24 record.

25 Q. Ma'am, you don't know what record anyone went



1 back into, do you?

2 MR. CONNOR: Objection, Your Honor. May we  
3 approach?

4 THE COURT: Sure.

5 (Sidebar conference.)

6 MR. BLAKE: I'll withdraw the last question.

7 BY MR. BLAKE:

8 Q. And then, ma'am, I'm sorry, you had another  
9 assessment. I don't want to skip over any of the  
10 assessments that you had a problem with. I want to  
11 make sure we've discussed them all. And I know what  
12 it was; it was the Ativan. You talked about Ativan  
13 and the failure to do an assessment between 5:25, or  
14 whenever it was given, and 7:25, the time she fell;  
15 correct?

16 A. Correct.

17 Q. 5:30 and 7:25; correct?

18 A. Correct.

19 Q. Now, we've talked about that record with  
20 Ms. McDaniel and she confirmed that that paragraph  
21 was a chronological entry that she made; that it's  
22 this happened, then this happened, and then this  
23 happened. And in that chronology, she said, as we  
24 talked about with her yesterday, she said that she  
25 was -- that the patient was given the medicine at

1 5:30, and then she remained combative; correct?

2 That's what you recall the note saying; right?

3 A. Yes.

4 Q. And then she was moved to the nurses station;  
5 correct?

6 A. Correct.

7 Q. So a treatment was provided by giving Ativan;  
8 right?

9 A. Correct.

10 Q. And that Ativan was ordered by a Lexington  
11 Medical Center doctor on discharge; correct?

12 A. Correct.

13 Q. And that Ativan was ordered again on July 2nd  
14 by Dr. Margalit?

15 A. Correct.

16 Q. Given, per the order, by the nurse at 5:30;  
17 correct?

18 A. Correct.

19 Q. And then the nurse assessed her and found that  
20 she was combative. Isn't that what the record says?

21 A. After she gave her the Ativan, yes.

22 Q. So there was an assessment after she had the  
23 Ativan?

24 A. That's correct. But assessing is -- it's an  
25 ongoing process.

1 Q. I agree. I agree.

2 A. It's not just looking at her one time. Okay?  
3 You go back; you check; you're worried about the  
4 patient; you're worried about their well-being. You  
5 want to make sure they're doing okay. That's  
6 assessing.

7 Q. Right. So she assessed her. And then she  
8 implemented a new intervention, didn't she? She  
9 moved her to the nurses station; right?

10 A. Correct. It wasn't effective, but, yes, she  
11 did.

12 Q. Well, it's not like she sat out at the nurses  
13 station for three days. The nurses are provided  
14 some amount of time, ma'am, to see if the  
15 interventions that they've put in place in response  
16 to an assessment are going to be effective, aren't  
17 they? Isn't that within the standard of care to  
18 have time to see if the interventions are working?

19 A. Correct. But you have to use your common sense  
20 and judgment. And if you're looking at the resident  
21 and you see that they're still combative, you gave  
22 them the Ativan, they're still agitated, they're not  
23 responding to your intervention of being at the  
24 nurses station, call the doctor; ask a CNA, hey, I  
25 need some help; help me keep eyes on this patient.

1 Q. Ma'am, I asked you this in your deposition  
2 testimony: Do you have any idea how long she had  
3 been at the nurses station prior to the fall?

4 A. No. And the two nurses had no idea either.

5 Q. Well, they don't recall, because they're being  
6 asked this years later; right? That was  
7 Ms. McDaniel's testimony?

8 A. Correct.

9 Q. Right.

10 A. So they don't recall.

11 Q. Right.

12 A. Well, they didn't know.

13 Q. Right. So you can't opine then, to a  
14 reasonable degree of nursing certainty, that they  
15 didn't give that intervention enough time, because  
16 you don't know how long that intervention was in  
17 place; correct?

18 A. Correct. But we know it wasn't working. So  
19 the nurse was there and she saw that the patient had  
20 moved away from the nurses station, so you have to  
21 come up with another intervention.

22 Q. Well, read that to me. Does it actually say  
23 that she moved away or she didn't want to stay  
24 there?

25 A. Did not want to remain in that area. But we

1 know she ultimately did move away, because she was  
2 close to the PT room.

3 Q. Well, how far is that?

4 A. I looked at the map. I don't know foot-wise,  
5 but there's some distance there.

6 Q. Let's look at the map together. Showing Joint  
7 Exhibit 24 here. I hope y'all can see that with  
8 some clarity. I'll highlight the words as I talk,  
9 just so y'all will know what I'm referencing. This  
10 here says nurses station; this here says therapy;  
11 and this is the area next to the nurses station near  
12 the PT door.

13 And your testimony is, ma'am, you don't know  
14 how many feet that is; correct?

15 A. Correct.

16 Q. But that's where you understood she fell; is  
17 that right?

18 A. Correct.

19 Q. Okay. You testified about keeping somebody  
20 within line of sight. It's not your opinion -- we  
21 talked about this in your deposition. It's not your  
22 opinion that someone has to have physical eyes on  
23 Ms. Shealy 24 hours a day; correct?

24 A. If Ms. Shealy is not stable and she's not doing  
25 well and you've accepted her into the facility, you

1 have to keep your eye on her. She's in a new  
2 environment; she's a high fall risk. You know, they  
3 had already utilized the family the night before;  
4 the family came back. Why didn't they call the  
5 family to come back again? You have to keep your  
6 eyes on them.

7 Q. Okay. But --

8 A. It can be difficult, but you have to do it.

9 Q. Keep your eyes on them doesn't mean that you  
10 can't turn your head; right? Keep your eyes on them  
11 doesn't literally mean I have to lock eyes with  
12 Ms. Shealy for 24 hours a day, does it?

13 A. If that patient, if that resident is going to  
14 fall, and you have patients that every time you turn  
15 around they're up, they're trying to get up, trying  
16 to get up, so then you -- that's why we use the  
17 other interventions. We have them sitting right  
18 next to us at the nurses station. Walk around with  
19 them, have somebody take them for a walk in the  
20 wheelchair, push her in the wheelchair, do an  
21 intervention to -- to keep her busy so that -- to  
22 get her mind off of it to adjust to the new  
23 surroundings.

24 Q. When you were testifying earlier, you said that  
25 if you had someone like Ms. Shealy, you might walk

1 her to the room if you were -- where you were  
2 providing treatment to other patients, have her in  
3 the hallway, and you would step inside the room --

4 A. If --

5 Q. -- and treat that resident.

6 A. -- that was appropriate.

7 Q. Right.

8 A. If it was appropriate. If it wasn't, then I  
9 would not do that. If I was going to place her at  
10 risk or I was -- I wouldn't be able to do my job,  
11 then I wouldn't do that.

12 Q. Well, ma'am, she'd been given Ativan; correct?

13 A. She did.

14 Q. And Ativan doesn't kick in right away, does it?

15 A. It takes 15 to 20 minutes.

16 Q. To start to react. But it takes a couple hours  
17 to metabolize and reach full efficacy inside the  
18 human body, doesn't it?

19 A. Probably by about an hour, you're going to see  
20 it working.

21 Q. Okay. So she's on Ativan. That's an  
22 intervention; correct?

23 A. Correct.

24 Q. She's been moved to the nurses station for  
25 close observation. That's an intervention; correct?

1       A.    And one that didn't work.  And the Ativan  
2       didn't work.  Yes.

3       Q.    Well, we know it didn't work after the fact,  
4       but the standard of care is not that nurses have  
5       some type of prescient foresight where they can  
6       predict everything that's about to happen to a  
7       resident, is it?  That's not the standard of care.

8       A.    No.  But, you know, we know that we have to  
9       monitor patients, we -- they gave her the Ativan, so  
10      you want to see if it's effective.  If it's not  
11      effective, the doctor even has an order in the  
12      chart:  Call the doctor if the intervention is not  
13      effective with agitation.

14      Q.    Right.  And that's what I'm saying:  The nurses  
15      are afforded a period of time -- before they would  
16      have to call the family or call the doctor to say  
17      that the Ativan intervention and the moving out of  
18      the room and into the busier area by the nurses  
19      station where she can be closely monitored, the  
20      nurses are afforded a period of time before they  
21      have to then move on to other interventions;  
22      correct?

23      A.    Not necessarily.  I mean, you may have four  
24      interventions all at once..  She might have the Lap  
25      Buddy; you might still need someone to keep their



1 eyes on the patient; you might still need the  
2 Ativan.

3 Q. Let's talk about the Lap Buddy. The Lap Buddy  
4 is a restraint, isn't it?

5 A. It is considered a restraint.

6 Q. At least the CMS definition of a restraint;  
7 correct?

8 A. Correct. This facility still used restraints.

9 Q. I understand. But to have a restraint, there  
10 needed to be an order for a restraint; isn't that  
11 the law?

12 A. Correct. So that's another reason why we call  
13 the doctor.

14 Q. Well, a nurse had met with Dr. Margalit that  
15 morning and explained to Dr. Margalit that she was  
16 having increased confusion and agitation; isn't that  
17 true?

18 A. Where is that documented?

19 Q. In Dr. Margalit's visit record where it says  
20 per nurse and he describes the nurse's explanation  
21 of her increased agitation.

22 A. Okay. Yes.

23 Q. Okay. Dr. Margalit, higher standard of care  
24 than a nurse, you'd agree with me; correct?

25 MR. CONNOR: Object to form -- or, I'm sorry,

1 objection, Your Honor. There's no testimony at all  
2 about -- these are totally different professionals.

3 THE COURT: Sustained.

4 BY MR. BLAKE:

5 Q. You're a nurse practitioner; correct?

6 A. Yes.

7 Q. And you work subordinate to a physician;  
8 correct?

9 A. Correct.

10 Q. You don't tell physicians how to do their job.  
11 It's vice-versa; right?

12 A. I mean, I've made suggestions to physicians.

13 Q. Sure.

14 A. You have to do it the right way. If I know the  
15 patient better and if the patient is in front of me,  
16 I'm going to make a suggestion if they're on the  
17 phone. I'm not going to say it rudely or, you know,  
18 condescendingly. But, no, I certainly make  
19 suggestions to physicians.

20 Q. Sure. But you don't tell them, ultimately,  
21 what to do. They make their own independent  
22 determinations; correct?

23 A. Correct.

24 Q. And nurses follow doctors' orders; right?

25 A. Correct.

1 Q. That's the standard of care; correct?

2 A. Correct.

3 Q. And Dr. Margalit, once armed with the change in  
4 the patient's condition, he opted for an  
5 intervention, didn't he?

6 A. Yes.

7 Q. And he increased the amount of Ativan from one  
8 time a day to four times a day; correct?

9 A. Correct.

10 Q. He didn't order any type of physical restraint  
11 to be placed on Ms. Shealy, did he?

12 A. Correct. However, you know, this is a -- we  
13 have situations where we're taking care of residents  
14 that, as time goes on, as the hours pass, things  
15 change; interventions have to change; things that  
16 you do with the resident have to change.

17 Q. I understand, ma'am. She was in this building  
18 for 27 hours; correct?

19 A. Yes.

20 Q. And it's easy for us to come in after the fact  
21 and say this, this, and this should have been done.  
22 But over the course of 27 hours, she was assessed  
23 repeatedly by a host of different disciplinary  
24 professionals; wouldn't you agree?

25 A. Yes. Not always accurately, but, yes. But

1 we -- going back to the beginning of that statement,  
2 we do know. When I see a patient going like this  
3 and they're trying to get up, I'm like, whoa, that  
4 patient is going to fall. So if I'm there, I'm  
5 going to make sure that they're safe while they're  
6 under my care.

7 And then when I'm finished with them, I'm going  
8 to turn them over to someone or put them in a public  
9 area and let them know, I brought Ms. Smith back;  
10 you know, she's trying to get up. And then I have  
11 relinquished my duties and I can move on to my  
12 patients.

13 Q. Her records don't say anywhere in it, at all,  
14 anywhere until the time of her fall that she ever  
15 attempted to get out of that chair, does it?

16 A. Correct. But she was agitated; she was  
17 combative; she was confused and she was propelling  
18 the wheelchair away from the nurses station. And we  
19 don't even know who was at the nurses station, how  
20 many people.

21 Q. Would you expect it to be several people,  
22 considering the time of day it was?

23 A. Not necessarily. Sometimes at the nurses  
24 station, there isn't anyone there. Sometimes  
25 there's five people. You know, you can't really say

1           because of a certain time of day.

2           Q.     What do nurses typically do at a shift-change?

3           Do they give each other reports?

4           A.     Yes. But they do that in different places.

5           Sometimes they do it in the med room when they're

6           counting the narcotics. It's done in different

7           places.

8           Q.     Okay.

9           A.     It's not always at the nurses station.

10          Q.     Okay. But if a report was given at that nurses

11          station, you'd expect there to be more people there

12          at 7:00; correct?

13                 MR. CONNOR: Lack of foundation, Your Honor.

14          There's been no testimony to that effect whatsoever.

15                 THE COURT: Overruled. He's asking her in her

16          opinion as a nurse.

17                 THE WITNESS: Would I expect more people? Not

18          necessarily. If you have one nurse going off and

19          one coming on, there could just be two people and

20          one is giving a report and one is trying to get a

21          report. And so if Ms. Shealy is in front of the PT

22          room and, you know, she's trying to get up, then you

23          might not see; you're distracted because you're

24          getting a report.

25          Q.     We've entered into evidence a joint stipulated

1 exhibit 29 that Mr. Connor discussed some with you.  
2 It also includes -- that's what we were talking  
3 about a moment ago, right, restraints need to be  
4 ordered by a physician; correct?

5 A. Yes.

6 Q. And why, in 2007, did CMS -- the agency --  
7 federal agency we discussed earlier, why, in 2007,  
8 did CMS revise its position on restraints?

9 A. They wanted them to be used only when  
10 appropriate and to be used in less frequency.

11 Q. And why is that?

12 A. There's information out there that sometimes  
13 restraints aren't appropriate, but Ms. Shealy was  
14 never given that option.

15 Q. Well, Dr. Margalit had that within his ability  
16 when he visited with her, didn't he?

17 A. Correct. And the nurse had the option to call  
18 Dr. Margalit when the patient was not responding to  
19 the Ativan.

20 Q. I understand. But I'm saying she had the  
21 option when she was seen by a physician. How about  
22 this: What do the regulations say a doctor needs to  
23 see a resident in a nursing home for the first time?

24 A. When do they have to?

25 Q. Yeah. How many days does a doctor have before

1       they have to see the patient for the first time?

2       A.    I believe for a doctor -- I'm not exactly sure.  
3       Since I'm not a doctor, I'm not exactly sure. But  
4       there is a time frame.

5       Q.    Well, I mean, you've been testifying about  
6       nursing home administration; right? That's a  
7       responsibility of nursing home administration, to  
8       ensure that there's treating physician care inside  
9       that building; correct?

10      A.    Correct.

11      Q.    And there's regulations that govern that;  
12      correct?

13      A.    Correct.

14      Q.    And per the administration regulations, are you  
15      able to tell us how long a doctor has before he's  
16      required to come in and see a patient for the first  
17      time in a nursing home?

18      A.    Again, I'm not a doctor, so, you know, I don't  
19      want to misstate the requirements. I just can't  
20      recall off the top of my head right now. So I don't  
21      know.

22      Q.    Do you know if it's more than a day?

23      A.    I don't recall.

24      Q.    Okay. Well, I'll represent to you that it is  
25      more than a day and that the records here show that

1 Dr. Margalit saw this patient approximately, let's  
2 say, 18 hours after discharge. You would agree,  
3 getting a doctor in early to see a resident who is  
4 experiencing increased agitation is another  
5 intervention that nurses can use; correct?

6 A. Correct.

7 MR. CONNOR: Objection, Your Honor; no basis  
8 for that evidence. The lawyer is testifying here.  
9 There's been no evidence whatsoever that the -- the  
10 nursing home is who acquired this assessment by the  
11 physician.

12 MR. BLAKE: I can't testify about CMS  
13 regulations after the direct that we just went  
14 through?

15 THE COURT: Overruled.

16 MR. BLAKE: Thank you.

17 BY MR. BLAKE:

18 Q. So is it dignified to be restrained?

19 A. It would depend on why you're using the  
20 restraint. If you're using the restraint to keep  
21 the resident safe, then it would be dignified. But  
22 if you're using it for convenience of the staff, if,  
23 you know, they can't take care of the resident or  
24 what have you, then it would not be dignified. But  
25 it would add to her dignity by keeping her safe so



1       that she doesn't fall and have to have another  
2       surgery.

3       Q.     I'm going to read something, and I want you to  
4       tell me if you agree with me. Falls do not  
5       constitute self-injurious behavior or a medical  
6       symptom that warrants the use of a physical  
7       restraint. Do you agree with that?

8       A.     No.

9       Q.     Have you ever read CMS 483.13(a)?

10      A.     I don't recall. No.

11      Q.     Okay. That's what I was reading from, is a  
12      note in the federal regulations that says, quote:  
13      Falls do not constitute self-injurious behavior or a  
14      medical system that warrants the use of a physical  
15      restraint. So you don't agree with the regulation  
16      statements on the use of restraints?

17      A.     Well, that's talking about falls. And        Ms.  
18      Shealy's behavior was -- the fact that she was being  
19      agitated. And it wouldn't be considered a  
20      restraint, for example, if they used a bell, if she  
21      could do a self-release. So it would not be  
22      considered a restraint. And a pommel cushion would  
23      not be considered a restraint; the deep-seated  
24      cushion that they put in the chair wouldn't be a  
25      restraint if she could still get up.

1 Q. Let's talk about the differentiation of a  
2 restraint, because I think we probably need to get  
3 on the same page. You would agree that any device  
4 that limits your ability to move under CMS  
5 regulations meets the definition of a restraint;  
6 correct?

7 A. I would have to see their definition because  
8 if they -- for example, a belt, if they can remove  
9 it, it's not a restraint.

10 Q. And, ma'am, given this lady's advanced dementia  
11 and the fact that she's hallucinating children  
12 outside of the window on the day that she fell at  
13 Agape and the fact that she is only alert and  
14 oriented times one and that she is not even  
15 responding, according to you, well to the Ativan  
16 that her doctors have prescribed her, are you saying  
17 that she's enough quality of mind that she's able to  
18 remove physical restraints from her chair?

19 A. Well, first of all, I wasn't the one that  
20 assessed and said the Ativan wasn't working. The  
21 nurse documented that in the chart. And, you know,  
22 you would be surprised with patients removing  
23 restraints. They -- they somehow are able to do it.  
24 Like I said, sometimes they take the Lap Buddy and  
25 throw it across the room. So you would be

1 surprised.

2 Q. You would agree that for it to meet the  
3 regulatory definition of removes easily, that you  
4 have to consider the mental status of the patient  
5 before you use any type of restraint; correct?

6 A. That is correct. And that's why they should  
7 have taken a minute and put a restraint on  
8 Ms. Shealy and see if she can remove it. And that's  
9 what you do, is you put it on them to see if they're  
10 able to remove it.

11 Q. You wanted these nurses to put a restraint on  
12 Ms. Shealy without a doctor's order?

13 A. Oh, no. You have to have a doctor's order.

14 Q. Thank you.

15 A. But that's how you test to see if they're able  
16 to remove it. You actually put it on and then you  
17 watch them and see if they're -- you talk with them  
18 about it and see if they're able to remove it. How  
19 else are you going to know for sure that they can  
20 remove it --

21 Q. Sure.

22 A. -- and how are you going to be able to document  
23 what it is, whether it's a restraint or whether it's  
24 just offering support in the chair?

25 Q. Sure. These nurses needed a doctor's orders

1 first; that's all I'm saying. They can't put a  
2 restraint on her, as you've already testified,  
3 without a doctor's order; correct?

4 A. Correct.

5 Q. And they didn't have a doctor's order; correct?

6 A. Correct. So you pick up the phone and you tell  
7 the doctor what's going on, like what is in the  
8 order, to tell the doctor whenever the Ativan or the  
9 agitation is not resolved with the previous  
10 interventions.

11 Q. Yes, ma'am. I think we talked about the amount  
12 of time that nurses are provided to determine if  
13 their interventions are working. So you're not  
14 suggesting that some type of chair alarm would have  
15 been appropriate, are you?

16 A. They used a chair alarm on Ms. Shealy in the  
17 hospital and they used a chair alarm on Ms. Shealy  
18 when she went to the extended care facility. So  
19 they could have tried a chair alarm, yes.

20 Q. Right. And, again, a chair alarm is only  
21 appropriate if somebody is of enough of a mental  
22 state that the sounding of the alarm and the fact  
23 that it can, quote, startle the resident, it can  
24 restrain the resident from normal repositioning  
25 movements, which can be problematic; right?

1 A. No, not necessarily. I mean, that's why you  
2 have to try it. You know, okay, if it didn't work,  
3 you try something else. You have to try. You can't  
4 just say -- you can't look at her and say, oh, no,  
5 chair alarm won't work; you try it.

6 Q. But, again, a chair alarm can be a restraint,  
7 but it requires a physician order?

8 A. Right. And they're not for everybody.

9 Q. Right.

10 A. You have to try it. That's the whole thing  
11 here, is you have to try and see what's going to  
12 help her.

13 Q. After you get a doctor's order for it; right?

14 A. That's correct.

15 Q. Okay. So your complaint is not then that they  
16 didn't have these restraints on Ms. Shealy, because  
17 you agree they had to have a doctor order or a  
18 doctor's order to use these restraints on Ms.  
19 Shealy. Your complaint is that they didn't --  
20 between sometime after when you contend they should  
21 have learned the Ativan wasn't working and the other  
22 interventions weren't working, they should have  
23 called the doctor and maybe gotten an order for a  
24 restraint before she fell?

25 A. Or see what the suggestion was from the doctor.

1 Q. Okay.

2 A. That's the whole point of calling the doctor,  
3 to have another resource to get interventions from.

4 Q. Do you know how long the family was there that  
5 afternoon?

6 A. I believe they were there most of the day. I  
7 believe I remember seeing they were there most of  
8 the day.

9 Q. Do you recall how long they were there, like  
10 how late they were there?

11 A. No. I don't have the exact number of hours in  
12 my head. No.

13 Q. You talked about the provision of ADL  
14 services -- sorry, the documentation of ADL  
15 services. It's true, isn't it, that the  
16 documentation of ADLs, as discussed in CMS's RAI  
17 Version 3.0 Manual Section G, it says, quote:  
18 Although it is not necessary to know the actual  
19 number of times the activity occurs, it is necessary  
20 to know whether or not the activity occurred three  
21 or more times within the last seven days.

22 Do you agree that that's what CMS's manuals for  
23 ADL documentations say?

24 A. I'd have to look at the manual.

25 Q. You're not familiar with that manual?

1 A. I would have to look at it.

2 Q. I'm just asking, are you familiar with it?

3 A. I'm not sure. I would have to look at it and  
4 then I'll let you know.

5 Q. You don't know if you've ever seen that manual?

6 A. That's what I'm saying. I'd have to look at  
7 it.

8 Q. Okay. Okay. It's just that you've testified  
9 about the need to document ADLs in this case; you've  
10 discussed a lot of CMS guidance on these things.  
11 And I'm asking, this CMS guidance on ADL on  
12 documentation, you don't know if you've ever seen it  
13 before?

14 A. Well, I would have to look. I mean, I don't  
15 have everything memorized that I've ever looked at  
16 in my entire life.

17 Q. Fair enough. I certainly don't either. What  
18 CMS regulation have you looked at to prepare for  
19 your testimony today whereby I can go see some  
20 guidance from the federal government that says -- or  
21 the state government, either one, that says that any  
22 time a nurse or someone else in a nursing home takes  
23 someone to the restroom or offers someone a drink of  
24 water they have to document that in the medical  
25 record?

1       A.    Well, they have their flowsheet that they were  
2       documenting that before 5:30.  So they were setting  
3       the standard that they were doing it and then it  
4       just stops.

5       Q.    That's a different question.  I'll get to their  
6       own documentation.  Right now I'm just asking if the  
7       law is right.  CMS, State DHEC, some regulation that  
8       says that they needed to document every time someone  
9       in that nursing home took a resident to either use  
10      the restroom or offered them a drink of water.  Is  
11      that what the law requires?

12     A.    No.  But the documents have to be accurate,  
13     reproducible, describe what happened to the patient.  
14     So --

15     Q.    Sure.  But that doesn't require, for example,  
16     every activity such as toileting or the offering of  
17     food and water to be documented; right?

18     A.    Correct.  But, clearly, Ms. Shealy needed  
19     either toileting or she needed her brief changed, as  
20     described by the family saying that they could wring  
21     it out, wring out the brief, and get urine out of  
22     it.

23     Q.    Did you see that anywhere in the Lexington  
24     Medical Center hospital records whenever they  
25     admitted her?



1 A. No.

2 Q. That wasn't confirmed in the medical records;  
3 correct?

4 A. Well, not everything is always confirmed like  
5 that. Sometimes you do see things like that, but  
6 sometimes you don't.

7 Q. Wouldn't that be something important for a  
8 treating person to put in their medical record?

9 A. Well, it's possible that the daughter removed  
10 the brief herself.

11 Q. Without there being personnel in the emergency  
12 room to --

13 A. It's possible. The family was very involved.

14 Q. It is possible that things occurred that were  
15 not entered into the hospital record?

16 A. Correct.

17 Q. Yeah. It's possible that care was provided at  
18 Agape Nursing Rehabilitation Center that wasn't  
19 entered in an ADL chart?

20 A. Well, it is possible; however, she still ended  
21 up in the situation where her brief was very wet,  
22 according to the family. She still was in a  
23 situation where, you know, the documentation is  
24 showing some of the interventions, very little  
25 interventions that were put in place, so we would

1 look for that. And that's not in the chart,  
2 adequate and appropriate interventions. So --

3 Q. You're saying -- I'm sorry. I didn't follow  
4 the rest of your answer there. You said that we  
5 would look for --

6 A. You look in the chart to see what interventions  
7 they had in place. And they had minimal  
8 interventions documented. So if there was an  
9 intervention in place, it should have been  
10 documented in the chart.

11 Q. But there was a toileting intervention in  
12 place; it's the care plan, isn't it?

13 A. It says incontinence care as needed.

14 Q. And we -- I know -- again, I'm just going to  
15 tell you because you didn't have the benefit of  
16 being here for the trial, there was testimony  
17 provided by Ms. Shealy's sister-in-law earlier this  
18 week that described an incident of toileting that  
19 happened on July 2nd that doesn't appear in an ADL.  
20 Okay?

21 A. Yes.

22 Q. Are you saying that the failure to document the  
23 fact that they took her to the toilet at 10:30 or  
24 11:00 that morning is a breach of the standard of  
25 care?

1       A.    Not necessarily, not that in and of itself.  If  
2       you look at this -- the whole picture of everything  
3       that happened, we have a situation where we had an  
4       agitated, confused person who clearly needed more  
5       interventions to keep her safe, and it wasn't done.

6       Q.    You would agree with me that she went to  
7       Lexington Medical Center following the fall that she  
8       unfortunately had at Agape, that when she was  
9       assessed by the ER doctor, he noted that she had no  
10      pain to report?

11      A.    Sometimes that -- yeah.  But perhaps whenever  
12      he did that assessment, she didn't have any pain.  
13      She had dementia, so it might have been difficult at  
14      times for her to report her pain.

15      Q.    Okay.  But you don't dispute that an hour after  
16      the fall, her medical records confirm she wasn't  
17      experiencing pain?

18      A.    No, I don't dispute that, because the EMS also  
19      said something similar to that.

20      Q.    Do you recall --

21      A.    I'm sorry.  I just wanted to say the statement.  
22      Excuse me.  One minute.

23      Q.    Oh, I'm sorry.  Go ahead.

24      A.    Staff relays that patient has dementia and  
25      they're unable to determine if the patient is

1       injured due to the patient's dementia. Patient is  
2       unable -- this is the EMS records, the paramedics.  
3       Patient is able to relay that she is in pain.  
4       However, when asked where she's hurting, she gives  
5       multiple answers that aren't consistent. So, you  
6       know, it's -- like I said, it waxes and wanes.

7       Q.    And, again, that could explain the  
8       inaccurate -- what you claim to be an inaccurate  
9       assessment on the pain report and Donna Shafer's  
10      initial assessment too, couldn't it?

11     A.    Well, the nurse should not be waxing and waning  
12     with her assessment. She should be accurate. No,  
13     that -- that wouldn't, no.

14     Q.    You would agree that when she arrived at  
15     Lexington Medical Center, she was alert and oriented  
16     times three?

17     A.    I did see that in the record. That's not  
18     accurate.

19     Q.    What do you mean that's not accurate?

20     A.    Alert. So she can sit there and say what her  
21     name is, where she is, and the date.

22     Q.    What's not accurate about that?

23     A.    Well, Ms. Shealy had dementia and I didn't see  
24     that anywhere else where she could say that. So  
25     someone made an error.

1 Q. You're saying someone at Lexington Medical  
2 Center made an error in her ER evaluation?

3 A. Yes.

4 Q. Okay. And how do you know that? Did you talk  
5 to somebody?

6 A. No. But if you look at the entire record, you  
7 know that she hasn't exhibited that type of behavior  
8 where she can say all that. In fact, the day  
9 before, she was -- they described she was  
10 unintelligible, meaning she was having a hard time  
11 getting her words out, and she even had a hard time  
12 saying her name.

13 Q. So despite this professional saying this is my  
14 observations, you'd disagree with that  
15 professional's observations?

16 A. Yes, I do. I think that's an error.

17 Q. Do you think they breached a standard of care?

18 A. No.

19 Q. That documentation error that they've made in  
20 her medical record is not a breach of the standard  
21 of care?

22 A. Well, in my opinion it's an error. I don't see  
23 how Ms. Shealy would go from barely able to say her  
24 name and then sometimes she's able to say her name  
25 to then saying her name, saying I'm in the

1 courthouse in Lexington, South Carolina, and today  
2 is October 24th, 2018, and it's about 2:20.

3 Q. So that error in their medical records, though  
4 wrong, is not a breach of the standard of care?

5 A. It would be a breach because the records should  
6 be accurate. And it's possible that -- I don't  
7 know. I don't know why that's in there. But it --  
8 and it's not in there anywhere else where she's  
9 alert and oriented times three.

10 Q. So it is -- I'm sorry, I --

11 A. Would be a breach, yes.

12 Q. Would be a breach of the standard of care?

13 A. Right. It's an error and would be a breach.

14 Q. And did she suffer any harm as a result of  
15 that?

16 A. No.

17 Q. Okay. Tell me this: What caused Ms. Shealy to  
18 fall when she fell at home back on June 22nd?

19 A. She was out in the garden, she was doing yard  
20 work, and she fell. That's the information that I  
21 have.

22 Q. I'm not asking what she was doing in the yard.  
23 I'm asking what caused -- what was the cause of her  
24 fall?

25 A. Well, it could have been a variety of things.

1 Q. Well, which one was it?

2 A. Well, sometimes it's not just one thing.

3 Q. Which variety of things was it that caused her  
4 to fall on June 22nd?

5 A. Advanced age, all of her diagnoses, impaired  
6 decisionmaking. Maybe she called the wrong shot;  
7 maybe she stumbled. It could be a number of things  
8 that contributed to it.

9 Q. I'm not asking you to speculate, ma'am. Do you  
10 have an opinion as to what caused her to fall?

11 A. No. I can only go by what's in the record.

12 Q. Have you discussed it with family?

13 A. No.

14 Q. And you've been involved in this case for a  
15 number of years now; right?

16 A. I believe they sent me the records in 2015 --

17 Q. 2015.

18 A. -- and it sat for a while.

19 Q. Yep. And, so, at any point during that time,  
20 have you had any communications with her family or  
21 her lawyers about what caused her to fall on June  
22 22nd, 2014?

23 A. No. I didn't find -- that's not necessary for  
24 me to know that. I mean, it would have been nice to  
25 know, but I didn't feel like it was necessary for me

1 to render my opinions, because now she's in a new  
2 environment. Her condition has changed once she's  
3 at Agape because now she's had the fall; she's had  
4 the surgery. She's had the effects of the  
5 anesthesia that she's recovering from, so she has a  
6 different situation. She was more independent when  
7 she was in the yard doing the yard work.

8 Q. Okay. So you formed no opinion as to the cause  
9 of the first fall, just the second fall; right?

10 A. I wasn't asked to form any opinions about the  
11 first fall.

12 Q. So you haven't been paid to form any opinions  
13 about the first fall?

14 A. I wasn't asked to form any opinions about the  
15 first fall.

16 Q. Right. So you weren't compensated to provide  
17 an opinion on that issue; correct?

18 A. I'm not sure if I understand your question.

19 Q. Well, were you paid money by the plaintiff or  
20 the plaintiff's law firm to form an opinion as to  
21 the cause of the first fall?

22 A. No.

23 Q. Okay. Were you paid money to offer an opinion  
24 in this case about the second fall?

25 A. I wasn't paid to offer opinions in this case; I



1        was paid to look at the records. And then if I had  
2        opinions, I was asked to share those with the  
3        attorney. So I wasn't paid to just look at this and  
4        form opinions. That's not how it works. You look  
5        at the records and if you have any opinions, you  
6        share those.

7        Q.    Okay. Well, tell me this: How much have you  
8        been paid for the opinions that you're here  
9        providing for the plaintiff today?

10       A.    I don't have my bills. And I don't know if  
11       their office sent you that one that we talked about  
12       in the deposition, but we have the one. And then I  
13       would have had a bill for my preparation for my  
14       deposition that you and I had together over the  
15       phone, and then also -- you mean just paid by --

16       Q.    I want to know how much money, from the  
17       beginning of your engagement til today, have you  
18       been paid for the opinions that you're here offering  
19       in this courtroom.

20       A.    I'm not paid for the opinions; I'm paid to look  
21       at the records. And if I form opinions, then I  
22       share those.

23       Q.    Okay. Well, how much have you been paid to  
24       share these opinions today?

25       A.    Okay. I don't have an exact number, but I can

1       give an estimate. And if the attorneys can -- I  
2       wasn't asked to bring my bills today, so I don't  
3       have them.

4       Q.    An estimate is fine.

5       A.    Well, I know I had five hours on the first  
6       bill. I can't remember how much my prep was for the  
7       deposition. It seems like our deposition was two or  
8       three hours. And that's it.

9       Q.    You've reviewed a number of records since the  
10      deposition; correct?

11     A.    Correct.

12     Q.    And you're being paid \$145 an hour to review  
13      records as well; correct?

14     A.    Correct.

15     Q.    And you're billing for your travel time here  
16      today?

17     A.    I will bill for -- I drove, so I'll probably --  
18      I'll bill for the travel time. Yes.

19     Q.    And you're billing that at what rate?

20     A.    It was two hours and -- it was like three  
21      hours, so I'll probably charge like 180. Uber would  
22      have been 220, a driver would have been 500, so I  
23      said I'll just drive. So it'll be 180.

24     Q.    I'm sorry, ma'am. I don't mean mileage. I  
25      mean time. How much per hour are you charging?

1 A. I'll charge \$180.

2 Q. An hour for coming here?

3 A. No, no, for the whole trip from Atlanta to  
4 here.

5 Q. Oh, to travel back and forth. And then you're  
6 being paid \$195 an hour for the time that you're  
7 testifying here in the courtroom today; correct?

8 A. Correct.

9 Q. So now that we've kind of reassembled it, can  
10 you tell the jury how much you're being paid for the  
11 opinions that you're sharing with us today?

12 A. Well, I mean, I would have to sit down and --  
13 if we could take a break and sit down and -- since  
14 I'm under oath, I don't want to just throw a number  
15 out there. I haven't created my bill for my time up  
16 until today.

17 Q. Fair enough. I don't want to ask you to put  
18 anything on the record that you're uncomfortable  
19 saying.

20 Tell me about the physical mechanism whereby  
21 Ms. Shealy fell on July 2nd.

22 A. Well, there's two different versions. One was  
23 saying that it was not witnessed and they found her  
24 on the floor, and then there's another one that says  
25 that she was in the wheelchair and she was pulling

1 up on the molding on the side of the hallway or on  
2 the wall and she fell.

3 Q. Okay. Well, let me ask the question another  
4 way. Do you have any information as to what she  
5 physically did to get on the ground?

6 A. No. And I should. It should have been in the  
7 record.

8 Q. When I took your deposition, you told me  
9 initially that she was up walking and should have  
10 had people walking with her when she fell; correct?

11 A. I don't believe I specifically said that she  
12 was walking. I said that she needed assistance.

13 Q. And I asked you on January 30th of 2017. I  
14 said: Are you aware of an environmental hazard that  
15 contributed to Ms. Shealy's fall? And we have your  
16 deposition up there too. We can open it and --

17 A. I have it right here too. Yes. What page are  
18 you on?

19 Q. Page 48. And your answer was: On July 2nd,  
20 2014, I think the fact that she was walking by  
21 herself when the nursing home had determined that  
22 she needed assistance contributed to the fall.

23 A. Okay. And I think my opinion was stated that  
24 way because there was still confusion about how did  
25 she fall, how did she get from being safe to being

1 on the floor being unsafe. So because of the  
2 conflicting information, one thing said that she was  
3 found on the floor, that it wasn't witnessed, and  
4 then they also said, like I described earlier, that  
5 she was pulling up on the molding from her  
6 wheelchair and she fell. So my answer is that way  
7 because of the conflicting information.

8 Q. Okay. Neither of those said she was up  
9 walking; correct?

10 A. Correct.

11 Q. And that was your initial opinion as to why she  
12 fell, that she was up walking without assistance;  
13 correct?

14 A. Correct.

15 Q. That's not your opinion anymore though;  
16 correct?

17 A. Well, like I said, the information is so  
18 confusing as far as what happened with Ms. Shealy in  
19 that day residency.

20 Q. Yes, ma'am. But that information is the same  
21 today as it was when I took your deposition;  
22 correct?

23 A. Correct.

24 Q. And your initial opinion was the reason she  
25 fell was because she was up walking without

1 assistance and that's why she fell; correct?

2 A. Correct.

3 Q. And I'm saying that's no longer your opinion.

4 Correct?

5 A. Correct.

6 Q. You've changed your opinion on why she fell.

7 A. I believe, after looking at the records a  
8 second time and seeing all the consistencies, it  
9 doesn't appear that she was walking. They just said  
10 not witnessed and then they said about pulling up on  
11 the molding.

12 Q. Okay. So can you tell the jury what,  
13 physically, she was doing when she fell?

14 A. No, I can't tell. And I should be able to.  
15 The documents should reflect the information  
16 accurately. We shouldn't have two different  
17 versions.

18 Q. Ma'am, again, I know you didn't have the  
19 benefit of Ebonie McDaniel, a nurse's deposition --  
20 testimony yesterday. She said that when she checked  
21 unwitnessed on the box, she meant that she didn't  
22 see it and she was the one that was completing that  
23 report. Okay? I'm going to tell you that was her  
24 testimony. Okay?

25 A. Okay.

1 Q. Now, it's true that Ebonie McDaniel might not  
2 have been physically looking at Utricia Shealy when  
3 she fell, but there was another nurse there with Ms.  
4 McDaniel [sic] whenever they were -- found her and  
5 were helping assess her. So those two statements  
6 can be completely consistent, can't they?

7 A. Well, then it should have been clarified in the  
8 record if that was the case.

9 Q. Well, semantics can always be better. We could  
10 always be more precise in our word choice. But --

11 MR. CONNOR: Your Honor, this is -- no witness  
12 has ever been identified in the entire history of  
13 this case. This is ridiculous.

14 MR. BLAKE: Her name was stated in the record.  
15 Nurse Fran's name was stated by Ebonie McDaniel from  
16 the stand yesterday.

17 MR. CONNOR: That's the first time we've ever  
18 heard that name.

19 MR. BLAKE: Okay.

20 THE COURT: Proceed.

21 MR. BLAKE: Thank you, Your Honor.

22 BY MR. BLAKE:

23 Q. So, ma'am, with that clarification about the  
24 inconsistencies and how they can be reconciled, can  
25 you tell the jury how she fell?

1       A.    Okay.  No, I still can't, because then the  
2       report should say -- say what Nurse Ebonie said and  
3       then other information that was provided.  It should  
4       be contained in the record and it should be  
5       accurate.  It should describe what happened, what  
6       they saw, if anything.

7       Q.    What does her ER note -- and, again, that ER  
8       note, those are used in nursing homes whenever  
9       something happens and someone is transferred to an  
10      emergency room.  They prepare that record and put it  
11      with the records that go with EMS; correct?

12     A.    Correct.

13     Q.    Right.  And so in that medical record, she  
14      charted a time line of what happened, didn't she?

15     A.    Yes.

16     Q.    Okay.  And that time line describes to the  
17      minute what happened, doesn't it?

18     A.    Yes, it does.  I mean, it doesn't help       Ms.  
19      Shealy as far as her fall and her second hip  
20      fracture.  But, yes.

21     Q.    Sure.  I agree.  I don't disagree that what's  
22      contained in a document necessarily has no bearing  
23      on the outcome of Ms. Shealy's fall or subsequent  
24      treatment.  What I'm saying is you're accusing nurse  
25      McDaniel of breaches of the standard of care, which



1 are serious allegations, aren't they?

2 A. Yes.

3 Q. Because she could lose her nurse's license,  
4 can't she?

5 A. Yes.

6 Q. Right. Any of these nurses that have violated  
7 the regulations that we've spent so much time today  
8 going through, these are all professionals that  
9 could lose their professional licenses for the  
10 opinions that you're sharing in the courtroom with  
11 us today, can't they?

12 A. Correct. But so if they have that information,  
13 then they should have that in the chart reflecting  
14 it.

15 Q. What information is missing?

16 A. The discussion of the other nurse being there  
17 and seeing that. And so the way they have it  
18 charted, it looks like there's two different  
19 versions of what happened.

20 Q. What does the ER note say?

21 A. Before -- at what point?

22 Q. Start at the beginning.

23 A. Ms. Shealy fell to the floor in the hallway by  
24 the PT room.

25 Q. It says where she fell; right?

1 A. Yes.

2 Q. Okay. What's the next sentence?

3 A. Myself and another nurse assessed the patient  
4 and gathered vital signs, and then it has the vital  
5 signs. Patient had complaints of right hip pain,  
6 right shoulder pain, and head pain that stings.  
7 M.D. was notified. M.D. ordered to send resident to  
8 ER. 911 was called. Family was notified. EMS  
9 arrived.

10 Before incident, patient had increased  
11 agitation and was combative. Patient's family was  
12 present with the patient all afternoon while she was  
13 exhibiting these signs. Do you want me to keep  
14 going?

15 Q. Yes, please.

16 A. Patient's family was notified of signs and  
17 symptoms of dementia and why the person was having  
18 the increased confusion and agitation. Patient was  
19 given Ativan 0.5 at 5:30 PM. Patient remained  
20 agitated, confused, and combative. Patient was  
21 moved to the nurses station for close monitoring,  
22 but did not want to remain in that area.

23 Q. Okay. So the part you're saying is missing is  
24 what?

25 A. The part about the wheelchair and the molding.

1 Q. Okay. And why would Lexington Medical Center's  
2 ER need to know that information?

3 A. Well, for the same reason that the EMS needed  
4 to know it. And the EMS said, per staff, patient  
5 was found on the floor in room. Because you want to  
6 know the mechanics of what happened.

7 Q. Okay. And do you assume that that's an error  
8 as well, much like the treating physician's  
9 assessment once she got to Lexington Medical Center  
10 about her being alert and oriented times three?

11 MR. CONNOR: Objection. We've not seen that  
12 record. We have no idea if that's a physician  
13 record.

14 MR. BLAKE: It's in evidence. It's in  
15 evidence.

16 THE COURT: Which document?

17 MR. CONNOR: He's just testifying that this  
18 alert and oriented was some physician assessment.

19 MR. BLAKE: It's Dr. Krusling's assessment that  
20 you asked to be stipulated into the evidence and is  
21 in evidence. I can find it.

22 BY MR. BLAKE:

23 Q. Ma'am, I'm going to show you a record that's  
24 been stipulated into evidence that bears Bates  
25 number 440 on the bottom there. The provider is a

1 Dr. David Krusling. And you received these records  
2 years ago.

3 A. Yes. I saw that in the chart.

4 MR. CONNOR: Your Honor, his question was  
5 not -- his question before --

6 MR. BLAKE: I'm moving on to my next question.

7 THE COURT: Was the question even answered?

8 MR. BLAKE: No.

9 THE COURT: Then withdraw the question.

10 MR. BLAKE: The question is withdrawn. I'll  
11 move on.

12 BY MR. BLAKE:

13 Q. And Dr. Krusling notes that he performed a  
14 physical exam of the patient; correct?

15 A. Yes.

16 Q. And he, as a part of that physical exam, said  
17 that she is oriented to person, place, and time;  
18 correct?

19 A. Correct.

20 Q. She appears well-developed, no distress;  
21 correct?

22 A. Yes.

23 Q. And you have a difference of opinion as  
24 Dr. Krusling does; correct?

25 A. Yes.

1 Q. You think this is a medication record error on  
2 his part?

3 A. Yes, because there's no other information in  
4 the records that I've reviewed. And the family  
5 certainly can comment on that whenever -- if you ask  
6 them questions. But I don't have any information  
7 that said Ms. Shealy was alert and oriented to  
8 person, place, and time.

9 Q. Okay. Just the record that says she was  
10 oriented to person, place, and time?

11 A. That's it. That's the only thing.

12 Q. Okay. And earlier, just so that you don't feel  
13 like I'm talking about records without showing them  
14 to you, I did ask you about this entry in the  
15 record. And, again, it's Dr. David Krusling after  
16 the EMS transport on July 2nd; yes?

17 A. Yes.

18 Q. It says: The severity of the pain is no pain.  
19 Correct?

20 A. Correct.

21 Q. Do you believe that's an error as well?

22 A. That was his assessment. That's what he has in  
23 the record. So...

24 Q. Are there any other physician or provider  
25 records that you reviewed in preparation to share

1       your opinion with us here today that you believe  
2       have errors in them?

3       A.    Not that I recall, no.

4       Q.    So I'll go back to my question.  I got  
5       sidetracked, and I apologize.  I was trying to  
6       understand if you can tell us the mechanism of how  
7       she fell.  And I understand that your testimony is  
8       that you cannot.  Correct?

9       A.    Right.  We have -- it's in the record that it  
10      was not witnessed, and then we have information that  
11      sounds like it was witnessed, about the molding when  
12      she was pulling up.

13      Q.    Okay.  And do you dispute that she was pulling  
14      up on the molding?

15      A.    I mean, I don't know.  I mean, it's in the  
16      records.  So, you know, there's so many  
17      inconsistencies, inaccuracies.  All I can say is  
18      it's in the record.

19      Q.    Okay.  So can you then tell us why she fell?

20      A.    I think she fell because she had decreased  
21      safety awareness, she was agitated, she was  
22      confused, she was in a new environment, and she  
23      wasn't able to -- whether she got up out of the  
24      wheelchair or fell out of the wheelchair, she wasn't  
25      able to prevent that from happening.  So she needed

1 interventions by nursing home staff to prevent that  
2 from happening.

3 Q. Okay. And aside from the one that we've talked  
4 about enough, which is the need to call the doctor  
5 once they determine that enough time had passed and  
6 the interventions of Ativan and put her by the  
7 nurses station weren't enough, what else were they  
8 supposed to do? What other interventions? What  
9 would have prevented this fall?

10 A. You would receive information from the doctor  
11 that would hopefully generate interventions. So  
12 that is one thing, like we said.

13 Q. Yeah. Totally got that covered.

14 A. Okay. Talk with the physical therapist and the  
15 occupational therapist. They had already worked  
16 with her in the morning. They had worked with her,  
17 I believe, at least a couple hours. Their minutes  
18 are charted in the record. So they knew how she  
19 was. So talk with the physical therapist or the  
20 occupational therapist. Get some suggestions from  
21 them. They're great to work with about preventing  
22 falls.

23 Q. Okay. Well, let's pause. What interventions,  
24 after they talked to the physical therapist and the  
25 occupational therapist, should they have put in

1 place that would have prevented this lady from  
2 falling?

3 A. Well, that would depend on what the physical  
4 therapist or the occupational therapist recommended.  
5 They would have had a discussion.

6 Q. Sure. But we don't know what that is; right?

7 A. Correct. I don't know specifically what they  
8 would say. I can't speak for them, but I know  
9 generally what interventions would have been  
10 appropriate.

11 Q. Okay.

12 A. And that's one. One of your resources is PT  
13 and OT.

14 Q. Okay. So aside from calling a doctor or  
15 calling PT and OT because, much like the doctor,  
16 that call to PT and OT, that's only necessary once  
17 you've followed the nursing process that we looked  
18 at on that board and you've determined that the  
19 current interventions are not working; correct?

20 A. Correct.

21 Q. Okay. So what other interventions besides  
22 calling somebody else?

23 A. Okay. Lab Buddy, like we talked about.

24 Q. Well, and, again, correct me if I'm wrong, but  
25 I understand your testimony to be that that had to



1 have a doctor's order. So that puts us back at call  
2 the doctor; right?

3 A. Okay. But you could say, hey, can we try a Lap  
4 Buddy?

5 Q. I understand.

6 A. If he says no, you don't do it or you say --  
7 you know, you could ask him why you don't think it's  
8 appropriate, can we try a seatbelt?

9 Q. Ma'am, I completely understand. I'm not trying  
10 to be rude at all, I'm just trying to keep this  
11 moving. Aside from call the doctor, call the PT,  
12 call the OT, what could they have done absent a  
13 physician's order -- what should they have done  
14 under the standard of care, absent a physician's  
15 order to, prevent this woman from falling?

16 A. Okay. Increased monitoring. And you don't  
17 need an order to talk to PT and OT. You would need  
18 an order for an alarm, you would need an order for  
19 the pommel cushion, you would need an order to put  
20 her in a recliner. That's another option. But, you  
21 know, that keeps patients safe, when they're  
22 appropriate for that. Call the family, I mentioned  
23 that. Ongoing, assessing, and using the nursing  
24 process. Talking to the CNAs. Hey, we got a new  
25 patient, she's a high fall risk, she already fell

1 and broke one hip, let's keep our eyes on her.

2 Q. Okay. Well --

3 A. Talk to the CNAs, make sure they know the  
4 situation.

5 Q. You're suggesting that talking to the CNAs  
6 didn't happen in this case?

7 A. No, I'm not suggesting it didn't happen. But  
8 if it did happen, it wasn't effective.

9 Q. Okay.

10 A. You asked me for ways -- what else could they  
11 have done and --

12 Q. I'm asking you, what intervention, without a  
13 doctor's order, could they have done that would have  
14 prevented this fall?

15 A. Okay. And I'm trying to clarify. Like,  
16 talking to CNAs and educating them would -- you  
17 don't need a doctor's order for that. Let's see.  
18 Hipsters, you need an order for that. The nonskid  
19 socks and shoes, no, you don't need an order for  
20 that. Monitoring the patient after you give them  
21 Ativan, you don't need an order for that.

22 Q. Okay. Do you have any information available to  
23 you that suggests that the absence of nonskid socks  
24 or shoes contributed to this fall?

25 A. I would say that it's an intervention. It is

1 one of the ones you put in place. You know, you  
2 would need to most likely -- with Ms. Shealy, she  
3 needed more than that. That's just one of the  
4 smaller things in her case.

5 Q. Totally understand. I'm just saying, because  
6 you don't know how the mechanism of the fall  
7 happened, you're not offering opinion here for the  
8 jury today that the failure to provide socks or  
9 shoes contributed to the fall; correct?

10 A. Not in and of itself. But it's just another  
11 intervention that's easy to do.

12 Q. There are lots of boxes that you can go down.  
13 I understand.

14 A. And, also, they had all this available to them  
15 too, so they could have gone down that --

16 Q. Sure. But you're not opining that the failure  
17 to get socks or shoes caused her to fall?

18 A. No. Not that in and of itself. No.

19 Q. Okay. And you're not opining that the failure  
20 to have a communication with the CNA caused her to  
21 fall?

22 A. Well, either a failure to have the  
23 communication with the CNA or once the CNA has had  
24 the information, they didn't act on it. That could  
25 have contributed to the fall. Yes.

1 Q. Ma'am, someone could have just turned their  
2 head and looked the other way; correct? They could  
3 have been doing something else at the nurses station  
4 for a moment; correct?

5 A. Okay. So they were very much aware of her  
6 situation, of her agitation, and her confusion.

7 Q. Right.

8 A. Okay? So if she needed -- you are right; that  
9 could have happened. So then as you see her leaving  
10 the nurses station, you go and get her, you talk  
11 with her, and either put her in an activity, call  
12 the family, all the things that I've talked about.

13 Q. Okay. Again -- and you don't know that she  
14 actually left the nurses station; right? As we've  
15 seen, where she is right next to the nurses station;  
16 right?

17 A. It was near the nurses station, but she was not  
18 at the nurses station.

19 Q. Okay. Fair enough. So have I elicited from  
20 you your full opinion on what they should have done  
21 and should have done under the standard of care, but  
22 failed to do that actually caused this fall?

23 A. Yes.

24 Q. Okay. I want to touch on a couple other  
25 points, and then I'll wrap up very quickly.

1           You talked about the inadequacy of training.

2           We've talked about that together before, haven't we?

3           A.    Yes.

4           Q.    You signed an affidavit in this case back in  
5           2015; correct?

6           A.    Yes.

7           Q.    And at that time, you'd never seen the first  
8           piece of training documentation from Agape; true?

9           A.    True.

10          Q.    And in that affidavit, you were under oath,  
11          just like you are here today?

12          A.    Correct.

13          Q.    And in that affidavit -- which you were  
14          compensated for; correct?

15          A.    For what?

16          Q.    The affidavit that you provided.

17          A.    I was paid to look at the records. I wasn't  
18          paid to execute the affidavit, if that's what you're  
19          asking.

20          Q.    Okay. You weren't even paid to type it up  
21          because the plaintiff's lawyers typed it up for you;  
22          correct?

23          A.    They took my opinions that I told them and they  
24          created that.

25          Q.    Sure. And you signed an affidavit saying there

1 was an inadequate training without ever having seen  
2 the first piece of training documentation or video  
3 from Agape; correct?

4 A. That is correct because the records  
5 demonstrated to me that there was a lack of  
6 training. Or if there wasn't a lack of training,  
7 then the people who knew what they were supposed to  
8 do didn't do it.

9 Q. Sure. So I understand that you're saying from  
10 the conclusion, because there was a bad result,  
11 you're inferring from that that there must be  
12 failure of training; correct?

13 A. No. It wasn't from the conclusion; it was from  
14 looking at all the records from Agape.

15 Q. Okay. Now that you've had the benefit of going  
16 through training videos, training materials, you  
17 agree that Agape provided its employees appropriate  
18 training materials under the standard of care, don't  
19 you?

20 A. I thought the video was very appropriate. Yes.

21 Q. And --

22 A. Yes. That video was very appropriate.

23 Q. And you looked at inservice records; correct?

24 A. Yes.

25 Q. And you've looked at the written training

1 materials that were produced in this case by Agape;  
2 right?

3 A. Yes.

4 Q. So is there any flaw or inadequacy in the  
5 training program that was in place?

6 A. I -- no, I didn't notice a flaw. No.

7 Q. Thank you. And, again, nurses, like yourself,  
8 they're just people; correct?

9 A. Correct.

10 Q. And even while well-trained, they might click  
11 on an inappropriate box on an electronic record form  
12 from time to time; true?

13 A. From time to time or several times within a  
14 one-day stay, there's a difference.

15 Q. Okay. But, again, we don't have to go back and  
16 forth on the date stamp issue. You'd agree that  
17 nurses, just like yourself, sometimes make mistakes;  
18 correct?

19 A. We can, yes.

20 Q. And not every mistake, just like Dr. Krusling's  
21 mistake, that's not necessarily a breach of any  
22 standard of care that causes a patient harm;  
23 correct?

24 A. Correct.

25 Q. It's easy to go through a record, thousands and

1 thousands of pages long, and find documentation  
2 errors; right? You have that experience as an  
3 expert witness for attorneys all the time, don't  
4 you?

5 A. I wouldn't say all the time. But, you know,  
6 whenever I'm looking at records, yes. But this was  
7 a very short stay to have so many errors  
8 consolidated with just 27 hours of care.

9 Q. Okay. And do you think that any of the  
10 professionals who did provide care breached the  
11 standard of care so egregiously that they should be  
12 reported to the licensure board here in South  
13 Carolina?

14 A. Well, in my opinion, they breached the standard  
15 of care. Should they be reported? I think that  
16 would be up to the facility to determine, you know,  
17 how their reviews are going and how they're going  
18 with the day-to-day care. And that should be  
19 handled first within the facility.

20 Q. The facility closed in December of 2015. I'm  
21 just asking your opinion as an expert and as a  
22 nurse. Are you here opining that these  
23 professionals' breach of their standard of care --  
24 I'm asking you, does it rise to the level that it  
25 requires a report to the licensure boards?



1 A. No. I think, in my opinion, you know, if they  
2 learn from this -- certainly if I went through  
3 something like this, I would learn. But if the  
4 facility -- I didn't know the facility was closed.  
5 But had they still been open, then this should have  
6 been something that could be handled internally with  
7 extra training, education, and ongoing evaluation  
8 with the particular people involved.

9 Q. Thanks. That's all the questions I have. I  
10 appreciate your time and patience with me. I wish I  
11 was better with documentation.

12 A. Me too.

13 THE COURT: Redirect?

14 REDIRECT EXAMINATION

15 BY MR. CONNOR:

16 Q. Ma'am, did you see any evidence in this case  
17 that this facility did anything to retrain or  
18 reorient these staff members who were involved in  
19 this resident's fall on how to care for a patient?

20 A. No. The inservice information I saw was all  
21 before.

22 Q. In fact, you read Ms. McDaniel's deposition;  
23 correct?

24 A. Yes.

25 Q. And I specifically asked her that question,

1       whether she ever received any training or was aware  
2       of any investigation into these incidents that  
3       resulted in inservice training, discipline, et  
4       cetera, and her answer to that was no; correct?

5       A.     That's correct.

6       Q.     Now, ma'am, the fact that you can't identify a  
7       specific nurse whose conduct was so egregious that  
8       they needed to lose their license is in part the  
9       result of the defendants' totally inappropriate  
10      documentation; correct?

11           MR. BLAKE:  Objection, Your Honor; he's  
12      leading.  Rephrase the question.

13           THE COURT:  All right.  You can try to rephrase  
14      the question.  But we are in redirect and I'm not --  
15      let's move efficiently, but to the best of your  
16      ability.

17      BY MR. CONNOR:

18      Q.     Are you able to even decipher who was involved  
19      in the care of this patient such that she was left  
20      abandoned out of the line of sight to fall to the  
21      floor and sit for an unknown period of time?

22      A.     Correct.  I can't identify because the ADLs  
23      stop -- the activities of daily living stop at  
24      2:20 PM on July 2nd.

25      Q.     Five hours before the fall.

1 A. And, you know, we know some of the people, but,  
2 you know, we don't -- I mean, I don't personally  
3 know any of the other CNAs who were there.

4 Q. Sure. How do we -- and Ms. McDaniel, you've  
5 read her testimony; correct?

6 A. Correct.

7 Q. She has no independent recollection of this  
8 even whatsoever; correct?

9 A. Correct.

10 Q. And for all we know, she was just the nurse who  
11 came upon her in the hall; correct?

12 A. Correct.

13 Q. Or in the room. We don't even know where that  
14 is; right?

15 A. Correct.

16 Q. So to suggest that we have some document that  
17 would point to some person who should lose their  
18 license over this, you're not able to do that, are  
19 you?

20 A. Correct.

21 Q. And that's because of all the things that we  
22 don't know about this case; correct?

23 A. Correct.

24 Q. But what we do know is that Ms. Shealy should  
25 have never ended up in the position that she was in;

1 correct?

2 A. That's correct.

3 Q. And did anything that Mr. Blake asked you --

4 MR. BLAKE: Your Honor --

5 Q. -- about whether --

6 THE COURT: I got to hear an objection.

7 MR. BLAKE: I'm sorry, Your Honor. So far  
8 we've gotten about seven answers -- one-word answers  
9 from the witness and 15-word questions from the  
10 lawyer. She's the expert. She actually needs to  
11 testify.

12 MR. CONNOR: Is that an objection?

13 THE COURT: Sustained.

14 BY MR. CONNOR:

15 Q. Ma'am, can you tell us whether any question  
16 Mr. Blake asked you changes the opinions that you've  
17 provided in this case?

18 A. No. No. Everything that I stated before, they  
19 could have tried, should have tried.

20 Q. And, in your opinion, is it a result of the --  
21 is it your opinion, ma'am -- can you tell us whether  
22 it is your opinion that but for those breaches, this  
23 injury could have been prevented?

24 A. Yes. In my opinion, it could have been  
25 prevented.

1 Q. Now, ma'am, you've read the hospital records  
2 about this patient postdischarge from the nursing  
3 home; correct?

4 A. Yes.

5 Q. And did you see entries in there where this  
6 patient received pain medication?

7 A. At the hospital?

8 Q. Yes, ma'am.

9 A. Yes.

10 Q. Can you tell us whether she underwent actual  
11 surgery to repair her hip?

12 A. She did. She had hip surgery on her right hip.

13 Q. And what is that? Explain to the jury what  
14 that entails.

15 A. Well, again, I'm not a doctor. But it is a  
16 surgery where they have to cut her open and put  
17 screws in and realign the bones and then sew her  
18 back up. So, you know, I've worked with hip  
19 fracture patients, and they have pain; it's painful.

20 Q. To save time, I'm just going to read you this  
21 note by Dr. Dedmond, the orthopedist who performed  
22 that surgery, who states in his history and physical  
23 on 7/3/14 at page 469. And I want to ask you a  
24 question about it.

25 It says: The patient is a 76-year-old female

1       who presents with a history of falls at the skilled  
2       nursing home resulting in inability to walk and  
3       groin pain on the right. Present with complaining  
4       of pain in hip which is constant, worse with  
5       movement, and better if held still.

6               Does that tell you whether or not this patient  
7       was in pain?

8       A.     Yes.

9       Q.     Based off your many years of experience in  
10      treating geriatric patients who have sustained falls  
11      and hip fractures, can you tell us whether common  
12      sense says those are painful injuries?

13      A.     Yes. In fact, the pain is what drives the  
14      patient to get to the hospital. You know, the  
15      nurses are concerned, and so they want to get an  
16      X-ray or sometimes they'll do an X-ray in the  
17      billing. But, yes, the pain is one of the biggest  
18      symptoms that they have a fracture.

19      Q.     Do you have any doubt in your mind, ma'am, that  
20      this patient was in pain as a consequence of her  
21      injury?

22      A.     In my opinion, she was in pain.

23      Q.     Sure. And we know that based off of even  
24      Ms. McDaniel's note; correct?

25      A.     Correct.

1 Q. As well as the EMT's note; correct?

2 A. Correct.

3 Q. And many, many subsequent treaters; fair?

4 A. Yes.

5 Q. Now, ma'am, you were asked what interventions  
6 this nursing home could have done to prevent this  
7 fall. And you've listed, I think, about 20 that you  
8 find that would have been easily implemented by this  
9 nursing home. But isn't the most simple one the one  
10 that was recommended by the therapist, and that  
11 being constant observation of this patient?

12 A. That's correct. The physical therapist had a  
13 note where patient needs constant supervision.

14 Q. And when was the last time we know that an aide  
15 saw this patient?

16 A. 2:20 on July 2nd.

17 Q. And when --

18 A. 2:20 PM.

19 Q. -- was the last time that we know that a nurse  
20 saw this patient?

21 A. 5:30.

22 Q. And when did she fall?

23 A. 7:25 PM.

24 Q. That's all the questions I have, ma'am. Thank  
25 you.

1 THE COURT: You may step down.

2 Ladies and gentlemen, we're going to take a  
3 short afternoon break here before we call our next  
4 witness. I ask that you retire to your jury room  
5 for the next few minutes, refresh yourself, and  
6 we'll get you back in here in a few minutes. Please  
7 don't discuss the case in any way. Thank you.

8 (The jury exits the courtroom at 2:57 PM.)

9 (Brief recess 2:57 PM - 3:14 PM.)

10 THE COURT: All right. Let's bring the jury  
11 back in, please.

12 (The jury enters the courtroom at 3:14 PM.)

13 THE COURT: Mr. Foreman, ladies and gentlemen  
14 of the jury, we'll pick back up with the plaintiff's  
15 case.

16 MR. MCALISTER: Your Honor, at this time, the  
17 plaintiff calls Jennifer Hartley.

18 JENNIFER HARTLEY

19 being first duly sworn, testified as follows:

20 THE WITNESS: I will.

21 THE CLERK: Have a seat and state your full  
22 name, please.

23 THE WITNESS: Jennifer Shealy Hartley.

24 DIRECT EXAMINATION

25 BY MR. MCALISTER:



1 Q. Ms. Hartley, how are you today?

2 A. I'm fine, thank you.

3 Q. Where did you grow up?

4 A. I was born and raised in Batesburg-Leesville.

5 I grew up in Batesburg-Leesville. I graduated

6 Batesburg-Leesville High School.

7 Q. And when did you graduate?

8 A. In 1990.

9 Q. Okay. And what did you do after graduation?

10 A. After graduation, I went on to Midlands

11 Technical College Airport campus and pursued a

12 certificate in medical assistant and phlebotomy.

13 Q. And did you work as a medical assistant after

14 college?

15 A. I did mostly phlebotomy doing lab work.

16 Q. When did you work in that field?

17 A. Total, from 1990 to 2016.

18 Q. Now tell us, do you have children?

19 A. I do. I have two children; a daughter that's

20 23 and a son that's ten.

21 Q. And do they live here in Lexington County as

22 well?

23 A. They do.

24 Q. Please describe for the jury how you're related

25 to Ms. Utricia Shealy.

- 1           A.     That is my mother.
- 2           Q.     And we heard testimony earlier in the trial
- 3           from Amy Davis. How are you-all related?
- 4           A.     That's my sister.
- 5           Q.     Okay. Do you have any other siblings?
- 6           A.     I do; an older sister Debbie and an older
- 7           brother Ronnie. I'm the oldest of four.
- 8           Q.     And we also heard from Helen Koon. How are you
- 9           related to Ms. Koon?
- 10          A.     She's my aunt. That's my brother's -- my
- 11          mother's brother's wife.
- 12          Q.     And where do you presently reside?
- 13          A.     I presently reside on 1694 Ridge Road in
- 14          Leesville, which is on what we call the homeplace
- 15          for the Koon land, family land. I reside right
- 16          behind where my mother used to live.
- 17          Q.     So your property is adjacent to hers?
- 18          A.     Yes, sir.
- 19          Q.     Okay. How close?
- 20          A.     Her house is maybe 300 feet in front of me --
- 21          was.
- 22          Q.     So you could throw a rock and hit it?
- 23          A.     Yes, sir.
- 24          Q.     You share a driveway?
- 25          A.     We did.

1 Q. And how long has that property been in your  
2 family?

3 A. It has been in the Koon family -- they farmed  
4 cotton and did a lot farming on that land back in  
5 the day. There was over 200 acres. I believe, if I  
6 can recall, it's been in the family since the 1920s.

7 Q. So it holds some special meaning to y'all?

8 A. Very much so.

9 Q. Let me show you a photo that's been previously  
10 marked as Plaintiff's Exhibit 1E. I just want you  
11 to tell us about this photo. Where was this photo  
12 taken?

13 A. That photo was taken in my mother's garage.  
14 All of the family members spent a lot of time in the  
15 garage. She had it fixed up, like, with a little  
16 table and couch out there, especially for all the  
17 special occasions we had throughout the year.

18 All the grandchildren and all of us children,  
19 husbands, wives, aunts, uncles would sign this  
20 entire whole wall with a statement or saying to her  
21 of just how wonderful a person she was. And we did  
22 that at least four times a year.

23 Q. Now let's change gears just a moment. Tell the  
24 jury about what you understood the plan would be for  
25 her at Agape.

1       A.    After her first left hip surgery, the plan was  
2       the admission to Agape for a few weeks, four to six  
3       weeks, for rehabilitation to get her back on her  
4       feet and get her back home.

5       Q.    And in anticipation for your mom's return home,  
6       did the family do anything or take any -- make any  
7       preparations?

8       A.    We did. My Uncle Larry and a few others got  
9       together, and we helped, and they built a ramp going  
10      into her garage so it would be easier for her to  
11      even walk up on when she came home due to the  
12      surgery. My daughter done a lot of different  
13      rearranging to the gardening and the yard work  
14      outside, made the patio more accessible for her to  
15      be able to go out there.

16      Q.    Okay. And then did you have the opportunity to  
17      see your mother at Agape that first evening on July  
18      1st?

19      A.    July 1st, yes. It was myself and my daughter  
20      and my two other sisters when they admitted her --  
21      when they transferred her from the hospital to Agape  
22      on July 1st.

23      Q.    How about the next day?

24      A.    The next day, no. It was my son's birthday the  
25      next day on July 2nd and we had a gathering and a

1        little birthday party for him with the kids, so I  
2        didn't make it over that day.

3        Q.     How did you find out about your mother's fall  
4        that particular evening?

5        A.     That evening we were just wrapping up the  
6        birthday party, and right at 7:34 I got a call from  
7        my sister Amy stating that she had fell and we  
8        needed to get to the emergency room as soon as  
9        possible.

10       Q.     So you and your -- what did you do then?

11       A.     At that time, I basically yelled for my  
12       daughter Brianna to come on. And my husband was  
13       home at the time, so he stayed there back with my  
14       youngest child, and my daughter and I headed to the  
15       emergency room.

16       Q.     How were you feeling at that time?

17       A.     On the way over there, of course Brianna and I  
18       were just thinking the worst before we actually got  
19       there and wondering if this could actually be the  
20       last time, the last straw Mom had to even make it.  
21       And we had a lot emotions running through our head.  
22       Scared. I don't even remember driving there; I just  
23       know I got there.

24       Q.     And when you arrived at the hospital, what kind  
25       of condition was your mom in?

1       A.    Of course immediately they took us both back to  
2       join my two sisters.  She was laying there in  
3       intolerable pain, screaming, very agitated.  She was  
4       confused.  She -- there was a part of her that she  
5       knew she had fell once again and, like, why me, now  
6       another hip, so to speak.  And she was just  
7       miserable.

8       Q.    Okay.  Did she say anything to you?

9       A.    She did.  It's like she would grab towards you  
10      and pull you down and would say, I'm in pain; tell  
11      them to do something, you know, get me some help.  
12      She did at one point tell my -- all three of us that  
13      she needed to use the restroom, to please help her  
14      use the restroom.

15     Q.    And what did you do then?

16     A.    At that time we -- I stuck my head out the  
17      curtain to get help.  And, of course, everyone is  
18      busy.  With it being us four in the room, my two  
19      sisters and my daughter, we challenged to try to get  
20      a bedpan under her.  Actually, one of the aides  
21      handed us a bedpan and left us -- you know, we told  
22      them it was fine, left us to see if we could do it.

23               And when we pulled back the sheet, we  
24      discovered that that's one thing why she was so  
25      irritable besides the hip is that she had a diaper

1       on that I guarantee weighed six pounds or plus of  
2       urine. And we tried to get it off -- well, we did  
3       get it off and it just ripped into shreds getting it  
4       off.

5       Q.    And at some point thereafter, did you have  
6       discussions with orthopedist doctors about options?

7       A.    Correct. Once -- of course, after they took  
8       her for a CT scan of her head because she hit her  
9       head as well. The CT scans of her hip, I believe  
10      they did chest X-rays, you know, just to make sure  
11      everything was not damaged as well with the hip.

12           He said basically, repeatedly, here we are  
13      again, seven days later, opposite hip. It is  
14      basically broke or fractured the same way the left  
15      one was, but not as to the extent that he would not  
16      have to definitely go in invasively and fix it, that  
17      it still needed to be fixed. But he gave us the  
18      option between three different options, and his  
19      opinion was do the most noninvasive procedure, which  
20      was the pinning, and that that way he could  
21      hopefully just do it from the outside and not have  
22      to do any incision and that would not prolong her as  
23      well too to be under deeper and longer anesthesia.  
24      He wanted to help her as best he could.

25      Q.    What was your understanding of the nonoperative

1 option? What would her options be there?

2 A. The way he explained it to us -- and he was on  
3 our level. He didn't use a whole lot of medical  
4 terms. But there would be three options: The  
5 pinning, which he explained to us. The nonsurgical  
6 would just be not fix it at all. But at her age at  
7 that time and still trying to recover from a first  
8 hip surgery, that she would be bedbound and  
9 miserably lay there the rest of her life if we  
10 didn't do something to fix the second hip.

11 The third procedure would have been, basically,  
12 a total hip replacement, which was not an option  
13 because she didn't need that complete total hip.  
14 He, you know, didn't think she needed any plates,  
15 but just mostly the pins and screws.

16 Q. You-all didn't believe that she could handle it  
17 without the surgery; correct?

18 A. No, sir, not at that age. She would never have  
19 healed correctly. He advised us that wouldn't have  
20 healed correctly and she definitely would have never  
21 had even an opportunity to live a decent life.

22 Q. And were you concerned about your mom going  
23 back under anesthesia?

24 A. Absolutely. We all were. It was a sense that  
25 the -- Dr. Dedmond, he sat us down and explained



1       that, you know, she's a strong woman, but he  
2       couldn't promise that he could make her as strong as  
3       she needed to be. He promised us to give her the  
4       least anesthesia --

5               MR. MANN: Objection, Your Honor; hearsay.

6               THE COURT: It's an -- I mean, it's an ongoing  
7       testimony. I'll sustain the objections for hearsay  
8       because she's -- try to rephrase your question.

9               MR. MCALISTER: Your Honor, these are  
10       statements with respect to the medical diagnosis and  
11       it's her interaction regarding the anesthesia and  
12       the conversations she had with the doctor.

13              THE COURT: Okay. Let me have just one second.  
14       Y'all approach, just real quick.

15              (Sidebar conference.)

16       BY MR. MCALISTER:

17       Q.     Now, after this fall at Agape and the second  
18       surgery, how was your mother after that?

19       A.     After the second surgery, she was confused.  
20       She went in telling me that she loved me; I told her  
21       I loved her. She knew that I was Jennifer. After  
22       the second surgery, she could scream your name out,  
23       but she did not know you if you got in her face.  
24       She didn't know I was Jennifer. She could remember  
25       a name, but she didn't know who we were.

1 Q. So she did not seem to progress?

2 A. She did not. We were told to give it time.

3 Q. And I'm going to show you what's been marked as  
4 Joint Exhibit 3. And these are records from  
5 Lexington Orthopedic. I'm going to ask you about  
6 one particular section. It says: History of  
7 present illness. And it says: Family is concerned  
8 because mental status remains worse than prior to  
9 her injury. Is that something that you-all  
10 expressed to the doctors?

11 A. Yes.

12 Q. Okay. And that would have occurred after the  
13 second surgery; correct?

14 A. Correct.

15 Q. And what's the date of service at the top  
16 there?

17 A. July 17th, 2014.

18 Q. Thank you, ma'am.

19 Now, after the surgery, did the family try to  
20 see your mother as much as possible?

21 A. Absolutely.

22 Q. And were you able to take her away back home or  
23 back to the homeplace on occasion?

24 A. We did. I believe the first time we tried was  
25 in 2015 to bring her back home to her home on an

1 occasion -- it may have been Easter of 2015 -- to  
2 see if we could recollect her memory of where she  
3 was.

4 Q. Just to see if it might trigger something?

5 A. Just trigger something, yes.

6 Q. I'm going to show you a picture that's been  
7 previously marked as Plaintiff's Exhibit 1F. I want  
8 you to tell me a little bit about this picture.

9 A. That picture was actually that following  
10 Christmas at my house. That's our group picture of  
11 our family.

12 Q. So this would have been after that second fall  
13 at your home?

14 A. Correct.

15 Q. And that's you there to the right side of your  
16 mother?

17 A. Correct.

18 Q. Is that your daughter there beside you?

19 A. Standing, yes, sir.

20 Q. And is this some of the remaining family  
21 members in this photo?

22 A. It is my sister and brother and their families.

23 Q. You indicated that one of the reasons you  
24 brought your mother back home or to the homeplace  
25 was to try to elicit and trigger some additional

1 memories. Did that happen?

2 A. It did not. She didn't even recognize my own  
3 home.

4 Q. I'm going to show you one last picture marked  
5 as Plaintiff's Exhibit 1G. Tell me a little bit  
6 about this photo.

7 A. That's a photo exactly a week -- it was on a  
8 Sunday, the week before she fell the first time on  
9 June 24th -- or June 22nd at my house. I had cooked  
10 Sunday lunch and I called her and she walked down  
11 and came and ate with us.

12 Q. So she just walked over from -- her house was  
13 about 300 yards?

14 A. Correct. She'd always --

15 Q. Or 300 feet. I'm sorry.

16 A. Correct. She'd always walk instead of drive.

17 Q. Now, did she ever have an opportunity to walk  
18 over there again?

19 A. Not after that day.

20 MR. MCALISTER: No further questions. I'd ask  
21 the Court to admit these pictures into evidence.

22 MR. BLAKE: Without objection, Your Honor.

23 THE COURT: All right. We're now at 8? 9?

24 MR. MCALISTER: We put them at the end of 1, E,  
25 F, and G, since we already have pictures.

1 THE COURT: So these are already admitted?

2 MR. MCALISTER: Well, we had them previously  
3 marked. We just want to make sure --

4 THE COURT: Okay. So --

5 MR. MCALISTER: This is 1E, F, and G.

6 THE COURT: 1E, F, and G admitted into evidence  
7 without objection.

8 (Plaintiff's Exhibit Nos. 1E, 1F, 1G admitted  
9 into evidence.)

10 CROSS-EXAMINATION

11 BY MR. MANN:

12 Q. Ms. Hartley, how are you?

13 A. I'm good.

14 Q. I'm sorry we're meeting under these  
15 circumstances. I'm going to be very, very brief.  
16 Tell me what a phlebotomist is. I know I used to  
17 know.

18 A. A phlebotomist is -- you draw blood. You work  
19 in a lab or a doctor's office and you draw blood.

20 Q. Okay. So you've got somewhat of a healthcare  
21 background?

22 A. Somewhat, more in the lab.

23 Q. Tell me about your mom's condition. You lived  
24 on the same piece of property that she lived on;  
25 correct?

1 A. Correct.

2 Q. You're on the, I think, back side of it, as  
3 it's described, or she is?

4 A. I'm on the back side.

5 Q. All right. Tell me what condition she was in  
6 physically when she fell on, I believe it is, June  
7 22nd, 2014.

8 A. Physically, she was -- for her age, she was  
9 good. She did all of her gardening. She still  
10 prepared her small meals; she cleaned. She's a --  
11 she was a house freak, loved to clean house.

12 Q. How was she as far as ability to walk around?  
13 Did she use a cane?

14 A. She did not use a cane.

15 Q. Did she ever use a walker?

16 A. Never a walker.

17 Q. What type of -- and I believe we've already  
18 asked some of these questions of, I think, your  
19 sister Amy. What type of safety devices does she  
20 have? Does she carry a cell phone with her?

21 A. She had a cell phone. She used it  
22 occasionally.

23 Q. Did she have a pendant, like a ring pendant, if  
24 she fell somewhere where she could notify someone?

25 A. No.

1 Q. Okay. Now, I believe you testified that you  
2 went to Agape Nursing & Rehab on July 1. Did you go  
3 in response to the facility calling and saying that  
4 your mother was agitated or did you go there as a  
5 result of something else?

6 A. I went there as a result. That's when her  
7 admission date was, was July the 1st around 4:00 or  
8 4:30. And we were all at the hospital when they  
9 transferred her and we admitted her to Agape.

10 Q. Okay. So when the phone call came in that she  
11 was agitated, were you one of the ones who went back  
12 that night or did you --

13 A. I went to the ER first. And then, yes, at  
14 midnight that night, or somewhere around in that  
15 time, my sister and I, Amy, and my daughter,  
16 Brianna, went to Agape to gather her belongings.

17 Q. And I may have misphrased my question. On July  
18 1 -- I believe the testimony has been that on July  
19 1, Agape Nursing & Rehab called and said that your  
20 mother was agitated. Do you recall that?

21 A. Yes. I did not go to that visit; my sister  
22 did.

23 Q. And I believe that your testimony was that you  
24 got a telephone call on July 2 around 7:34 PM saying  
25 that your mom had fallen; correct?

- 1 A. Correct.
- 2 Q. And you went immediately to Lexington --
- 3 A. ER.
- 4 Q. Okay. Do you know what time, approximately,
- 5 you got there?
- 6 A. Shortly after 8:00; 8:15, 8:20. Shortly after.
- 7 Q. And if I'm correct, understanding your
- 8 testimony and the testimony so far in this case, the
- 9 family had been -- your sister and your, I believe,
- 10 aunt, Ms. Koon, had been with your mother up
- 11 until -- I believe your aunt may have left earlier
- 12 in the afternoon, but your sister had been, on July
- 13 2nd, at Agape Nursing & Rehab with your mom until
- 14 around 5:00 or 5:30; correct?
- 15 A. Yes, sir.
- 16 Q. Okay. And when you got to Lexington Medical
- 17 Center, how long was it before you discovered this
- 18 diaper that you estimate weighed six pounds?
- 19 A. Less than an hour since I had been -- since I
- 20 got there.
- 21 Q. Okay. And you were here earlier when your aunt
- 22 testified that when she was there that day, that
- 23 afternoon she had taken your mom to go toilet;
- 24 correct?
- 25 A. Correct.



1 Q. Okay. Let me ask you this: They showed you a  
2 Lexington Orthopedic record that said -- well,  
3 before I get there, did anyone in your family report  
4 to Lexington Medical Center regarding the adult  
5 diaper that was overflowing?

6 A. It was spoken to with the assistance of the  
7 nurses in the ER. Yes, it was. Whether they  
8 documented it, we don't know.

9 Q. Okay.

10 A. She was having some kidney issues as well.

11 Q. Are you aware that in that Lexington Orthopedic  
12 record, the staff at Lexington Orthopedic noted  
13 that, I believe, about seven days after your  
14 mother's surgery, that she was back to her baseline  
15 mentation, that she was back to where she was  
16 presurgery mentally?

17 A. No, sir. I don't recall that at all.

18 Q. Would it help if I showed you that?

19 A. You can show me. But I've never seen those  
20 medical records before, so it would be my first time  
21 seeing them.

22 Q. Okay. Would you disagree with those medical  
23 records? If I just told you that the medical record  
24 says that one week after the surgery, she's back to,  
25 quote, her baseline mentation, would you disagree

1 with that assessment?

2 A. Would you explain baseline mentation?

3 Q. Back to where she was mentally before the  
4 second surgery.

5 A. I would agree that that is not correct. That  
6 is not what we seen our mother as being. She was  
7 not back to her -- after her second surgery, to her  
8 mentation that she did before her first surgery.

9 Q. Would you say that's a mistake in the medical  
10 record?

11 A. I'm saying that that's my mother and I know  
12 what I seen and lived with from that day on.

13 Q. Yes, ma'am. Okay. That's all I have. Thank  
14 you.

15 THE COURT: Any redirect?

16 MR. MCALISTER: Very quickly, Your Honor.

17 REDIRECT EXAMINATION

18 BY MR. MCALISTER:

19 Q. Ms. Hartley, had you gotten a call from Agape  
20 on July 2nd, 2014, indicating that they needed you  
21 to come back to the nursing facility, would you have  
22 gone?

23 A. Of course I would have.

24 Q. And I'm going to show you what is marked as  
25 Joint Exhibit 1 -- 2A. I know you're not a medical

1 professional, but I'm going to ask you to take a  
2 look at this picture for me --

3 MR. MANN: Your Honor, I believe this is  
4 outside the scope of cross-examination.

5 THE COURT: Let me ask you -- let's see where  
6 he's going and make a determination.

7 (Sidebar conference.)

8 BY MR. MCALISTER:

9 Q. Ms. Hartley, after this second fall, in your  
10 observations, did your mom ever come back mentally?

11 A. No, sir, she did not.

12 Q. Thank you, ma'am. No further questions.

13 MR. MANN: No questions.

14 THE COURT: You may step down, ma'am.

15 MR. MCALISTER: Your Honor, at this time, the  
16 plaintiff would like to publish two X-rays.

17 THE COURT: Very well. From the joint  
18 exhibits?

19 MR. MCALISTER: Yes, sir. That's correct.

20 This is Joint Exhibit 1 -- excuse me. Joint  
21 Exhibit 2A. This is imaging from Lexington Medical  
22 Center on July 3rd, 2014 at 5:37 PM. It shows  
23 Utricia Shealy, pinning right hip. And this is  
24 Joint Exhibit 2B. This is also a film from  
25 Lexington Medical Center on July 3rd, 2014 at

1       5:37 PM, also of Utricia Shealy, pinning of the  
2       right hip,               Dr. Dedmond. Thank you, Your  
3       Honor.

4               MR. CONNOR: Your Honor, at this time the  
5       plaintiff rests.

6               THE COURT: Very well.

7               Ladies and gentlemen, I've got some matters to  
8       discuss with the attorneys at this time. I'm going  
9       to go ahead and send you back to your jury room for  
10      now. I'll try to get you back in here as soon as  
11      possible.

12              (The jury exits the courtroom at 3:45 PM.)

13              THE COURT: Counsel?

14              MR. BLAKE: Can I have two minutes, Your Honor?

15              THE COURT: Sure.

16              MR. BLAKE: Thank you.

17              THE COURT: Okay. Counsel?

18              MR. BLAKE: At this time, both defendants would  
19      like to move for directed verdict. As Your Honor is  
20      familiar with, there are two primary causes of  
21      action and something stated as a third cause of  
22      punitive damages which is under two causes of  
23      action. But I'll deal with them in the order in  
24      which they're pled.

25              So the first cause of action raised in the

1 complaint is a cause of action for professional  
2 negligence. And the theory that was pled in the  
3 complaint is basically sort of a seven-bullet-point  
4 allegation within paragraph 48. That deals with an  
5 alleged failure to provide accurate and appropriate  
6 admission assessment and failure to provide adequate  
7 and appropriate fall prevention, failure to provide  
8 adequate and appropriate care plans specific to Ms.  
9 Shealy relating to fall and safety, adequate and  
10 appropriate services to accommodate individual  
11 needs, failure to provide staff with knowledge and  
12 skills in the residence, frequent falls, and failure  
13 to provide Ms. Shealy with the necessary care and  
14 services to allow her to maintain the highest  
15 practical mental, physical, and psychosocial  
16 well-being. They've alleged federal and state law,  
17 the South Carolina Adult Protection Act, South  
18 Carolina Department of Health and Environmental  
19 regulations 61-17, the South Carolina Bill of  
20 Rights, and the South Carolina Nurse Practices Act.

21 So these allegations stem essentially to those  
22 professional persons working in the nursing home and  
23 it alleges that they failed to meet the professional  
24 standard of care, that Mr. Connor has done a good  
25 job of presenting to the Court in this case, the

1 evidence in and of itself to the jury. The flaw in  
2 most of the evidence, pointed out best by their  
3 expert, which she came in and tried to tie together  
4 professional negligence, while there is  
5 documentation error, those errors have not been  
6 shown, and whether those errors have any type of  
7 causal connection that in any way resulted in the  
8 harm that I saw, which is the harm that that  
9 happened because she fell at Agape on July 2nd,  
10 2014. At most, when pressed upon it, Plaintiff's  
11 expert testified that it was the failure to call  
12 physicians, failure to call the physical therapist,  
13 failure to call the occupational therapist and,  
14 essentially, the failure to assess quick enough that  
15 there has not been successful intervention by the  
16 Ativan that was undisputably given in the patient's  
17 location near the nurses station. And we don't  
18 believe -- because they were able to establish the  
19 time line, they were unable to establish how they  
20 were.

21 The standard of care on that board, the circle  
22 of the evaluation, that must occur. They failed to  
23 show that the nursing process was violated in any  
24 way because of the time line. Medicine given to the  
25 patient, assessed and found to still be combative,

1 patient moved to the nursing station. The expert,  
2 when pressed, was unable to give us a time line to  
3 to establish for the jury that they delayed too long  
4 in seeking the next intervention; they delayed too  
5 long in calling the doctor. She fell, therefore  
6 they must have delayed too long. And that type of  
7 backwards-looking analysis, it's, well, she fell; it  
8 must have been too long. But, in fact, she has no  
9 idea and no evidence that the nursing process was  
10 too delayed, that that cycle had ran its course for  
11 too long for someone to have made the decision to,  
12 you're right, we should call the doctor now. The  
13 jury is just not armed with the facts to make that  
14 finding. And she testified she had no personal  
15 knowledge, no one else who has testified has said  
16 they had knowledge; they were gone; they weren't  
17 there. There's not a single piece of evidence for  
18 the jury to take back and say, you know what, we  
19 agree these folks breached the standard of care.  
20 Because of that, both defendants are entitled to  
21 directed verdict on that ground on the first cause  
22 of action for professional negligence.

23 Additionally, I would say that the defendant  
24 Agape Management Services, Inc., is further entitled  
25 to directed verdict on this cause of action because .

1       there's been no evidence established in this case  
2       that they had any employee or agent involved  
3       directly in the allegations that fall under  
4       professional negligence. All of those persons  
5       employed by defendant Agape Nursing & Rehab Center,  
6       Inc. -- therefore, no licensed professional who was  
7       alleged for whom the management company who provides  
8       the contract to the services in the record, the IT  
9       services, the training services that the legal and  
10      financial support services -- essentially, they  
11      weren't an employing entity. They may have employed  
12      professionals that may have breached the standard of  
13      care as an additional ground. I can either keep  
14      moving or he can respond in turn. However you  
15      prefer to do it.

16           THE COURT: Just go through all three.

17           MR. BLAKE: So the second cause of action is  
18      one of ordinary simple negligence. And the theory  
19      here is that there are essentially evidence in this  
20      case that while not within the umbrella of  
21      negligence, that falls within professional  
22      negligence, perhaps some other negligence that  
23      occurred in this case whereby the jury can say we  
24      can disregard the professional liability under  
25      another standard of care. And first, as to the



1       defendant Agape Nursing & Rehab, every person that  
2       is alleged to have done something wrong is a  
3       professional license holder that is entitled to the  
4       protection of the statute. While it's not  
5       all-inclusive, the only acts identified by the  
6       expert who has been providing causation testimony in  
7       this case, the only acts identified were  
8       professional acts. Failure to follow the licensed  
9       professionals. Everything that has been presented  
10      in this case, in the plaintiff's case in chief, are  
11      professional acts that are subject to professional  
12      regulation. That's the very basis for negligence,  
13      per se, is all of this conduct is OBRA or CMS or  
14      some other framework, and within that framework,  
15      they have to meet the burden. So there's been no  
16      evidence that has been tied through any kind of  
17      causative evidence to have caused this plan of harm.  
18      Without doing that, the elements for ordinary  
19      negligence, as it relates to the operating entity,  
20      Agape Nursing & Rehabilitation, Inc., should not be  
21      submitted to the jury.

22             The management for which they could possibly be  
23      directly liable for ordinary negligence relates to  
24      the training. Yes, there's been evidence of  
25      training conduct relative to this case that Agape

1 Management Services, Inc., provided to Agape Nursing  
2 & Rehabilitation, Inc. under its contract, that when  
3 pushed upon the expert that said, hey, the training  
4 was inadequate, she immediately conceded on cross,  
5 I've been through everything and, you're right, the  
6 training materials themselves are not inadequate.  
7 It's inadequate because she fell. That's dearth of  
8 any opinion, right but the jury has to have some  
9 factual basis by which to weigh the credibility of  
10 that expert's opinion. And when I pushed her on  
11 that today, she said, no, you're right. Now that  
12 I've seen everything, now that I've waded through  
13 the materials, now that I've watched the video, it's  
14 up to snuff, and I have no objection to the training  
15 provided. So just the mere fact that an accident  
16 occurred allowed the jury to believe that an  
17 accident must be a breakdown in training; therefore,  
18 we can infer ordinary negligence that they had  
19 contracted Agape Nursing & Rehab to provide those  
20 services. I think that's a bridge too far and the  
21 only other ground for the management company is that  
22 I do believe that the duty may be too -- I haven't  
23 had time to do legal research on this. I'm not  
24 aware though, off the top of my head, and if  
25 Mr. Connor has case law, case law in South Carolina,

1       that says a management company that's an independent  
2       contractor provide training services that that  
3       agreement creates a co-duty to third parties and,  
4       ultimately, we're here on a claim by a resident. I  
5       would have to see some case law on contractual  
6       parties between accountant and corporation that  
7       doesn't let third parties do that. I have not  
8       researched that in the context of management company  
9       and nursing home. That's a question of law for the  
10      Court to decide.

11             I think directed verdict may also be  
12      appropriate to that ground -- and then finally,  
13      again, I don't believe -- this is a bifurcated  
14      trial --

15             MR. CONNOR: Not going to argue as long as it's  
16      preserved --

17             THE COURT: And I don't want to step on  
18      anybody, but --

19             MR. CONNOR: On the punitives, it's appropriate  
20      for this Court -- for the jury to decide whether the  
21      circumstances warrant a punitive whether by clear  
22      and convincing evidence, the conduct warranted  
23      reaches the level of punitive conduct, then the next  
24      phase is on the actual damages. We're not going to  
25      retry the whole case on --

1           THE COURT: Right. I was going to say if they  
2 come back with a verdict, then they get a shot at  
3 punitives. Punitives should just be thrown out.

4           MR. BLAKE: Yeah. At this point -- and I don't  
5 expect you to grant it at this point. I don't think  
6 punitive damages have been established. The  
7 punitives conduct has to have a direct causal  
8 relationship for the harm for punitive damages. One  
9 of these nurses or some person within the building  
10 should have known to pick up the phone, call family,  
11 a doctor, physical therapist, or occupational  
12 therapist. And without the jury knowing how much  
13 time was passing between those, I don't know how  
14 they could say that the failure to do so was so  
15 egregious that it warrants punitive damages.

16          MR. CONNOR: Thank you, Your Honor. On the  
17 negligence claim -- that was a lot to try to  
18 remember to respond to in this fashion. But there's  
19 undisputed evidence. And, given the fact that  
20 there's no expert here on behalf of the defendant,  
21 that will remain undisputed that these defendants  
22 were professionally negligent. Mr. Blake seemed to  
23 forget everything that the expert in this case --  
24 that the expert testified to. And that was failure  
25 after failure after failure that caused harm to this

1 patient.

2 As you're well aware, when you're considering a  
3 motion in the light most favorable to the nonmoving  
4 party, that would be us. You've heard from witness  
5 after witness, including professionals employed by  
6 the defendants, that cannot explain the conduct of  
7 the defendants at issue. We even heard one of the  
8 witnesses acknowledge that she breached the standard  
9 of care as it related to the administration of one  
10 of these medications.

11 The defendant should not get the benefit of the  
12 fact that their own recordkeeping practices don't  
13 allow us to recreate this two-hour window where  
14 there was no care provided. That, in and of itself,  
15 is negligent. A facility should not be leaving  
16 residents in the condition that this resident was  
17 last assessed in, in the fashion that she was  
18 unattended for two hours.

19 We know that they found her; found her on the  
20 floor after an unwitnessed fall. That has already  
21 been attested to as being negligent. The defendants  
22 were well aware of the consequences of the harm. He  
23 did not ask her the question that was the important  
24 question about this training, and that is, were the  
25 staff members appropriately trained? He asked

1       them, were the materials sufficient, which she  
2       acknowledged. She had already testified that it was  
3       clear that they were not trained appropriately, and  
4       that as a consequence of that, this woman suffered  
5       harm. These are just examples of the theories or  
6       the violations of negligence that we intend.  
7       There's a multitude of others that have been shorn  
8       out. The jury can find others in addition to that.  
9       So I think there's a host of evidence in the case,  
10      when viewed in the light most favorable to us, that  
11      there's been a duty of breach and causation of harm  
12      and we've offered an expert who is qualified to  
13      comment, at least as it relates to the professional  
14      nursing staff, that that exists.

15             The other thing that the defendant seems to  
16      ignore is the fact that this is a fall. This is an  
17      unwitnessed fall in a skilled nursing facility. The  
18      case law is very clear that when you have a  
19      circumstance like that, that that can, in and of  
20      itself, be evidence or not fall within the realm of  
21      professional negligence.

22             Moving to the ordinary negligence count, a  
23      fall, if it's the result of nonmedical,  
24      administrative, ministerial, or routine care, I  
25      don't need an expert to testify as to that. We

1 don't know what happened here. Was she under the  
2 care of a CNA? Clearly not, because that's not  
3 been -- she's never, or he, been identified as a  
4 witness. Was she under the care of an RN that would  
5 warrant this then being a professional claim? We  
6 don't know the answer to that.

7 But what we do know is that she sustained an  
8 injury. We've established that there were breaches  
9 in the standard of care from a professional  
10 standpoint. And, from an ordinary negligence  
11 standpoint, we know if it did not involve the  
12 exercise of professional judgment, which there's  
13 been no testimony -- the only testimony that we have  
14 that elicits the exercise of professional judgment  
15 was providing this medication PRN. Beyond that,  
16 those two hours afterward could have easily been the  
17 deficit or the result of ordinary negligence. And  
18 leaving someone in this condition, an aide -- if an  
19 aide intentionally left or even mistakenly left a  
20 patient in this condition to her own devices  
21 allowing for her to fall, that can certainly qualify  
22 as ordinary negligence, and the jury can make that  
23 determination.

24 On the training issue, again, these defendants  
25 have a contractual obligation to the management

1 company to offer this training and to ensure that it  
2 is effective. Just because they have a nice  
3 PowerPoint with data from 1990 to show folks ten  
4 years later about the risks of these falls and a  
5 video about the same age and can show a training  
6 record or two that maybe those were shown to the  
7 different witnesses, that does not meet their burden  
8 to ensure that these witnesses are appropriately  
9 trained. Many of these witnesses could not explain  
10 basic consequences of residents having falls. In  
11 their depositions, they could not answer many of  
12 those questions in the trivia forms. You did not  
13 allow us to get into the deficiencies of some of  
14 these witnesses including license restrictions and  
15 that sort of thing. But it's clear from the  
16 evidence that these staff members were not  
17 appropriately trained, given how they charted and  
18 how they left this patient and the consequences that  
19 she sustained as a result of their acts and  
20 omissions.

21 So the defendants, the management company, had  
22 an affirmative obligation to ensure -- one of their  
23 responsibilities was to ensure that they were -- the  
24 staff at the facility providing care were  
25 appropriately trained, they had corporate compliance



1       officers as well as corporate officers that provided  
2       support and auditing. We've looked at the surveys  
3       that show that they have those resources, that  
4       they're supposed to be ensuring that these  
5       treatments and fall-prevention measures are in place  
6       and that they did not do that. So to suggest that  
7       they don't have a role in the professional  
8       negligence that's occurring within this facility, I  
9       think, is a misstatement on the evidence that we've  
10      heard.

11             On the ordinary negligence claim, again, it  
12      doesn't require, when you have a ministerial act or  
13      an administrative act or a nonethical act, we have a  
14      host of aides that are not subject to the  
15      professional requirement. Any one of these people  
16      could be an aide if they've completed a two-week  
17      course. We even heard from one of the officers of  
18      the company that he, in high school, in three weeks,  
19      had a certified nursing license. You don't even  
20      have to be a certified nurse assistant in many cases  
21      and it does not require the exercise of professional  
22      judgment. And many of the interventions that were  
23      not put into place were effectively followed,  
24      including simply observing a patient and ensuring  
25      that they're in the line of sight could be construed

1 as not requiring the exercise of professional  
2 judgment, but just someone's -- some aide's job.

3 I'm trying to recall all the other bases that  
4 were raised. On the punitive count, the undisputed  
5 evidence is that the conduct of the defendants  
6 responsible for the operation of this facility was  
7 reckless. She was in conscious disregard for this  
8 patient and that she sustained harm as a result of  
9 that. The jury can infer that from the evidence  
10 that they've heard. They see a pattern of conduct  
11 before this occurred, representations made by the  
12 facility about how they were going to correct the  
13 problem, yet a systemic continued failure, even  
14 after such that this facility, after this resident  
15 had been discharged, would remain a one-star,  
16 receiving citations, quality measures for the same  
17 exact problems that happened here. So you've got  
18 this entire pattern of conduct that suggests the  
19 continued failure on the part of both the management  
20 company as well as the licensee in caring for  
21 patients. We've provided evidence and pled why that  
22 is.

23 They were looking to sell this facility. The  
24 cost reports will reflect in the punitive phase that  
25 money was being significantly drawn out. We've

1       heard evidence of broken beds, evidence of broken  
2       wheelchairs. Those are all things that support an  
3       ordinary negligence count that could explain how she  
4       ended up on the floor and there's a reason why those  
5       things weren't being fixed.

6                Anyway, I think there's a host of reasons for  
7       both claims, as well as the punitive count at this  
8       point. And I think a grant of any directed verdict  
9       at this point would be a reversible error and would  
10      result in undue prejudice to our clients that have  
11      worked tirelessly to try to have their day in court.

12             MR. BLAKE: May I reply briefly?

13             THE COURT: Yes, very briefly.

14             MR. BLAKE: There's a couple things I heard  
15      that sounded almost like burden shifting to me, and  
16      I just want to make clear that I'm not aware of any  
17      authority that says because there's an error in  
18      documentation, the absence of it is allowed --  
19      substitutes for any --

20             THE COURT: I didn't take it as burden  
21      shifting.

22             MR. BLAKE: Okay. Okay. I mean, same thing  
23      about -- they talk about depositions. Those  
24      depositions have not been entered into evidence --

25             THE COURT: I agree.

1           MR. BLAKE: -- so whatever was said is not  
2 relevant for your consideration.

3           And then, finally, on the ordinary negligence  
4 claim, if CNAs are not professionally liable, then  
5 the evidence that was testified about the CNAs'  
6 failure to chart being a breach of standard of care  
7 is -- it's inconsistent with that. Either the CNAs  
8 owe professional standards of care for which experts  
9 can get up and testify and say it was a breach of  
10 standard of care for them to chart their ADLs or  
11 they're not subject to professional standards of  
12 care, but Plaintiff has to decide which way they'd  
13 like to go with that. Are they professionals that  
14 have a subject that's the topic of expert testimony  
15 for a professional standard of care or not? And if  
16 we're talking about ordinary negligence -- and,  
17 again, we're essentially being asked, well, because  
18 we don't know what happened during that time period,  
19 the jury gets to consider it. That's no different  
20 than a property owner and -- well, we're not sure if  
21 there was a puddle of water there; there's no video  
22 evidence. There's no note around the fall saying  
23 that there was a puddle inside the grocery store,  
24 but they fell. And because there's no records of  
25 whether or not there was a puddle and there's no

1 video of the puddle, therefore the jury is allowed  
2 to determine whether or not the store was negligent  
3 because there could have been a puddle there.  
4 Right?

5 I mean, that analysis has been found to be  
6 improper because the court says that under ordinary  
7 negligence, just because you're on my property or I  
8 owe you some ordinary standard of care, I'm not your  
9 insurer; you have to show actual things that I did  
10 that was a breach of standard of care. Right?  
11 Ordinary negligence. And I believe you're being  
12 asked for the jury to be allowed to say, well, we  
13 don't know; therefore, it could be negligent. And I  
14 don't believe that's within the ambit of ordinary  
15 negligence.

16 MR. CONNOR: Your Honor, if I may, for the  
17 record's sake, we know exactly what happened to this  
18 resident. We know exactly what happened. She was  
19 provided medication that was not documented. She  
20 was left unassisted and unattended to, such that she  
21 was allowed, despite being agitated, confused, and  
22 irritated, to arise from a seat, whether it be in a  
23 room or in a hallway, have a fall, end up on the  
24 floor, suffer a fractured hip, and be discovered by  
25 nursing staff. We know exactly what happened. So

1 to suggest that we don't know what happened in those  
2 two hours is a false statement. We know exactly  
3 what happened. And that, in and of itself, is  
4 outrageous conduct that I think warrants all of our  
5 claims.

6 THE COURT: As it's your motion, I feel  
7 obligated that you get the last word, but I don't  
8 think you need it.

9 MR. BLAKE: I don't need it. Thank you, Your  
10 Honor.

11 THE COURT: All right. I've heard all the  
12 arguments. At this point, I just think there -- in  
13 the light most favorable to the non-moving party, I  
14 think there's sufficient evidence, certainly  
15 susceptible to more than one reasonable inference  
16 that the jury could find for all these causes of  
17 action, at this time. That said, of course you'll  
18 have a chance to talk again after you present your  
19 case so -- or during your case. So I'm going to  
20 deny the directed verdict motions at this time.

21 MR. BLAKE: Thank you for your consideration.

22 THE COURT: Is there anything else for the  
23 record we need to do? I'd like to meet with y'all  
24 and address some housekeeping items. And I think  
25 I'll just go ahead -- unless you want to have a

1 witness -- well, we're kind of -- what time is it,  
2 4:20?

3 MR. BLAKE: It's probably a little late, Your  
4 Honor. I mean --

5 THE COURT: Yeah. Let's not start with  
6 somebody else. I kept them all til 5:45, 6:00,  
7 basically, yesterday. So we'll go ahead and recess  
8 for the day. Unless y'all want me to bring them in,  
9 I'll just go tell them they can go home.

10 MR. BLAKE: I'm fine with that.

11 THE COURT: I'm going to tell them 8:45 in the  
12 morning. That way, in theory, we start right at  
13 9:00 with you presenting your case in chief. We'll  
14 talk about it tomorrow. Anything else for the  
15 record?

16 MR. BLAKE: That's it, Your Honor.

17 THE COURT: We're in recess until the morning.  
18 I'll go tell the jury they can go home.

19 (The following proceedings were held October  
20 25, 2018.)

21 THE COURT: Are we ready to go?

22 MR. BLAKE: Your Honor, we have one document  
23 that we were going to try to get the Court to take  
24 judicial notice of because it's a public record,  
25 it's self-authenticating, under seal, signed by the

1 director of CMS. There has been an objection raised  
2 by counsel to it that it's not in an applicable time  
3 period. That's what we were sort of discussing when  
4 you --

5 THE COURT: All right. Do y'all still want to  
6 talk some more? I mean, if you can figure it out,  
7 keep talking. I didn't mean to cut y'all off.

8 MR. CONNOR: No, sir. I think we have an  
9 objection to it.

10 THE COURT: Okay. Tell me about the document;  
11 show me the document.

12 MR. BLAKE: May I approach, Your Honor?

13 THE COURT: Sure.

14 MR. BLAKE: So, Your Honor, this is a  
15 memorandum issued by the director of the center for  
16 Medicare and Medicaid services dated June 27th,  
17 2007. It is sent to the surveyors as a  
18 clarification on how they should survey. And, as  
19 you'll recall, in the plaintiff's case in chief,  
20 Ms. Henderson was cross-examined vigorously on the  
21 contents of the watermelon book. That watermelon  
22 book was described by plaintiff's counsel as the  
23 book that the surveyors who come in and survey the  
24 facility and gave those F-tags that we've talked  
25 about on the record and in bench conferences, that



1       that's the book that they use to decide whether or  
2       not we're compliant with CMS regulations and to cite  
3       a facility for violations.

4               In 2007, CMS renewed its focus on the use of  
5       restraints. That was a topic that I discussed  
6       yesterday with plaintiff's expert witness. And we  
7       wanted to show the jury, by putting this into  
8       evidence alongside of the other CMS regulations that  
9       are in evidence, that this was an issuance by CMS in  
10      2007 where they were clarifying to the surveyors,  
11      hey, when you're using the watermelon book and  
12      you're going out surveying for are they compliant  
13      with 42 CFR 483.13(a), that you need to make sure  
14      that you're looking at restraints.

15             So in this memorandum, they clarified the  
16      phrases remove easily and freedom of movement, which  
17      are terms that appear in the watermelon book, and  
18      they further clarify the meaning of the medical  
19      system, a term used in the watermelon book, and it  
20      has instructions to the surveyors. And,  
21      importantly, there's a note that appears on page 3  
22      and 4 of what I handed where they tell surveyors:  
23      Note, falls do not constitute self-injurious  
24      behavior or a medical symptom that warrants the use  
25      of a physical restraint. While those restraints

1 have been traditionally used --

2 THE COURT: What page are you on?

3 MR. BLAKE: I'm sorry. Page 3 of 4 at the very  
4 top.

5 The note goes on to say: Although restraints  
6 have been traditionally used as a falls-prevention  
7 approach, they have major serious drawbacks and can  
8 contribute to serious injuries. There's no evidence  
9 that the use of physical restraints including, but  
10 not limited to, side rails will prevent or reduce  
11 falls. Additionally, falls that occur while a  
12 person is physically restrained often result in more  
13 severe injuries.

14 And that is the official statement of the  
15 United States agency, the Center for Medicare and  
16 Medicaid Services. That official statement is  
17 contained in a public record that's widely  
18 available, just like those other public records that  
19 have been admitted. It is bearing the seal of the  
20 department on the first page and it is signed by the  
21 director of the department on the last page;  
22 therefore, it meets the definition of a  
23 self-authenticating public record under seal, it  
24 meets the hearsay exception for public records, and  
25 it is relevant because it provides guidance

1        regarding testimony provided in this case regarding  
2        the use of things like Lap Buddies that the  
3        plaintiff's expert testified to and other types of  
4        restraints that have been discussed and suggested it  
5        was a breach of the standard of care that those  
6        interventions were not employed after 5:30 on the  
7        date of the fall.

8                So we'd like for the jury to be able to see  
9        this record and see the federal government's  
10       position statement to its state surveyors on how to  
11       interpret the restriction on restraint guidance  
12       that's contained in CMS and that has then been put  
13       out in the operations manual and the survey manual.

14               THE COURT:    Okay.

15               Yes, sir?

16               MR. CONNOR:   Your Honor, there's been no  
17       allegation by Plaintiffs that these defendants  
18       violated the provision this seeks to provide  
19       clarification on.   We did not ask Ms. Hill O'Neil.  
20       The statute at issue, which is cited in this, is  
21       42 CFR 483.13.   It says:   Restraints, the resident  
22       has the right to be free from any physical or  
23       chemical restraints imposed for purposes of  
24       discipline or convenience and not required to treat  
25       the resident's medical symptoms.

1           There's, one, been no allegation that that was  
2           breached here. Our allegation is that the  
3           defendants breached the standard of care in not  
4           considering restraints under their own -- under  
5           their own policies that Dee Dee Henderson testified  
6           that she provided. That was the breach; that they  
7           didn't consider these. And if you look at this  
8           document, what this is simply doing is when a  
9           surveyor is in a building and finds chemically or  
10          physically restrained people who they believe are  
11          there for punishment or as a matter of convenience  
12          of the nursing home, then -- then you look to see if  
13          the medical symptoms warrant the restraint and  
14          whether it restricts their freedom of movement and  
15          can be removed easily.

16                 That is not an issue in this case whatsoever.  
17          We do not contend that she was improperly  
18          restrained. We do not contend that she was  
19          restrained as a matter of convenience. What we do  
20          contend is that her medical symptoms warranted the  
21          consideration for restraints until her condition  
22          could be managed appropriately.

23                 And if you look in the definition under medical  
24          symptoms, it clearly says that medical symptoms that  
25          warrant the use of restraints must be documented in

1 the resident's medical record, ongoing assessment  
2 and care plan, and that, despite the defendants'  
3 contention in this courtroom, that while there must  
4 be a physician order reflecting the presence of a  
5 medical symptom, that CMS holds the facility,  
6 ultimately, accountable for the appropriateness of  
7 that determination.

8           So this has no relevance whatsoever. We've not  
9 asserted that they were improperly restraining this  
10 patient. Now, I believe that that happens and we  
11 can look at their surveys and see that they've  
12 chemically restrained a host of residents, they have  
13 a much higher incidence of that use, but that's not  
14 what we contend happened with this particular  
15 resident.

16           So this just has no -- and then the note that  
17 he says -- the note is actually a citation to a  
18 statement from the American Geriatric Society. It's  
19 just a quote from that resource. So to suggest that  
20 this is -- this is from 2017 -- I mean, 2007, seven  
21 years before. We've not alleged that she was  
22 improperly restrained. To the contrary, we contend  
23 that they did not do what they should have done,  
24 which was, until her condition was stable, consider  
25 the use of restraints. It has no relevance

1       whatsoever and is simply put in in an attempt to  
2       confuse the jury.

3               MR. BLAKE:  And, Your Honor, if I may just  
4       briefly, again --

5               THE COURT:  Well, my question is the fact that  
6       they're not asserting any claim under that specific  
7       CFR.  Why is that still --

8               MR. BLAKE:  Because I don't -- I completely  
9       agree they've not asserted a claim under that CFR.  
10      What they've said is, is that she had a medical  
11      condition whereby we should have considered the use  
12      of restraints.  And what this document says is, the  
13      risk of falls is not such a medical condition.  It  
14      says that you may -- if the resident needs emergency  
15      care, restraints may be used for a brief period of  
16      time.  That follows their instructions that falls is  
17      not the type of emergency care where you may  
18      consider using a restraint.  It says -- the next  
19      paragraph says:  A patient who is injuring himself,  
20      herself, or is a threat of physical harm to others  
21      may be restrained.  But it says in the note before  
22      that:  A fall is not the type of self-injurious  
23      behavior wherefore you may be able to use a  
24      restraint.  And that's why we want this in.

25              The allegation that we should have considered a

1 restraint assumes that the risk of fall is something  
2 that you can use a restraint for. And since 2007,  
3 and including in the watermelon book that they've  
4 used in this case, this note is in every state  
5 operations manual saying, surveyors, you cannot tag  
6 them if they're -- you cannot tag them for failing  
7 to restrain if the only reason why they should have  
8 restrained is a fall.

9 MR. CONNOR: Your Honor, if you would read the  
10 paragraph actually before the note, which it's there  
11 to explain, it says: Restraints may be used, if  
12 warranted, as a temporary symptomatic intervention  
13 while the actual cause of the medical symptom is  
14 being evaluated and managed. Additionally, physical  
15 restraints may be used as a symptomatic intervention  
16 when they are immediately necessary to prevent a  
17 resident from injuring himself or herself or others  
18 or to prevent the resident from interfering with  
19 life-sustaining treatment or no other less  
20 restrictive or less risky interventions exist. That  
21 is what that is defining.

22 This is saying you can use restraints in  
23 instances exactly like this where, temporarily, the  
24 symptoms warrant the patient being restrained.  
25 That's exactly what our experts say should have

1       happened: One of the interventions, including  
2       watching her, including monitoring her, including a  
3       host of other things that she described. He's just  
4       taking this out of context. He even, yesterday,  
5       asked her as if this note was somehow part of the  
6       law, which it is clearly not, a question without  
7       ever providing any context for it. He's taken this  
8       and, again, is attempting to use this to distract  
9       the jury with what the actual obligations of the  
10      facility are.

11           THE COURT: And I actually think that's  
12      something you can easily point out on your cross, if  
13      I were to allow it in. I mean, there's been a lot  
14      of regulations quoted here. And there's a lot of --  
15      I mean, obviously, I haven't read this word for  
16      word, but I'm trying to scan it as quickly as I can  
17      and I understand both sides -- give me a few seconds  
18      here.

19           MR. BLAKE: Thank you, Your Honor.

20           (Brief pause in the proceedings.)

21           THE COURT: I'm going to allow the document.  
22      Obviously Mr. Connor is going to have every  
23      opportunity to go through it and pick at it, which  
24      I'm sure he will.

25           MR. CONNOR: I think his intention, though,



1 Your Honor, is to just publish it. So if he plans  
2 on doing that, am I going to be able to  
3 cross-publish it?

4 THE COURT: Oh. You're not going to use it  
5 with your witness? I thought that's -- you're  
6 right. You did say publish it.

7 MR. BLAKE: Yeah. We'll withdraw it, Your  
8 Honor. I don't want to build in some type of  
9 appellate issue. That's fine. That's fine.

10 THE COURT: All right. Well --

11 MR. CONNOR: I still reserve the right to use  
12 it on cross, if it's relevant.

13 MR. BLAKE: You've got to be kidding me.

14 THE COURT: Guys, it's either in or out. I  
15 mean, really. I mean, I just --

16 MR. BLAKE: I'm happy to withdraw it. We've  
17 spent 30 minutes on it this morning.

18 THE COURT: Let's let sleeping dogs lie.

19 MR. CONNOR: Yes, sir.

20 THE COURT: All right. Are we ready for the  
21 jury, folks?

22 MR. BLAKE: Yes, Your Honor.

23 THE COURT: Well, just give me a little bit of  
24 a -- Mr. Connor, I just have a quick question for  
25 him and I don't want to say it without you being

1 present.

2 (Sidebar conference.)

3 THE COURT: Let's get the jury in, please.

4 (The jury enters the courtroom at 9:16 AM.)

5 THE COURT: Mr. Foreman, ladies and gentlemen  
6 of the jury, good morning. It's almost 9:20. I had  
7 some things I had to take care of with law  
8 enforcement this morning, so I apologize. I was  
9 more later than I wanted. So I want you to know  
10 that explains why we didn't start exactly at 9:00  
11 like I told you we would.

12 We ended yesterday with the plaintiff resting  
13 their case. We're now going to hear from the  
14 defendant in putting forth their case. Please give  
15 them your undivided attention.

16 Counsel?

17 MR. MANN: Thank you, Your Honor. We call Dee  
18 Dee Henderson.

19 DANIELLE HENDERSON

20 being first duly sworn, testified as follows:

21 THE WITNESS: Yes.

22 THE CLERK: Have a seat and state your full  
23 name for the record.

24 THE WITNESS: My name is Danielle Brawley  
25 Henderson. Everyone calls me Dee Dee.

1 DIRECT EXAMINATION

2 BY MR. MANN:

3 Q. Good morning, Dee Dee. How are you?

4 A. Good morning. Good.

5 Q. Will you refresh quickly -- I think you've  
6 already gone through your bio somewhat extensively  
7 in front of the jury. But just quickly remind us of  
8 your education, your background, your work history.

9 A. Sure. I'm a social worker, registered nurse.  
10 I've been a director of nursing, nursing home  
11 administrator, director of operations for hospice,  
12 regional president for the Piedmont Upstate region,  
13 COO for hospice, and chief executive officer for  
14 hospice.

15 Q. Okay. Your current job title is what?

16 A. Chief executive officer for Agape Hospice of  
17 the Lowcountry, Incorporated.

18 Q. Okay. And this case is about incidents that  
19 occurred in July of 2014. Where were you employed  
20 and what were you doing in July of 2014?

21 A. I was the regional president for the Piedmont  
22 Upstate region for Agape Management Services,  
23 Incorporated.

24 Q. Okay. And the Piedmont Upstate region, did  
25 that include or not include Agape Nursing & Rehab of

1 West Columbia?

2 A. Did not include.

3 Q. Did not include. But you were somewhat  
4 familiar with the facility; correct?

5 A. Yes.

6 Q. All right. So you worked, at that time, for  
7 the defendant Agape Management Services; correct?

8 A. Correct.

9 Q. But you did not specifically oversee Agape  
10 Nursing & Rehab of West Columbia; correct?

11 A. No.

12 Q. But you were familiar with the building and  
13 with some of the practices there; correct?

14 A. Yes.

15 Q. Was Agape Nursing & Rehab of West Columbia a  
16 restraint-free facility?

17 A. Yes.

18 Q. Okay. Were all of the skilled nursing  
19 facilities that Agape Management Services provided  
20 management services to restraint-free facilities?

21 A. All of our facilities were a restraint-free  
22 facility unless a physician gave an order for a  
23 restraint, if it was deemed medically necessary. At  
24 that time, we would have to -- the physician would  
25 have to give an order if it was deemed medically

1       necessary for a restraint.

2       Q.     And thank you for saying that. That's what I  
3       was going to ask you. So restraint-free doesn't  
4       mean that in no circumstances can you not restrain.  
5       It simply means you can't restrain unless a doctor  
6       tells you to restrain; correct?

7       A.     Correct.

8       Q.     Okay. And did any doctors -- or any doctors  
9       employed by Defendant Agape Nursing & Rehab West  
10      Columbia in 2014 or at any time thereafter?

11     A.     Could you repeat the question?

12     Q.     Was a doctor employed by Agape Nursing & Rehab  
13     of West Columbia?

14     A.     No.

15     Q.     Okay. Was a doctor employed by Agape  
16     Management Services, Inc., 2014?

17     A.     No.

18     Q.     Okay. So no doctor was directly employed by  
19     either of the two defendants in this case --

20     A.     No.

21     Q.     -- in 2014?

22             Okay. Tell me why -- what's your understanding  
23     of why Agape Nursing & Rehab and the other skilled  
24     nursing facilities that were in your territory that  
25     you oversaw, tell me why the philosophy was that

1       these were restraint-free facilities?

2       A.     Sure.  There has been, in my tenure as a nurse  
3       and as a social worker in the industry, there  
4       definitely has been a shift away from using  
5       restraints.  There's been a lot of research that  
6       there's been a lot of risks outweighing the benefit  
7       of using restraints.

8       Q.     Okay.  What do you mean by that, risk  
9       outweighing the benefit?

10      A.     Okay.  So with physical restraints, there are a  
11      lot of adverse things that can occur with physical  
12      restraints.

13      Q.     Like what?

14      A.     Okay.  So with physical restraints, you can  
15      have skin integrity problems like bruising.  You can  
16      get decubitus ulcers.  There's been documentation of  
17      respiratory problems.  You can get strangulation.  
18      There's been concerns with further severe injuries  
19      like fractures, further complication of head trauma  
20      with using restraints --

21      Q.     By further --

22      A.     -- if you have incontinence, further issues  
23      with bowel and bladder.

24      Q.     So head trauma and fractures, are those  
25      because -- are you saying it's because restraints

1 can, in fact, increase the risk of a fall?

2 A. They can.

3 Q. Okay.

4 A. And that's with using physical restraints. If  
5 you're using mechanical restraints, you can also see  
6 that that causes confusion, agitation, fear,  
7 anxiety. So there's definitely been a shift in the  
8 industry to not use restraints, and that's why, as a  
9 company, we adopted that and became a restraint-free  
10 facility.

11 Q. Okay. And so as part of your training for the  
12 various skilled nursing facilities that were in your  
13 territory and, as you understand, the training at  
14 Agape Nursing & Rehab West Columbia, you trained  
15 nurses, CNAs, et cetera, that restraints were not to  
16 be used in any circumstances unless they were  
17 medically ordered; correct?

18 A. Correct.

19 Q. Okay. Now, there have been a couple of  
20 different types of restraints that I don't believe  
21 you were present to hear discussed yesterday by the  
22 plaintiff's expert, but I'm going to walk through  
23 them with you briefly, just to confirm that we're  
24 matching up as we go here. So do you know what a  
25 Lap Buddy restraint is?

1 A. Yes.

2 Q. Tell the jury just briefly what we're talking  
3 about when we talk about a Lap Buddy.

4 A. Okay. So a Lap Buddy, if you have a  
5 wheelchair, it's kind of exactly what it sounds  
6 like; it's a cushion that goes -- that sits right on  
7 top of a patient's lap. And you insert it into the  
8 wheelchair and it basically restrains them or it  
9 attempts to restrain them from standing up and  
10 getting out of the chair. So it's kind of a lap  
11 cushion, and goes into the wheelchair. So that's  
12 what it is.

13 Q. Okay. And I'll represent to you that  
14 yesterday, Ms. Lewis, the plaintiff's expert,  
15 testified that you can't use a Lap Buddy without a  
16 physician order. Is that your understanding?

17 A. That's correct. It's a restraint.

18 Q. And would you ever train any of your nurses,  
19 your CNAs, to use a Lap Buddy without a physician's  
20 order?

21 A. You have to have a physician's order.

22 Q. And are Lap Buddies even appropriate for  
23 severely demented patients?

24 A. It is not -- it should be a last resort and you  
25 need a physician's order.



1 Q. Okay. What about a lap belt? What is that?

2 A. A lap belt is kind of exactly what it's called.  
3 It's generally a belt that goes around your lap when  
4 you're up in a wheelchair.

5 Q. Ms. Lewis, yesterday -- Nurse Lewis testified  
6 that that requires a physician's order. Is that  
7 your understanding as well?

8 A. That's correct.

9 Q. Okay. And, again, same question: Would you  
10 ever train anyone who worked for any of the skilled  
11 nursing facilities that you oversaw in your  
12 territory at any time when you were director of  
13 nursing of any of these skilled nursing facilities,  
14 would you ever train anyone that they could use a  
15 lap belt without a physician's order?

16 A. Absolutely not.

17 Q. Okay. And then the last one is this  
18 deep-seated cushion. Tell me about that.

19 A. A deep-seated cushion?

20 Q. Yeah.

21 A. So I'm not familiar with a deep-seated cushion.  
22 But -- I'm not familiar with that, so I don't want  
23 to describe it.

24 Q. Okay.

25 A. Okay.

1 Q. If I represented to you that Plaintiff's expert  
2 also testified it requires a physician's order to  
3 use, you would -- you would concur with that? I  
4 mean, you're not aware of any restraint that you're  
5 able to put on a patient that does not require a  
6 physician's order; correct?

7 A. Correct.

8 Q. Okay. What about a chair alarm? Are you  
9 familiar with a chair alarm?

10 A. Absolutely. So a wheelchair alarm -- there are  
11 several different types of wheelchair alarms. But  
12 most of them are a mechanical alarm that you can  
13 attach to a wheelchair, and it's usually a string.  
14 So with the string, it has a clip. And with the  
15 clip, you usually clip it somewhere onto the  
16 patient's clothing. And then the wheelchair alarm  
17 is attached to the alarm. And so the purpose of it  
18 is that if a patient attempts to get up, when they  
19 move or if they make an attempt to get up, the alarm  
20 will sound. It is extremely loud. And a lot of  
21 times, even if they are not up but they make some  
22 type of movement, depending on where the clip is at  
23 -- so sometimes if the clip is on their arm and they  
24 just move like that and they aren't even attempting  
25 to get up, the alarm will sound. And so it's very

1 disruptive to that patient and to several other  
2 patients. But that's what a wheelchair alarm is.

3 Q. Requires a physician's order?

4 A. Yes.

5 Q. Would never train any of your nurses to use one  
6 without a physician's order; correct?

7 A. No.

8 Q. You can't; right? It violates the terms of the  
9 licensure --

10 A. You have to have a physician's order.

11 Q. Okay. All right. Moving on. You had been  
12 then -- I believe your testimony was that you have  
13 been to the Agape Nursing & Rehab facility in West  
14 Columbia; correct?

15 A. I have been in that facility, yes.

16 Q. And I'm going to represent to you that this has  
17 been introduced and stipulated to as a floor plan  
18 for the Agape Nursing & Rehab facility in West  
19 Columbia. Does this look correct to you?

20 A. Yes.

21 Q. All right. And I'll represent to you that  
22 yesterday, during the expert testimony of Ms. Lewis,  
23 it was established that Ms. Utricia Shealy fell  
24 approximately where my pen point is right here.

25 MR. CONNOR: Objection, Your Honor; lack of

1 foundation. That was testimony of Counsel. She did  
2 not confirm that. He put a highlight there and  
3 represented that.

4 THE COURT: Why don't you try to rephrase your  
5 characterization?

6 MR. MANN: Okay.

7 BY MR. MANN:

8 Q. Ms. Henderson, I'm going to ask you to assume,  
9 for the purposes of my question, that Utricia Shealy  
10 fell here where my pen point is --

11 MR. CONNOR: Lack of foundation, Your Honor, no  
12 evidence in the record whatsoever.

13 THE COURT: Well, he's asking her to assume.  
14 You can -- I mean, for a hypothetical --

15 MR. MANN: Absolutely.

16 BY MR. MANN:

17 Q. I'm going to ask you to assume, for the  
18 purposes of my questions --

19 A. Okay.

20 Q. -- that she fell where my pen point is here.  
21 Okay?

22 A. Okay.

23 Q. And you've been in the building; correct?

24 A. Yes.

25 Q. And you're familiar with the dimensions of the

1 building; correct?

2 A. Yes.

3 Q. Okay. And this, where my pen point is right  
4 here, is what?

5 A. That's the nurses station.

6 Q. Okay. Can you tell the jury what the  
7 approximate distance is between this pen point and  
8 this pen point?

9 A. It's probably less than 12 feet. To give,  
10 like, an example, I'd probably say from where I'm  
11 sitting to the table over there.

12 Q. Okay.

13 A. It's very close and it's in line of sight.

14 Q. Well, that was my next question: It's in the  
15 line of sight of the nurses station; correct?

16 A. Absolutely.

17 Q. Okay. Do you know much about the Agape Nursing  
18 & Rehab of West Columbia building? Do you know  
19 approximately when it was built?

20 A. No.

21 Q. Okay. Tell me about -- do you know about the  
22 flooring in the building?

23 A. Yes.

24 Q. Tell me what the flooring was made of.

25 A. Well, our flooring in all three of our nursing

1       centers is the same flooring in the common areas.  
2       And I know this because as an administrator, we  
3       learned more about carpet than I wanted to know, as  
4       an administrator at that time. We use a Tandus  
5       carpet. That was one of the things that we actually  
6       did training on with the environmental services and  
7       our maintenance department. The Tandus carpet had  
8       an ergo cushion on the back of it.

9               And what I remember about it, with us training,  
10       is that it was moisture-impeding, it was cushion  
11       form, and it was fall-reduction. And so we did a  
12       lot of training with our environmental service and  
13       our maintenance on making sure that we cleaned it  
14       properly so that we maintained it because it has  
15       safety measures included in it to reduce fall  
16       impact.

17              And so it was in our common areas and, like,  
18       the hallway, the dining room, and in, like, our  
19       lobby areas.

20       Q.     Okay.

21       A.     And so I know in the West Columbia area, it was  
22       in the hallway, lobby areas, kind of the area that  
23       you're pointing out for me to assume.

24       Q.     So the flooring through here has, actually, a  
25       rubber backing underneath it then, is what you're

1       telling me?

2       A.    Yes.

3       Q.    Okay.  And that's as a fall-prevention or  
4       fall-mitigation method to mitigate falls; correct?

5       A.    Yes, to -- yep.  Fall-impact protection, yes.

6       Q.    Okay.  Now, the -- there was a training video  
7       put up yesterday.  Plaintiff's counsel has  
8       repeatedly noted throughout the case that statistics  
9       like that one-third of all elderly people over the  
10      age of 65 fall at least once a year.  Are you  
11      familiar with this statistic?

12     A.    I am very familiar with this statistic.  You  
13     know, it's actually a staggering statistic, but it's  
14     true.  You know, our senior adults have a lot  
15     against them.  They are -- they're aging; they've  
16     got senses that are -- that are declining.  You've  
17     got hearing impairment, vision impairment.  You've  
18     got, you know, chronic disease process that's  
19     happening.  You've got lots of medications on top of  
20     that.

21               When we are caring for seniors, a lot of times  
22     we are getting them in our facilities when they are  
23     coming from an acute place like a hospital or an  
24     acute rehab.  And usually at that time, they've had  
25     a disease process exacerbation which means their

1 symptoms have flared up or maybe they have a UTI or  
2 maybe they've had surgery, and if that's happened,  
3 now they have pain. And all of these things, of  
4 course, make fall risk even more apparent. So, yes,  
5 those statistics that you gave me, yes, you know,  
6 are alarming.

7 So, yes, seniors do fall. You know, one of the  
8 things about it is, you know, even how regimented  
9 that you are, even inclusive of using every  
10 intervention, falls occur. And that's one of the  
11 reasons why we do educate and train on safety and  
12 ADLs with our staff and customer service, you know,  
13 anticipatory support in meeting needs. And, like I  
14 mentioned with even being creative with our  
15 environmental service, make sure you keep up the  
16 carpet because it has the safety measures that are  
17 in place.

18 You know, it's -- it would be easy to just go  
19 too and say restrain, but the regulations clearly  
20 tell us that you cannot restrain a patient just  
21 because you think they are going to fall. And even  
22 though that statistic is staggering because seniors  
23 are falling at that alarming number, there is no  
24 easy button.

25 Q. Well, tell me this: Have you ever heard the



1 expression that the elderly have the right to fall;  
2 that these people in these skilled nursing  
3 facilities, quote, have the right to fall? Have you  
4 ever heard that?

5 A. I have heard that expression.

6 Q. What does that mean?

7 A. You know, I think what that means is we cannot  
8 just use a restraint. We cannot, by any means  
9 necessary, restrain them. They have the right to  
10 free bodily movement, you know. So, you know, we do  
11 have to do necessary interventions and provide the  
12 best care, but we cannot restrain them. Regulations  
13 tell us that we cannot restrain them just because  
14 they are going to fall.

15 Q. Okay. And so -- but I want to be clear. Are  
16 you saying that, look, it's fine; we don't worry  
17 about it. They have the right to fall, so we're not  
18 worried about it at all?

19 A. Absolutely not. Absolutely not. That's not  
20 what I'm saying. I'm saying that in spite of,  
21 inclusive of our best efforts, inclusive of  
22 providing the very best care, inclusive of using  
23 every single approach, inclusive of doing that, my  
24 time as a nurse and as a social worker and as an  
25 administrator in Agape facilities, in hospice, when

1 I worked at the hospital, my time at the VA and at  
2 the cancer clinic, I have still seen, with using  
3 every implementation and approach, that seniors  
4 still fall.

5 Q. Are you familiar with the story on Ronald  
6 Reagan?

7 A. Yeah. Yeah. Senior -- yeah. Secret Service  
8 around him and he still fell.

9 Q. Fell and broke his hip, didn't he?

10 A. Uh-huh. Honestly, two years ago in uptown.  
11 Charlotte, I fell and broke my ankle.

12 Q. Tell me a little bit -- we've had some  
13 discussions regarding ADL, activities of daily  
14 living, documentation by CNAs; correct? Are you  
15 familiar with the requirement of CNAs and their  
16 documentation of ADLs, activities of daily living?

17 A. Yes.

18 Q. Okay. And a lot of time has been spent in  
19 testimony by Plaintiff's counsel and others  
20 regarding the, quote, alleged failure to document  
21 the giving of water and the toileting of Ms. Shealy  
22 as it happened. Is that the requirement on a CNA  
23 for documentation? Do they have to document if --  
24 if they give a cup of water to a resident, do they  
25 immediately have to go document that?

1 A. There is no state or federal regulation that  
2 requires that detail of documentation.

3 Q. Okay. So as a company, we say that we want  
4 them to document once a shift; is that correct?

5 A. That's our practice, to document once a shift.

6 Q. Okay. So you're telling me CMS doesn't have  
7 the requirement that they document every time they  
8 hand them a cup of water, every time they take them  
9 to the commode. They don't have a -- CMS doesn't  
10 require them to go document that immediately;  
11 correct?

12 A. CMS's requirement for -- CMS's requirement is  
13 that you have to know the level of ADL support. And  
14 what I mean by that is if a patient requires ADLs,  
15 CMS requires that you know if they need min assist  
16 or moderate assist or max assist. So CMS requires  
17 that you document that at least three times a week,  
18 so that's what CMS requires that you meet.

19 So our practice, to get that, is that our CNAs  
20 would document once a shift. So CMS's requirement  
21 is that you know min, max, or moderate, and then  
22 that flows into the MDS assessment.

23 Q. So you're telling me that we actually far  
24 exceed the requirement by CMS?

25 A. Yes.

1 Q. Okay. Let me ask you this: The plaintiff's  
2 aunt testified that at some point on July 1st she  
3 took Ms. Shealy to the restroom to use the commode  
4 and that in so doing, when she was taking her there,  
5 she noted that the wheelchair didn't have a brake,  
6 that she couldn't make the brake on the wheelchair  
7 work. Are you familiar with the wheelchairs that  
8 were used by Agape Nursing & Rehab of West Columbia?

9 MR. CONNOR: Objection, Your Honor. The  
10 specific wheelchair at issue in this case?

11 MR. MANN: I'll lay the foundation on it, Your  
12 Honor.

13 THE COURT: Okay.

14 BY MR. MANN:

15 Q. Are you familiar with the type of wheelchair  
16 that was used by Agape Nursing & Rehab of West  
17 Columbia?

18 A. I know that all of our skilled nursing  
19 facilities for Agape Management Service,  
20 Incorporated, use the same durable medical equipment  
21 company. And I know that our wheelchairs -- we used  
22 Agape durable medical equipment. All of our nursing  
23 homes use the same company. And all of our  
24 wheelchairs -- we had brakes on the side of our  
25 wheelchairs, so the brakes were on the side of each

1 wheel. And so to brake, you actually -- actually  
2 there were brakes there on the side. So to brake,  
3 you would have to use the hand brakes. And they  
4 were actually level on the side.

5 Q. So they were down in front of the seated  
6 resident in the wheelchair, not back behind the  
7 chair on the back?

8 A. No.

9 Q. Okay. Last question for you: Are you familiar  
10 with how long a physician has to see and perform an  
11 initial assessment on a resident after admission?

12 A. Federal regulation says that for a  
13 comprehensive visit, the initial visit, you have 30  
14 days.

15 Q. Thirty days?

16 A. Yes.

17 Q. Okay. Thank you, Ms. Henderson.

18 THE COURT: Cross-examination?

19 MR. CONNOR: Yes, Your Honor.

20 RECROSS-EXAMINATION

21 BY MR. CONNOR:

22 Q. Ma'am, tell me when Agape went restraint-free.

23 A. I don't know the exact date. But we -- I don't  
24 know the exact date.

25 Q. Okay. Well, when do you think it was?

1 A. I don't know.

2 Q. Do you have any idea if it was before July 1st  
3 of 2014?

4 A. Yes.

5 Q. Okay. How about before January 1st of 2014?

6 A. Yes.

7 Q. How about before October 1st of 2013?

8 A. Yes.

9 Q. So why then are you providing Mr. Faris  
10 resources specifically dealing with restraints if  
11 this is a restraint-free facility?

12 A. Because if a physician deems it medically  
13 necessary, then we would have to do a restraint.

14 Q. Well, you say you'd have to do a restraint. I  
15 mean, ma'am, don't the nurses frequently make the  
16 request for restraints in nursing home settings?

17 A. Do nurses frequently make a request?

18 Q. Right, of a physician to consider a restraint  
19 for a particular patient that they think would be in  
20 the best interest of that patient's --

21 A. Are you asking me do all nurses frequently make  
22 a request?

23 Q. No, ma'am. What I'm asking you is, aren't  
24 restraints frequently implemented after the request  
25 is made by a nurse?

1 A. Nurses will collaborate with physicians.

2 Q. That's right.

3 A. Yes.

4 Q. So a nurse can say, Doctor, we've got a patient  
5 who I think would benefit from this restraint;

6 correct?

7 A. Nurses will talk with physicians about all  
8 interventions that have been implemented, and then  
9 the physician will provide an order if he deems it  
10 necessary for a restraint.

11 Q. Ma'am, that wasn't my question. My question  
12 was, nurses can make the request of a physician for  
13 a restraint; correct?

14 A. A nurse -- yes. A nurse could, if she wanted  
15 to.

16 Q. Sure. And you've done that before, haven't  
17 you? You've called up a physician and said, sir, I  
18 think this lady would benefit from a chair alarm,  
19 can I get an order?

20 A. No, sir. I don't recall personally doing that.

21 Q. Okay. Well, are you aware of nurses under your  
22 supervision as an administrator or as a DON who have  
23 done that?

24 A. Am I aware of that?

25 Q. Yes, ma'am.

1 A. I would have to review a record, but, yes.

2 Q. Okay. Have you ever had a doctor say, no,  
3 we're not going to do that?

4 A. Yes.

5 Q. And you have. But how often have they said, if  
6 you think that's what's in the best interest of this  
7 patient, I'm happy to send the order over?

8 A. How often?

9 Q. Have you ever?

10 A. Have I ever had a physician say if -- can you  
11 repeat the question?

12 Q. Have you ever heard a physician say, ma'am, if  
13 that's what you think is necessary, of course I'll  
14 write you the order?

15 A. I have had a physician say that.

16 Q. Do you have any reason to believe that in this  
17 particular case, when a doctor had already seen this  
18 patient, identified her as a huge fall risk, that  
19 if the request had been made by a nurse for any  
20 sorts of restraints identified on your list of  
21 resources that you'd provided this facility that he  
22 would say no?

23 A. Do I have a reason to think a doctor would say  
24 no to that?

25 Q. Right.



1 A. I don't have a reason to think that a doctor  
2 would say no.

3 Q. Sure. And have you -- I haven't heard any  
4 evidence in this case that there had been. Are you  
5 aware of any? Are you aware of Dr. Margalit having  
6 some mandate against the use of these restraints  
7 that Agape Senior, after it became restraint-free,  
8 provided as a resource available to the nurses at  
9 Agape West Columbia?

10 A. Can you repeat the question?

11 Q. Yes, ma'am. Are you aware of any prohibition  
12 by this physician that would prohibit him from  
13 making the -- approving the request for an order of  
14 any of these various restraints identified by Agape  
15 Senior as available during the period of this --

16 A. No prohibitions against that.

17 Q. Sure. So you're not aware of any reason why  
18 this doctor in this particular case would have  
19 rejected a request by the nurse to implement any of  
20 these devices; correct?

21 A. No.

22 Q. Okay. But what we do know is that didn't  
23 happen, there was no request made; correct?

24 A. I don't know.

25 Q. Okay. I want you to assume that no such

1 request was made.

2 But the fact that you're restraint-free  
3 certainly has no bearing on whether or not these are  
4 still available to you if a doctor's order is  
5 provided; correct?

6 A. Yes.

7 Q. Okay. Now, restraints do serve a purpose;  
8 correct?

9 A. Restraints do serve a purpose?

10 Q. Yes, ma'am.

11 A. Yes.

12 Q. And they're only prohibited, isn't it true,  
13 when they're found to be not medically necessary;  
14 correct?

15 A. They are prohibited -- could you restate your  
16 question?

17 Q. They're only prohibited when they're found not  
18 medically necessary; correct? If they're medically  
19 necessary, they're permissible under the law;  
20 correct?

21 A. If there's a physician order, yes.

22 Q. Ma'am, would you agree with the statement that  
23 restraints may be used if warranted as a temporary  
24 systematic intervention while the actual cause of  
25 the medical symptom is being evaluated and managed?

1 A. Could you repeat that?

2 Q. Restraints may be used if warranted as a  
3 temporary systematic intervention while the actual  
4 cause of the medical symptom is being evaluated and  
5 managed.

6 A. Do I agree with that?

7 Q. Yes, ma'am.

8 A. Hmm. In a -- if needed, in an emergent  
9 situation.

10 Q. All right. How about this one: Additionally,  
11 physical restraints may be used as a systematic  
12 intervention when they are immediately necessary to  
13 prevent a resident from injuring himself or herself.

14 A. In an emergent situation.

15 Q. And how emergent does it have to get before --  
16 how serious does it have to be?

17 A. Well, just if a patient was going to harm  
18 himself, just as it says.

19 Q. Sure. So if a patient is known to have  
20 agitation, combativeness, medicated for that symptom  
21 with a medication that had been documented by the  
22 doctor previously that same day that that medication  
23 increased their risk for falls, and then after the  
24 administration of that medication, she remained  
25 agitated and combative and did not want to stay near

1 the nurses station, ma'am, you would agree that that  
2 would be a circumstance that you might want to bring  
3 to the attention of the physician; correct?

4 A. It depends. If other approaches were being  
5 utilized, it depends. If other approaches were in  
6 place and utilized, it would depend.

7 Q. Well, ma'am, are you familiar with the policies  
8 of Agape that require that when interventions are  
9 not effective, including the use of medications,  
10 that you're supposed to alert the physician of that?

11 A. I am.

12 Q. So tell me when then there's an exception to  
13 not alerting the physician when medical  
14 intervention, such as the provision of antianxiety  
15 medication are used, not effective, and the symptoms  
16 for which you're giving them are continuing, at what  
17 point do you not inform the doctor of those  
18 symptoms?

19 A. Well, I guess, you know, one of the things is a  
20 policy is a guide, so I guess I would have to look  
21 at a specific situation to see -- to give you an  
22 example.

23 Q. Ma'am, is there any reason why you wouldn't  
24 call a physician? I mean, does that hurt anything?

25 A. Ask your question again.

1 Q. Well, in a situation like that where it appears  
2 you have a very extreme risk for falls --

3 A. Uh-huh.

4 Q. -- the patient is very high risk, they're on  
5 anxiety medication --

6 A. Uh-huh.

7 Q. -- they've just suffered a recent hip  
8 fracture --

9 A. Uh-huh.

10 Q. -- they've been agitated and combative, you've  
11 medicated them, they remain that way, and they don't  
12 want to stay where you put them, at what point -- is  
13 that a situation where you may want to get the  
14 doctor involved?

15 A. You know, if I'm doing my nursing process and  
16 I'm assessing, I'm taking interventions, I'm  
17 reassessing, and I'm doing another approach, I may  
18 get a family member involved; I may take another  
19 approach. And so if that next approach -- and I  
20 also want to use a time span. You know, you have to  
21 give interventions the proper time to get -- you  
22 know, to take full efficacy and effect. And so if  
23 I'm giving a medication, I need to make sure the  
24 medication has taken full effect in the body to make  
25 sure the time has lapsed to assess it.

1           I also need to make sure that if I'm taking  
2           another intervention, that it has gone well. If I'm  
3           going to get a family involved, that approach may  
4           work. So you need to make sure that you're  
5           following through.

6           Q.    Sure. You're not saying that you only do one  
7           intervention at a time; correct?

8           A.    No, I'm not saying that. But if you do do an  
9           intervention, you do need to make sure that it's  
10          effective.

11          Q.    Right. But if it's clear that it's not  
12          effective or if it's clear that it's going to take  
13          time to determine that, you need to make sure that  
14          patient is safe in the interval; correct?

15          A.    Correct.

16          Q.    So if you've given a patient medication and it  
17          takes an hour for that medication to work, you'd  
18          better be watching the patient over that hour  
19          because if the first symptoms aren't being dealt  
20          with and you know it's going to be an hour for that  
21          medication to work, you better have other  
22          interventions in place to ensure that she's safe  
23          until that medication kicks in; correct?

24          A.    Yes.

25          Q.    And you can't say one way or the other, not

1       having reviewed the facts of this case, whether any  
2       of that occurred; correct?

3       A.    I don't know anything about the facts of this  
4       case.  Yes.

5       Q.    And you would expect, ma'am, wouldn't you, that  
6       those things that you've described, that following  
7       of the nursing process, that implementation of  
8       various interventions, that those would be  
9       well-documented in the chart related to the  
10      particular patient that you're treating; correct?

11      A.    It depends.

12      Q.    Okay.  Well, what's the policy require?

13      A.    What do you mean?

14      Q.    What does the policy require about whether  
15      services offered to a patient be documented in the  
16      patient's chart?

17      A.    Document once a shift.

18      Q.    What does the policy require about documenting  
19      the services offered to the patient?

20      A.    To speak specifically to a policy, I would have  
21      to have it in front of me.

22      Q.    Okay.  Well, ma'am, what does the law require  
23      about whether or not the nurse has an obligation to  
24      document the services to a patient?

25      A.    You document your care.

1 Q. That's right.

2 A. Uh-huh.

3 Q. Including the interventions that you put into  
4 place; correct?

5 A. Yes.

6 Q. Including the assessment that you perform;  
7 correct?

8 A. Yes.

9 Q. Including the response of the patient to the  
10 assessment -- I mean, to the intervention that you  
11 put into place; correct?

12 A. Yeah.

13 Q. Now, ma'am, doctors -- we looked at some  
14 marketing materials; do you recall that?

15 A. With me?

16 Q. Yes, ma'am.

17 A. I don't think I looked at any marketing  
18 material.

19 Q. Okay. Well, let me ask you about some then.

20 MR. MANN: Your Honor, I object. This is  
21 outside the scope of our direct examination.

22 MR. CONNOR: This is directly relevant, Your  
23 Honor. She talked about physicians.

24 THE COURT: Well, the scope of the cross is  
25 broad.



1 MR. MANN: But this is recross, Your Honor. He  
2 called her in his case in chief -- cross-examination  
3 in his case in chief. We called her here under  
4 direct. So it's limited to our direct.

5 MR. CONNOR: This is directly relevant, Your  
6 Honor. I intend on asking her --

7 THE COURT: Come up here.

8 (Sidebar conference.)

9 THE COURT: The objection is overruled.

10 BY MR. CONNOR:

11 Q. Ma'am, I'll represent that Plaintiffs have  
12 admitted into evidence various marketing materials  
13 that were produced in this case by the defendants.  
14 And you'd agree, would you not, that the physicians  
15 that provided services were part of Team Agape;  
16 correct?

17 A. I'm sorry. Ask your question again, sir.

18 Q. Sure. The physicians that saw these patients  
19 were actually part of and represented as part of  
20 Team Agape; correct?

21 A. Okay. I'm sorry. I'm reading the information  
22 because this is the first time I'm seeing it. I'm  
23 sorry. Ask your question again.

24 Q. Sure. The physicians --

25 A. Uh-huh.

1 Q. -- who provided services to the patients within  
2 your skilled nursing facility --

3 A. Uh-huh.

4 Q. -- were actually part of Team Agape; correct?

5 A. Part of the team, like we're part of a team  
6 providing care together? According to what I'm  
7 reading, it says: Team Agape -- reading the  
8 information that you have up here --

9 Q. Well, ma'am, I'm asking you --

10 A. Yes.

11 Q. -- as a regional president of Agape Senior, you  
12 know that Agape, another entity, actually employed  
13 the physicians providing care within Agape  
14 facilities; correct?

15 A. That another entity?

16 Q. Another Agape-owned entity was employing those  
17 physicians.

18 A. Yes, not the facility. Yes.

19 Q. Correct. And they, Agape Senior, marketed to  
20 the consumer that these were all part of the team;  
21 correct?

22 A. Yes.

23 Q. The physicians, as well as the nursing staff?

24 A. Yes.

25 Q. So the casual observer will see a Team Agape

1 name badge. They won't see whatever the related  
2 party name that employs the physicians' LLC is, will  
3 they?

4 A. The name badges were different.

5 Q. Right. But they are -- the consumer would be  
6 led to believe that they are part of the same team;  
7 correct?

8 A. The name badges were different.

9 Q. Well, ma'am, at least the marketing materials  
10 lead you to believe that; correct?

11 A. The marketing materials says what's -- what it  
12 is there. And I honestly don't have my glasses, so  
13 I can't read it all.

14 Q. But you can see Team Agape; right?

15 A. Yes.

16 Q. And you say it employs physicians and -- Senior  
17 employs -- and physicians and it identifies the  
18 various parts of that team; correct?

19 A. Yes.

20 Q. All right. Thank you, ma'am.

21 Now let me ask you this: We saw this floor  
22 plan that was put up on the screen. You haven't  
23 read the testimony of Ms. McDaniel, have you?

24 A. No.

25 Q. And she couldn't tell us where this resident

1       fell. In fact, she had no memory whatsoever. Are  
2       you aware of that?

3               MR. MANN: Objection, Your Honor. I disagree.

4               THE WITNESS: No.

5               MR. MANN: Withdrawn.

6       BY MR. CONNOR:

7       Q. Have you looked at the EMT, the run report in  
8       this case --

9       A. No.

10      Q. -- that identified this resident as actually  
11      being told by staff to them that this resident was  
12      found in a room? Do you know what room that was?

13      A. No.

14      Q. Now, looking at that diagram, I think you  
15      testified that from pen point to pen point, that  
16      would be in line of sight of the nurses station. Do  
17      you remember testifying to that?

18      A. Yes.

19      Q. But, ma'am, you would agree that for it to  
20      be in -- doesn't matter if it's in line of sight of  
21      the nurses station if there's not a nurse there,  
22      does it?

23      A. It doesn't matter if it's in line of sight if  
24      there's not a nurse there.

25      Q. Right. The fact that you move a resident in

1 front of a nurses station, if there's no nurse at  
2 the nurses station, the fact that it's in line of  
3 sight of the station has no --

4 MR. MANN: Objection, Your Honor.

5 Q. It's an ineffective intervention; correct?

6 THE COURT: Hold on just a second.

7 MR. MANN: He can certainly ask that as a  
8 hypothetical if he wants to, but that's not the  
9 testimony in this case. There's no testimony in  
10 this case establishing that there was no nurse at  
11 the nurses station.

12 MR. CONNOR: Your Honor, the testimony is -- by  
13 the only nurse, the testimony is that this is a  
14 nonwitnessed fall. That's what the incident report  
15 says.

16 THE COURT: Overruled.

17 BY MR. CONNOR:

18 Q. So, ma'am, would you agree that line of sight  
19 of the nurses station doesn't matter if there's no  
20 nurse there to see the resident?

21 A. Would I agree with that?

22 Q. Right.

23 A. If there wasn't a nurse. But there could be  
24 another staff member present.

25 Q. Okay. And are you aware of any staff member

1       that's been identified in this case or offered any  
2       testimony in this case that they observed this  
3       resident fall?

4       A.    I'm not aware of any testimony in this case,  
5       sir.

6       Q.    Then, ma'am -- well, let me ask you this: Are  
7       you aware of facility incident reports?

8       A.    Yes.

9       Q.    And are you familiar with that box that says  
10      witnessed or nonwitnessed fall?

11      A.    Yes.

12      Q.    And tell the jury what a nonwitnessed fall  
13      means.

14      A.    It means there was not a witness present.

15      Q.    Right. So if there was, you would expect that  
16      that witness would have been identified on the  
17      incident report; correct?

18      A.    Typically.

19           MR. MANN: Your Honor, may we approach?

20           THE COURT: Yes, sir.

21           (Sidebar conference.)

22      BY MR. CONNOR:

23      Q.    Now, ma'am, Agape Senior Management had  
24      responsibility, did it not, for providing training  
25      within these various facilities; correct?

1 A. Agape Senior Management provided management  
2 services, and one of the things that they did was  
3 training. Yes.

4 Q. And you would agree, would you not, that  
5 training is only as good as the teacher; correct?

6 A. I don't agree with that.

7 Q. Well, ma'am, if you have training materials but  
8 the staff isn't implementing them, you would agree  
9 that there's some breakdown somewhere; correct?

10 A. I don't agree with that.

11 Q. Well, what's an alternative explanation?

12 A. Well, I think sometimes if students don't come  
13 prepared to learn, that could -- that could inhibit  
14 learning as well.

15 Q. Okay. So maybe the quality of the student that  
16 you're getting too; right?

17 A. Well, I guess you're just talking about  
18 teaching and learning overall. So you asked me a  
19 general question; I gave you a response.

20 Q. Okay. So it's not sometimes just the bad  
21 teacher; sometimes you can have a bad student?

22 A. In learning, yes.

23 Q. Now let me ask you this: You mentioned this  
24 cushion, skid-free, slip-free flooring device. Is  
25 that a safety measure to rely on that you can just

1       leave residents unattended to if you know they're at  
2       risk for falls because there's a cushioned floor  
3       that may --

4       A.    No.  That's not what I said.

5       Q.    I just want to make sure I understand.  So the  
6       fact that you've got some cork under your floor tile  
7       is no way a substitute for providing supervision  
8       when necessary; correct?

9       A.    That's not what I said.

10      Q.    No.  I'm asking you a question.

11      A.    Okay.

12      Q.    You would agree that the flooring is not a  
13      substitute for necessary interventions to protect a  
14      patient; correct?

15      A.    I would agree that our flooring is a very  
16      high-quality flooring at the time while I was there.  
17      And what I did say, my test -- what I testified to  
18      is that one of the things we train on was ensuring  
19      that we kept up that flooring well.  One of the  
20      things that I learned while I was an administrator  
21      was keeping that carpet clean was very important  
22      because it did have safety protection built into it.  
23      That is what my testimony was.

24      Q.    Right.  And I want to understand your  
25      testimony.  You're not testifying that because your



1 floor has some safety enhancements that that's a  
2 substitute for keeping your residents from falling;  
3 correct?

4 A. Correct.

5 Q. And you know of residents, don't you, that have  
6 fallen on that special floor and still suffered  
7 fractures; right?

8 A. I'm sure.

9 Q. Sure. And that would be something that you  
10 would expect the staff that you were responsible for  
11 training to also understand, hey, guys, we got this  
12 nice floor, but if somebody falls, the results can  
13 still be catastrophic?

14 A. Yes.

15 Q. Now, you indicated that your aides document  
16 once a shift and that would far exceed CMS  
17 requirements. Did I hear that correctly?

18 A. I said that our process was once a shift.

19 Q. Okay. And then I think you said that would --  
20 in response to a question asked by your counsel, far  
21 exceed CMS requirements.

22 A. I believe he asked what was CMS requirements,  
23 and I answered that. And he said, so did that  
24 exceed it? And I think he was asking -- in  
25 response, I said, CMS requirements is that it's min,

1 moderate, or max. And he said, so us documenting  
2 once a shift would exceed that? And I said yes.

3 Q. Okay. So when were the CNA shifts?

4 A. They had twelve-hour shifts, 7:00 to 7:00.

5 Q. CNAs?

6 A. Yes.

7 Q. Okay. So you would expect that if the last  
8 documented charting on a patient for the day is at  
9 2:20, that you would see at least something  
10 documented, if care was offered to this resident  
11 after that fact, around 7:00, at the end of that  
12 shift?

13 A. I don't -- this is the first time I'm seeing  
14 this document.

15 Q. Right. I just want to understand your  
16 testimony. So there's been documents admitted in  
17 this case that show that the last documented care to  
18 this particular patient was at 2:19 PM, but that she  
19 remained at the facility for another five hours. So  
20 if services were provided after that fact, you would  
21 expect that at some point, the services provided  
22 during that five hours would be documented in that  
23 chart; correct?

24 A. Ask your question again, sir. Sorry.

25 Q. Sure.

1 A. And could you put the document -- I'm sorry.

2 Q. Sure. What's --

3 A. What -- what's your question, sir?

4 Q. What's been produced, ma'am, is an ADL report  
5 in this case that reflects when ADL services were  
6 provided. And it sounded like to me that you  
7 said --

8 A. Okay.

9 Q. -- that these completed tasks would be  
10 documented at the end of the shift.

11 A. Okay.

12 Q. So my question is, if the last documented tasks  
13 were documented at 2:20, yet the resident remained  
14 in the facility for another five hours, that at some  
15 point, whether it be at the end of that CNA's shift  
16 at 7:00, that you would expect to see the completed  
17 tasks documented.

18 A. Yeah. Our process was that we document it once  
19 a shift.

20 Q. Sure. So here, because there's no  
21 documentation of any services over those five hours  
22 ever, you would expect that, at some point, if they  
23 were given, that they would have been documented at  
24 the end of that shift; correct?

25 A. Typically, we document it once a shift.

1 Q. Now, ma'am, you also said that you also  
2 document once a shift the services or the level of  
3 services and support provided; correct? Right?

4 A. I said that, yeah, our process was that we  
5 document it once a shift.

6 MR. CONNOR: And, Your Honor, this is, for the  
7 jury's benefit, Plaintiff Exhibit 15. This is ADL  
8 support and assistance.

9 BY MR. CONNOR:

10 Q. Do you see any support offered on the 2nd for  
11 any of these categories by an aide including  
12 locomotion, walk in corridor, walk in room? Do you  
13 see any level of support offered by aides in those  
14 areas on that date?

15 A. I do not.

16 Q. Okay. But you would expect that, correct, per  
17 your testimony?

18 A. Typically, we document it once a shift.

19 Q. But here, we don't have anybody documenting  
20 that she was walking in a room, anyone documenting  
21 that she was walking in the corridor, anybody  
22 documenting any locomotion on or off the unit;  
23 correct?

24 A. I don't see anything there.

25 Q. And you don't know whether the nurse's notes

1 reflect in this case that this patient was taken to  
2 the dayroom, taken to the dining room, and taken to  
3 PT. If they were, you certainly would expect that  
4 several of those categories would have been  
5 identified and marked; correct?

6 A. I don't see anything.

7 Q. But you would expect if they took them to the  
8 PT room, if they took them to the dining room, that  
9 at least these locomotions on and off the unit and  
10 walking in the corridor would be documented;  
11 correct?

12 A. Typically, we document it once a shift. Again,  
13 there is not a requirement by any federal or state  
14 law for the detail of this documentation. But,  
15 typically, we document it once a shift.

16 Q. Right. I think that's what you said you do and  
17 I think you said that far exceeds CMS expectations.  
18 But here, it wasn't done, was it?

19 A. Yeah. I don't see anything there.

20 Q. So that would not meet your expectations if you  
21 were training that staff member; correct?

22 A. If I was training, I would have trained to  
23 document once a shift.

24 Q. That's all the questions I have, ma'am. Thank  
25 you.

1 A. You're welcome.

2 THE COURT: Mr. Mann?

3 MR. MANN: Very quickly, Your Honor.

4 THE COURT: Okay.

5 REDIRECT EXAMINATION

6 BY MR. MANN:

7 Q. Very, very briefly, Dee Dee. Mr. Connor read  
8 to you from a document and asked you if you agreed  
9 with the statement regarding physical restraints.  
10 I'm going to read you another statement from that  
11 same document and ask you if you agree with this:  
12 Note, falls do not constitute self-injurious  
13 behavior or a medical symptom that warrants the use  
14 of a physical restraint.

15 Although restraints have been traditionally  
16 used as a fall-prevention approach, they have major  
17 serious drawbacks and can contribute to serious  
18 injuries. There is no evidence that the use of  
19 physical restraints, including but not limited to  
20 side rails, will prevent or reduce falls.  
21 Additionally, falls that occur while a person is  
22 physically restrained, often result in more severe  
23 injuries.

24 Do you agree with that statement?

25 A. I 100 percent agreement with that statement.

1 Q. Okay. One more question. Once per shift;  
2 right?

3 A. Yes.

4 Q. Can you document it in the middle of your  
5 shift?

6 A. Yes.

7 Q. So you can document at 2:20 in the afternoon  
8 and that's your once-per-shift documentation?

9 A. Yes.

10 Q. Okay. Thank you very much.

11 THE COURT: You may step down.

12 MR. MANN: Your Honor, can we take five  
13 minutes?

14 THE COURT: Sure. Ladies and gentlemen, we're  
15 going to take a short break. I'm going to send you  
16 back to your jury room. Please don't discuss the  
17 case and we'll have you back out here in a few  
18 minutes.

19 MR. MANN: Thank you, Your Honor. We're going  
20 to introduce -- publish a couple documents and then  
21 rest.

22 THE COURT: Into evidence?

23 MR. MANN: Yes.

24 MR. BLAKE: They're already admitted; they're  
25 joint exhibits. We're just going to publish them.

1 THE COURT: All right, Counsel.

2 Let's go ahead and bring the jury back in,  
3 please.

4 (The jury enters the courtroom at 10:24 AM.)

5 THE COURT: Welcome back, ladies and gentlemen.  
6 We're going to continue on now with the defendants'  
7 case.

8 MR. BLAKE: Thank you, Your Honor. At this  
9 time, the defendants request to publish to the jury  
10 an excerpt from Joint Exhibit No. 32, the DHEC  
11 regulation, the standards for licensed nursing home  
12 61-17.

13 THE COURT: Very well.

14 MR. BLAKE: Thank you, Your Honor.

15 Section 606: Staffing. Licensed nursing  
16 staff. An adequate number of licensed nurses shall  
17 be on duty to meet the total nursing needs of  
18 residents. Licensed nursing staff shall be assigned  
19 to duties consistent with their scope of practice as  
20 determined through their licensure and educational  
21 preparation.

22 Number 2: There shall be at least one licensed  
23 nurse per shift for each staff work area. If there  
24 are more than 44 residents per staff work area,  
25 there shall be two licensed nurses on first shift



1 and at least one licensed nurse on second and third  
2 shift.

3 Section B: Non-licensed nursing staff. The  
4 required number of nurses' aides and other  
5 non-licensed nursing shall be determined by the  
6 number of residents assigned to the beds at the  
7 facility. Additional staff members shall be  
8 provided if the minimum staff requirements are  
9 inadequate to provide appropriate care and services  
10 to the residents of the facility.

11 Subsection 1: Non-licensed nursing staff shall  
12 be provided to meet at least the following  
13 resident-to-staff ratio schedule: 9 to 1 for shift  
14 one; 13 to 1 for shift two; 22 to 1 for shift three.

15 Subsection C: In those facilities using two  
16 12-hour shifts, both the licensed and non-licensed  
17 staff ratios for shift apply to the 12-hour shift  
18 occurring primarily during the day, and both the  
19 licensed and non-licensed staffing ratios for shift  
20 three apply to the 12-hour shift occurring primarily  
21 during the night.

22 MR. MANN: Your Honor, we'd also like to  
23 publish from Joint Exhibit 3, the Lexington  
24 Orthopedic health records.

25 THE COURT: All right. Very well.

1           MR. MANN:   DOS: 11/18/2014.   Patient: Utricia  
2           Shealy.   Active problems: Two, Alzheimer's disease.

3           DOS: 7/1/2014.   Patient: Utricia Shealy.  
4           Ambulation distance: 60 feet.   Patient has had  
5           post-op confusion.   She does have a baseline level  
6           of confusion normally.   She is followed by a  
7           neurologist for this and has been on an up.

8           Date of service: 7/8/2014.   Patient: Utricia  
9           Shealy.   Ambulation distance: 110 feet.   During the  
10          hospitalization, there were not additional medical  
11          issues.   Patient has mild post-op confusion.  
12          However, this is chronic and she's back to what  
13          appears to be her baseline dementia.

14          DOS: 10/23/2014.   Patient: Utirica Shealy.  
15          The patient's family tells me that she has been  
16          weaker over the last few weeks, but may be starting  
17          to turn the corner.   And she was able to walk some  
18          today.   Does not seem to be related to hip pain;  
19          rather, it seems to be more generalized weakness.

20          Affected: Right lower extremity.   Pain-free  
21          range of motion right hip.   Neurovascularly intact.  
22          Plan: I wonder if there was a medical issue causing  
23          her to be weaker over the last few weeks.   Per the  
24          family, this seems to be improving but that does not  
25          recommend a medical evaluation.   As for her hip, she

1           may follow up as needed.

2           Thank you, Your Honor.

3           MR. BLAKE: At this time, Your Honor, the  
4           Defense rests.

5           THE COURT: Ladies and gentlemen of the jury,  
6           I've got some matters I need to talk about with the  
7           lawyers now. I'm going to send you back to your  
8           jury room. I will give you an update momentarily.  
9           Please do not discuss the case in any way. Thank  
10          you.

11          (The jury exits the courtroom at 10:34 AM.)

12          THE COURT: Y'all need a minute or are you  
13          ready to go?

14          MR. BLAKE: I didn't know if we were expecting  
15          rebuttal or no rebuttal.

16          MR. CONNOR: No rebuttal at this point, Your  
17          Honor.

18          MR. BLAKE: So we can let Mitzi go?

19          MR. CONNOR: Yes.

20          MR. BLAKE: Can I go ahead and renew my motion  
21          then, Your Honor?

22          THE COURT: Sure. Sure.

23          MR. BLAKE: I appreciate it, Your Honor. For  
24          the convenience of time, I'm going to incorporate  
25          the arguments I made yesterday, Your Honor, so you

1 don't have to hear me spout it all out and hear  
2 Mr. Connor respond to all of it.

3 Your Honor, we just feel at this time that a  
4 lot of the absence of evidence of what occurred  
5 after 5:30, it's -- all we have for what happened in  
6 that time period is one note, one record, that ER  
7 note that describes it. And from that, we don't  
8 believe that the jury is able to determine why this  
9 lady fell. Right?

10 And what we heard from an expert and what we've  
11 heard repeatedly argued is, well, we should be able  
12 to tell from your records. Because we can't tell  
13 from your records, that's a breach of the standard  
14 of care, and we don't know, but we should know -- I  
15 mean, the expert said repeatedly to my question  
16 yesterday, no, I don't know, but I should be able to  
17 tell. And that's true, she should be able to tell.  
18 But that has no bearing on what the burden of proof  
19 is in this case.

20 The burden of proof for the plaintiff doesn't  
21 shift simply because their expert -- and none of us  
22 really know what happened between 5:30 and 7:25 that  
23 caused this lady to fall. And they can cite to 100  
24 breaches of standards of care. None of those  
25 citations to the standards of care on how to

1 document have any bearing on the question of, does  
2 it amount to a breach of the standard of care that  
3 has been causally connected to the fall?

4 There's no -- the expert said herself, sure, we  
5 should have written the medication administration on  
6 the MAR; we didn't. That's a breach of the standard  
7 of care. Did that cause her to fall? Even in  
8 response to direct examination, the expert said, no,  
9 there's no evidence she was given a subsequent  
10 Ativan because of a document error. If that had  
11 happened, sure, that could have caused her to fall,  
12 but I don't have any evidence of that, is what the  
13 expert says.

14 They've cited to all sorts of documentation  
15 errors, breaches of policies on how to document.  
16 And those are all a breach of a standard of care,  
17 but the jury can't infer from causation because  
18 there's been nothing to link it to the actual fall.  
19 This is nothing more, at the end of the day, of res  
20 ipsa loquitur, which our courts do not allow. You  
21 have to give us some reason. It can't just be,  
22 well, she fell when she was on your property, when  
23 she was in your care, and even though I can't tell  
24 you why she fell or how she fell, we know she fell,  
25 and that's not okay to us; therefore, a jury gets to

1 make a causal connection.

2 The absence of evidence is unfortunate, but it  
3 does not shift the burden. They have to meet the  
4 burden. We don't feel they've met that burden, so  
5 we believe that directed verdict is appropriate on  
6 all counts. Thank you, Your Honor.

7 THE COURT: Thank you.

8 MR. CONNOR: Your Honor, I thought we were not  
9 rearguing our points. I'm happy to do it. The  
10 defendant --

11 THE COURT: Well, he didn't go all the way.  
12 Don't feel like you need to.

13 MR. CONNOR: I won't, Your Honor. I don't  
14 think it's necessary. The defendants' focus on one  
15 of the plaintiff's allegations that they contend  
16 that supports this cause of action, that being the  
17 defendants' breaches in the standard of care as it  
18 relates to their failure to document. What they  
19 ignore, however, are all of the other acts and  
20 omissions that our expert as well as our complaint  
21 have alleged were causally linked to this injury  
22 including the failure to have appropriate steps  
23 along each of the -- failure to have  
24 appropriate steps along each -- failure to have  
25 appropriate -- excuse me. I'm getting tongue-tied

1       here.

2               They failed to have appropriate assessments,  
3       diagnoses, plans, interventions, and re-evaluations,  
4       all five active steps of the nursing process; the  
5       plaintiff has also contended were violated, were  
6       negligent, and caused this resident the injury that  
7       she sustained. The fact that the documentation  
8       can't be linked directly to the fall is only one of  
9       the theories that we contend are at issue here and  
10      we think that the evidence is overwhelming that  
11      these defendants did not provide the appropriate  
12      acts or omissions to protect this patient from her  
13      fall that she sustained and, therefore, a directed  
14      verdict is completely inappropriate.

15             MR. BLAKE: Briefly in response -- and I'm not  
16      saying he's conceding; I know he's not. I don't  
17      want to feel like he's got to put that in the  
18      record. But if the Court finds that it's -- it is  
19      an issue of this failure and assessment, diagnosis,  
20      plan, implementation, evaluation, and not related to  
21      some violation of the statutes, for this per se  
22      claim to go to the jury, they're going to have to  
23      show you a law that was violated that they have  
24      shown evidence that is causally connected to the  
25      fall. And, at a minimum, if they can't show that,

1       then the per se cause of action does need to come  
2       out.

3               MR. CONNOR: Your Honor, she's testified. The  
4       rules and regulations that we looked over again  
5       cover a myriad of issues including appropriate  
6       staffing, appropriate provision of care, appropriate  
7       fall interventions and preventions. They cover the  
8       whole host of those various steps within the nursing  
9       process, not just documentation. And she contended  
10      that all of those were breached. So as to the  
11      negligence per se count, there is evidence that  
12      those have been causally linked to the injury that  
13      she sustained.

14             THE COURT: Okay. To the extent that I've  
15      heard any new statements from counsel, those are,  
16      for the record, incorporated in their arguments from  
17      yesterday on both sides. In similar form, I still  
18      believe the evidence as a whole is susceptible to  
19      more than one reasonable inference for the jury to  
20      decide in this case, and I'll deny your motions.

21             MR. BLAKE: Thank you, Your Honor. I  
22      appreciate that.

23             MR. MCALISTER: Your Honor, the plaintiff does  
24      have a couple motions for directed verdict. As far  
25      as their defenses go of comparative negligence and



1           intervening cause --

2           MR. BLAKE: Your Honor, we'll withdraw the  
3           comparative to save them the time. We agree we  
4           haven't put on evidence of Ms. Shealy's own  
5           negligence in this case.

6           THE COURT: So noted.

7           MR. MCALISTER: Yes. And then with respect to  
8           the intervening cause, Your Honor, there's been no  
9           testimony offered to provide causation or  
10          intervening causation subsequent to her fall that  
11          establishes that that interferes with liability in  
12          any kind of way. And we've talked about this in  
13          chambers and we cited some case law to you, Locklear  
14          v. Southeastern Stages 193 S.C. 309. It talks about  
15          intervening negligence of a third person will not  
16          excuse the first wrongdoer. In this case, there's  
17          been no testimony, no evidence whatsoever of an  
18          intervening cause and we don't feel that would be  
19          appropriate either.

20          MR. CONNOR: Your Honor, in addition to that --

21          THE COURT: Well, who's arguing it here? I  
22          mean --

23          MR. BLAKE: If they need to converse, I can  
24          wait.

25          THE COURT: Okay.

1           MR. CONNOR: Your Honor, just a couple further  
2 points: They've offered no expert testimony to  
3 establish that causation, which they're required to  
4 by law. And, further, these patients and these  
5 fractures come with foreseeable risks and those  
6 foreseeable risks would override any intervening.

7           THE COURT: All right.

8           MR. BLAKE: As to the suggestion we need expert  
9 testimony, Your Honor, there's a -- the intervening  
10 causation does not itself require expert testimony.  
11 More importantly, there's also still an ordinary  
12 negligence claim that's still going to the jury that  
13 does not require expert testimony on causation. And  
14 that content is always left to the, quote, sound  
15 discretion of the jury.

16           The intervening cause in particular I would  
17 point the Court to would be the actions of  
18 Dr. Margalit who -- the only evidence in this case  
19 shows he is not an employee of either defendant.  
20 The -- we have put on evidence that the nurses on  
21 the day of the fall brought the physician in early  
22 as an intervention, informed him of her condition,  
23 and asked that orders be issued. He, in fact, did  
24 respond and issue orders.

25           There's no evidence that the condition that she

1        was in at 6:00 PM or at 6:30 or at 7:00 PM is any  
2        different than she was at the time that Dr. Margalit  
3        evaluated her that morning. And so the conduct of a  
4        third party, Dr. Margalit, is a potential  
5        intervening cause that the jury may look and say the  
6        physician was to order a restraint or to take some  
7        other action to prevent her to cause harm to herself  
8        or others. It was within the scope of his authority  
9        to do so on the day of July 2nd. His failure to do  
10       so, the jury may find, is an intervening cause for  
11       which the nurses are not responsible. Thank you.

12                MR. MCALISTER: Your Honor, obviously we  
13       disagree. There's no evidence whatsoever that  
14       Dr. Margalit was negligent in any fashion. In fact,  
15       there have been subsequent issues after the fact  
16       noted in the record including, you know, increased  
17       agitation, which would require those nurses to  
18       contact him, to let him know of this change in  
19       condition.

20                So -- and prior to his evaluation, the only --  
21       or after his evaluation, the only notes in the chart  
22       were that there were no signs or symptoms of  
23       distress and she was eating lunch.

24                MR. CONNOR: Participating in therapy and -- to  
25       suggest that there was no change in her status from

1 the time that he saw her completely contradicts the  
2 nurse Ms. Ebonie McDaniel that says that everything  
3 was fine.

4 MR. BLAKE: And, Your Honor, again, they  
5 themselves have disputed the timing of those  
6 injuries, when they were made. But what's not in  
7 dispute though is that the evidence is subject to  
8 more than one inference. The doctor says, per  
9 nurse, she is agitated. The description in that  
10 per-nurse entry on Dr. Margalit's note is identical  
11 to the description of her condition in the ER note.  
12 There's no other evidence of her condition.

13 THE COURT: So by arguing intervening cause,  
14 you're arguing that the doctor is also a causative  
15 factor?

16 MR. BLAKE: The doctor -- our whole defense is,  
17 at the end of the day, their expert's only real  
18 testimony is what caused this lady to fall is that  
19 we didn't pick up the phone and call a friend; we  
20 didn't call the doctor; we didn't call the family;  
21 we didn't call somebody could have issued an order  
22 to intervene.

23 On closing, I intend to address with the jury  
24 the family factor. But as it relates to call the  
25 doctor, we already called the doctor; we already

1 reported to the doctor the condition. It's in  
2 evidence. And if the doctor determined that her  
3 agitation level required additional orders, it was  
4 incumbent upon him to do so. That's an intervening  
5 cause for which we're not responsible.

6 Again, they can argue that their reading of the  
7 notes throughout the day suggest variation, but  
8 that's not placing the burden of proof in the right  
9 place. This is an affirmative defense that they're  
10 saying, well, hold on now, hold on; we think this  
11 must be stricken. They're not entitled to directed  
12 verdict on our affirmative defense because there is  
13 a reasonable inference the jury can draw. Well,  
14 yeah, I'm looking at Ms. McDaniel's note and I'm  
15 looking at the doctor's note; they sure look the  
16 same to me. Why didn't the doctor order a  
17 restraint? Why didn't the doctor order her  
18 discharged? Why didn't the doctor do some other  
19 action whenever he viewed her that morning to say,  
20 you know what, maybe more interventions or some  
21 other action is necessary?

22 THE COURT: Inference. But has there been any  
23 testimony to support that?

24 MR. BLAKE: There's no testimony from any  
25 person at all in this whole trial of what happened

1       that day. It's 100 percent from paper records.  
2       There's not a single human being with knowledge that  
3       has testified outside this scope of records about  
4       July 2nd, 2014. The record is dearth of it.

5               MR. CONNOR: I believe there were three that  
6       are sitting in this courtroom --

7               MR. BLAKE: I'm referring to medical providers,  
8       Your Honor.

9               MR. CONNOR: And there's been no testimony by  
10      any medical provider that this doctor breached the  
11      standard of care.

12              MR. BLAKE: Couldn't agree more. But I'm not  
13      saying he breached the standard of care. I'm saying  
14      that his conduct is an intervening cause.

15              MR. CONNOR: She fell after his conduct, Your  
16      Honor.

17              MR. BLAKE: She did. I couldn't agree more.

18              MR. CONNOR: Hours after his conduct.

19              MR. BLAKE: She fell after our conduct. That's  
20      a fact.

21              MR. CONNOR: While under your care.

22              Your Honor, this is like saying her fall in her  
23      yard for seven, eight days before was some  
24      intervening cause to their -- because they --  
25      because she was now debilitated and more prone to a

1 fall. That is outrageous.

2 THE COURT: Okay. I'll -- give me a few  
3 minutes. I'll be back. Stand at ease.

4 (Brief pause in the proceedings.)

5 THE COURT: I tried to examine this question.  
6 And in the context of the facts in evidence in this  
7 case, there's been a great deal of evidence  
8 presented, time lines and acts that were or were not  
9 properly done. I don't see Dr. Margalit as an  
10 independent -- an active independent agency which  
11 destroys the causal connection to where he could be  
12 an intervening third-party cause. It's a tough  
13 question, mind you. But in light of the totality of  
14 the testimony I've heard, I'll grant the motion on  
15 intervening cause.

16 We'll begin the charge conference -- do you  
17 want to take a break, eat lunch, and come back at  
18 1:00? I'm sure y'all have had enough of the  
19 courthouse for a few minutes.

20 MR. BLAKE: Sure.

21 THE COURT: All right. Anything else for the  
22 record?

23 MR. CONNOR: I don't know what else they have.  
24 I haven't had a chance to look at it yet. Our  
25 revisions are minor. I didn't know --

1 THE COURT: Okay. Then we can go ahead and  
2 knock it out since we're here.

3 MR. CONNOR: If they're ready. I don't want  
4 to --

5 THE COURT: Let me tell you what; I'm going to  
6 bring the jury in, since they're hanging out, and  
7 I'm going to tell them both parties have rested; the  
8 evidence is closed; there are no more witnesses.  
9 We'll proceed with closing arguments tomorrow  
10 morning at 9:00 AM and have them be in their jury  
11 room at 8:45. Does that sound good?

12 MR. CONNOR: Yes, Your Honor.

13 MR. BLAKE: Yes, Your Honor.

14 THE COURT: All right. Let's bring them in  
15 real quick.

16 MR. CONNOR: Would you prefer we try to close  
17 today?

18 THE COURT: At this point, no. I mean, we're  
19 going to be -- I mean, based off what you told me  
20 yesterday, we -- it was requested that we start on  
21 Friday morning.

22 MR. CONNOR: Sure. I also thought we were  
23 going to go until noon. It's fine. Whatever you --

24 THE COURT: At this point, I mean, let's take  
25 our time, let's get --



1           (The jury enters the courtroom at 11:36 AM.)

2           THE COURT: Mr. Foreman, ladies and gentlemen  
3 of the jury, at this time, the defense has rested.  
4 Both parties have presented their cases, the  
5 evidence is closed, and there are no more witnesses.

6           With just the current schedule, what I'm going  
7 to do at this point is I'm going to let you go for  
8 the day. And tomorrow morning, we'll begin closing  
9 arguments in this case at 9:00 AM. Be back in your  
10 jury room at 8:45. I've got some things to discuss  
11 with the lawyers before we do all that, so I just  
12 want to go ahead and do that today with as much time  
13 as we need.

14           We'll begin tomorrow morning at 9:00 AM with  
15 closing arguments. And then after closing arguments  
16 are complete, I'll charge you on the law of this  
17 case, and then you'll have the opportunity to begin  
18 your deliberations. Like I've told you all week,  
19 please don't discuss this case at any time between  
20 now and when I tell you you can. And I certainly --  
21 I kept you late at least one day, so consider this  
22 me paying you back for keeping you late one day and  
23 you'll get to go home early today. Okay? All  
24 right. Thank you. We'll see you tomorrow morning  
25 at 8:45.

1           (The jury exits the courtroom at 11:38 AM.)

2           THE COURT: Anything else for the record at the  
3 moment?

4           MR. CONNOR: No, Your Honor.

5           MR. BLAKE: No, Your Honor.

6           (Off-the-record discussion.)

7           THE COURT: Okay. We just had an extensive  
8 bench conference. The jury charge has been  
9 finalized. I'll allow counsel now to note any  
10 objections they may have at this point.

11          MR. BLAKE: Thank you, Your Honor. The  
12 objection to the charge that we have raised is that  
13 we had requested on the requirement of expert  
14 testimony charge in addition, a sentence following  
15 the third sentence of the charge. So it would have  
16 been the fourth sentence of the charge to read:  
17 However, comma, a defendant is not required to  
18 provide expert testimony to rebut a plaintiff's  
19 expert, period. And we understand the Court's  
20 ruling on that, and we just wanted to note that for  
21 the record.

22          THE COURT: So noted.

23          MR. CONNOR: Your Honor, for the record, the  
24 plaintiff has one objection, that being to the  
25 negligence unavoidable accident defense. We contend

1       there's no evidence of an avoidable accident as  
2       defined within the charge, unincluding an  
3       unavoidable accident is defined as an occurrence  
4       which was not intended or could not have been  
5       foreseen, prevented, or avoided by the exercise of  
6       reasonable caution or ordinary care. And it goes  
7       on. But we contend that that's not been established  
8       by any evidence in this case, and we think that that  
9       should be removed from the instruction altogether.

10           THE COURT: The objection is noted. All right.  
11       And just for the record, we have a verdict form that  
12       we discussed back in chambers and we've all agreed  
13       on to use tomorrow. Anything else for the record  
14       today?

15           MR. CONNOR: No, Your Honor.

16           MR. BLAKE: No, Your Honor.

17           THE COURT: I know y'all are finishing up the  
18       redaction of the document, which we don't need to  
19       discuss. Other than that, we'll see you tomorrow  
20       morning bright and early. I've asked the jury to be  
21       back at 8:45 and we'll commence with closing  
22       arguments at 9:00 AM.

23           (The following proceedings were held October  
24       26, 2018.)

25           (The jury enters the courtroom at 9:15 AM.)

1           THE COURT: Mr. Foreman, ladies and gentlemen  
2 of the jury, welcome back on a lovely Friday  
3 morning. I hope your trip in was nice this morning.  
4 It's just one of those days with the weather. But I  
5 appreciate you being here.

6           Ladies and gentlemen, the parties have  
7 presented the evidence in their case. It's now time  
8 for the attorneys to make their closing arguments.  
9 The arguments of the attorneys are not evidence in  
10 the case. Their statements are arguments and meant  
11 to help you understand the evidence and apply the  
12 law to the evidence. You should disregard any  
13 remark, statement, or argument which is not  
14 supported by the evidence presented during the trial  
15 or the law that I'll explain to you after the  
16 arguments. At this point, we'll proceed with  
17 closing arguments by the plaintiff.

18           MR. CONNOR: Thank you, Your Honor. May it  
19 please the Court?

20           THE COURT: Yes, sir.

21           MR. CONNOR: Good morning, ladies and  
22 gentlemen. First I want to thank you all for your  
23 patience with us and for your attention through this  
24 matter. I know this has been trying and it's been a  
25 sacrifice for you all, but I want you to know that

1       it's very important and it means a lot to both of  
2       the parties here. And we trust that y'all will  
3       ultimately get the right decision in this case.

4               As you know, we're here on the Utricia Shealy  
5       vs. Agape Nursing & Rehab and Agape Management  
6       Services case that's now pending in Lexington  
7       County. Before we get started, I want to talk about  
8       just some basic, fundamental rules of nursing that I  
9       think you-all have had the opportunity to hear about  
10      throughout this case. It mirrors that nursing  
11      process. Every resident in a skilled facility needs  
12      an adequate assessment to evaluate their condition  
13      appropriately.

14             They need an individualized plan of care, one  
15      that outlines goals and strategies to ensure that  
16      their care, while in that facility, is done  
17      appropriately and safely. They need interventions  
18      to be implemented to ensure that that plan of care  
19      and those goals that are established are met. And  
20      they need, when issues arise, when conditions  
21      change, to be re-evaluated. They're entitled to  
22      that. That's a fundamental rule of nursing. This  
23      is Ms. Shealy. Y'all have had the opportunity to  
24      hear from several family members. Utricia, lifelong  
25      resident of this county. This is the week before

1 her initial fall in her home where she lives  
2 independently.

3 She was admitted, as you know, on July 1st of  
4 2014 to Agape Senior. The anticipated length of  
5 stay was for short-term rehab. The goal was to  
6 increase mobility and strength. Now, when this  
7 resident was admitted to the facility, Agape Rehab  
8 had a policy; they had a standard that they held  
9 themselves to that they would only admit those  
10 residents whose medical and nursing care needs could  
11 be met. That's what they said that they would do.

12 They had the opportunity to accept patients or  
13 decline patients. And they chose, given the needs  
14 of this patient, given their knowledge of the  
15 problems that she had, to take her on. Now, they  
16 didn't do this as a charity, as you know. They were  
17 paid for these services, and we're going to talk  
18 about that in a little bit. There's a reason why  
19 they accepted this patient. She was a Medicare  
20 patient. She needed rehab.

21 Now, the family, in part, chose Team Agape  
22 because of the representations that they made about  
23 the services that they offered. One of those  
24 included a representation that they would provide  
25 24-hour nursing care. Now, the defendants have

1 attempted to skirt that, pointing to the law that  
2 says, well, technically, that's not what's required.  
3 But, ladies and gentlemen, when you hold yourself  
4 out as offering services to the public and the  
5 public relies on those, then you've created the  
6 duty.

7 Now this, along with those representations,  
8 representations like this made in the public, that,  
9 again, was the expectation of the family and the  
10 promise that the facility made that they would be  
11 able to offer Ms. Shealy. On July 1st of 2014, she  
12 was assessed in an admissions assessment. And,  
13 based on the facility's own assessment of this  
14 patient, they, like the family, anticipated that  
15 this patient, this resident, Ms. Utricia Shealy,  
16 would be discharged home.

17 This was not a long-term care resident. This  
18 was not someone that they expected would remain in  
19 their facility inevitably. This is not a woman who  
20 required skilled nursing care for the remainder of  
21 her life due to some disease process. This is a  
22 lady who, with appropriate rehabilitative care and  
23 with appropriate nursing care, should have been able  
24 to return home. Yes, she had dementia. Everybody  
25 acknowledged that; the family acknowledged that.

1       The staff members have acknowledged that. But many  
2       people live for many years with dementia symptoms.  
3       It's not something that is a life sentence to a  
4       nursing home.

5               Now, as you know, you've seen this, this  
6       facility offered training about falls. Their staff  
7       knew and should have known that falls were dangerous  
8       in the elderly and that elderly patients at risk for  
9       falls need to be protected. The statistics related  
10      to falls in this patient population are staggering.

11             Now, you also saw their training videos on fall  
12      prevention. In that video, it directly states --  
13      and you-all will have the ability to re-watch this  
14      if this is something that you'd like to do, it's  
15      part of the evidence -- quote, most resident falls  
16      are preventable if you take a close look at  
17      residents in your care and learn how to identify  
18      risk factors.

19             Now, in order to identify risk factors, you  
20      have to be appropriately trained; you have to be  
21      provided education; you have to have the experience  
22      to know what to look out for. As part of that  
23      training, there was a fall trivia question: Name  
24      three characteristics or conditions that make  
25      someone more prone to falling. And listed in the



1 key was a host of different factors that would have  
2 been appropriate answers.

3 For this particular patient, she had many of  
4 these risk factors: Female, white, 65 or older,  
5 thin, history of falls, lower body weakness, balance  
6 problems, stroke, physical limitations,  
7 incontinence, Alzheimer's or dementia, lack of  
8 exercise, psychotropic medications, vision problems,  
9 and multiple medications. Now, that's certainly  
10 more than three. And with every additional  
11 characteristic that makes someone prone for falling,  
12 your incidence of suspicion, your alertness to their  
13 conditions should also rise.

14 Now, as you know, when she was admitted, she  
15 was ambulatory; she was. We heard about that. She  
16 was making progress in therapy. She was not forever  
17 bound to a bed at this point. She was suffering  
18 from dementia, and that dementia had been  
19 exacerbated because of her recent surgery associated  
20 with her first fall. She had a history of falls.  
21 She was assessed as a high risk for falls. She was  
22 identified as a maximum assist, meaning when she was  
23 being transferred, that she required one or two  
24 staff members to assist her in that. And it was  
25 very clear throughout the record that this patient

1 required close monitoring and care by experienced  
2 professionals. That's why she was there.

3 On the morning of the 2nd, again the facility  
4 is on notice that this patient is a huge risk for  
5 falls. The physical therapists and occupational  
6 therapists, they spent, per their records which are  
7 in evidence that you'll have the opportunity to look  
8 at, 150 minutes, allegedly, assessing this patient.  
9 This is on the day of the 2nd.

10 During that assessment, they found her  
11 extremely prone to falls, lacking complete safety  
12 awareness -- not diminished safety awareness, no  
13 safety awareness -- needs constant supervision.  
14 Now, ladies and gentlemen, this was in the records  
15 specific to this patient prior to her fall. The  
16 facility was on notice that this patient needed  
17 constant supervision. And they had a policy that  
18 said if you have a resident who has a condition  
19 we're not able to meet, then we should not accept  
20 her. We should transfer her elsewhere. She should  
21 be sent somewhere else that's capable of managing  
22 her condition appropriately.

23 Ladies and gentlemen, they were on notice, they  
24 accepted this patient, and they continued to retain  
25 this patient, even though it had been identified in

1       their own records that she required constant  
2       supervision.

3               Now, as you know and you have seen and you've  
4       heard the testimony, the records in this place make  
5       no sense. They're not able to make sense. And  
6       there's been no testimony. You may have heard  
7       counsel ask some questions, but if you recall the  
8       answers by the witnesses, there's been no testimony,  
9       no explanation by anyone who worked at this facility  
10      why the records were like this. No explanation.

11             The only explanation that you heard was from  
12      Kathleen Hill O'Neil who suspected that these  
13      records had been fudged. And, ladies and gentlemen,  
14      I believe, based off the records as you go deep  
15      inside of those, you'll come to that same  
16      conclusion, because there's no way to justify what  
17      they show.

18             At 2:20 was the last documented ADL care for  
19      this patient. Now, we've heard conflicting  
20      testimony about when aides are supposed to chart  
21      from a regional president who disclaims any  
22      knowledge of the facts of this case and no  
23      supervisory authority over the aides. We didn't  
24      hear from one CNA in this case about what they did  
25      or didn't do. But what we do know is that this

1       resident remained in this facility for four and a  
2       half hours longer, and there's not a single  
3       documented ADL care being given.

4           And, ladies and gentlemen, you can look at this  
5       list. You can see the detail with which they were  
6       documented. They want to talk about offering drinks  
7       or toileting a patient. Look at the things that  
8       they're documenting and wonder where, even if they  
9       only did it at the end of the shift, the rest of her  
10      care was, if any, in those last four and a half  
11      hours, because, certainly, at the end of the shift,  
12      there should have been some notation about the  
13      services offered.

14           If you look at the statutes that have been  
15      cited by the plaintiffs in this case as having been  
16      violated, you'll see that the facility has an  
17      obligation to document the services provided to the  
18      patient, including ADL services. And when you have  
19      a patient who is at need with assistance with  
20      toileting, who is incontinent, and requires to be  
21      taken to the restroom, that that is a service that  
22      has to be documented.

23           You'll see, ladies and gentlemen, how they're  
24      documenting intake of food, yet where is dinner?  
25      You'll see how they document other instances;

1 transfers, ambulation, other activities of daily  
2 living, how her urine smells, whether it's got a  
3 color to it, that much detail, yet there's not a  
4 single thing noted after 2:20 in the afternoon.

5 Now, we know at 3:22 PM, somehow, amazingly,  
6 the nurse caring for this patient was able to  
7 foresee four hours into the future and predict that  
8 this resident was going to have a fall, because she  
9 documents, at 3:22 PM, before the fall ever occurs,  
10 that this is what transpired.

11 Now, ladies and gentlemen, again, you've heard  
12 Mr. Blake testify about how time stamps are put on  
13 records. But, again, you've never heard anyone from  
14 the staff confirm any knowledge of any -- anything.  
15 But, ladies and gentlemen, if you accept that, that  
16 these time stamps are entered after the record is  
17 closed, well, this record is closed at 3:22 PM, four  
18 hours before. That doesn't make sense. Don't  
19 abandon common sense when we know what's really  
20 happened.

21 Now, at 5:30, although the policy requires it,  
22 although the laws require it, this patient was given  
23 a dangerous antipsychotic and antianxiety medication  
24 that requires documentation of the condition for  
25 which it's given, documentation for the response of

1 the patient, and there's no documentation whatsoever  
2 in the MAR that it was given.

3 Again, it's documented in a record two hours  
4 before this administration had actually occurred and  
5 not where it's supposed to be. That does not make  
6 sense. That is not possible. This lady did not  
7 have a time machine. So to suggest that -- and you  
8 heard the testimony of Ebonie McDaniel. She was a  
9 two-month nurse. She had never been a nurse before,  
10 two months in when she was treating this resident.  
11 And she acknowledged under oath that it was a breach  
12 in the standard of care to provide this medication  
13 and not document it on the MAR.

14 Ladies and gentlemen, these are 115 minutes,  
15 115 opportunities for this facility to keep this  
16 patient safe, to provide the services that she  
17 needed, to provide the care that she needed.  
18 There's not a single record of what transpired in  
19 that entire time, from the notation at 5:30, to the  
20 time at 7:25, but, again, is in the note at 3:00 in  
21 the afternoon before this happened, about the fall.

22 And what does the records say? Now, you'll see  
23 two different notes. One was done the day after.  
24 And that one says: Patient found on the floor with  
25 complaints of right hip pain, right shoulder pain,

1       and head pain that stings. Ladies and gentlemen,  
2       this is what really happened: We have a patient who  
3       was not being monitored for an unknown period of  
4       time. The testimony is undisputed that she had no  
5       idea how long Ms. Shealy was on the floor before she  
6       found her. She didn't say, oh, I know it was a  
7       second; I just ran and did an errand and came back.  
8       She said, I have no idea how long she was there.  
9       That's what she testified to. But what we do know  
10      is she was discovered on the floor with a broken  
11      hip.

12             Now, an incident report was created. And while  
13      the defendants want to run from it now, it clearly  
14      notes that this was a nonwitnessed fall. And  
15      Ms. McDaniel testified to that. She didn't watch  
16      this patient fall. She's not aware of anybody who  
17      observed her fall. This was a nonwitnessed fall.  
18      They discovered this patient.

19             At 8:07, we have a note, this is after she's  
20      gone to the hospital, that the patient is fine.  
21      Patient had no complaints today. Again, this is  
22      when she's in the hospital. Did they go interview  
23      her there and say, hey, ma'am, are you -- any  
24      complaints about everything that's transpired? No  
25      complaints today; she's been out of the bed, been to

1 the dining hall; she's been to therapy; she's  
2 incontinent of bowel and bladder. She's got an  
3 order for Ativan; she's showed no signs or symptoms  
4 of distress.

5 Now, the defendants want you to believe that  
6 this woman has been irate, combative, you know,  
7 since day one; there are no change in her symptoms,  
8 there's nothing -- you know, she's always been like  
9 this. Either way, there's no -- if that's how she  
10 is, they're documenting that she's got no signs or  
11 symptoms of distress. She's been oriented to her  
12 call light? Where? I mean, they also note that  
13 they'll continue to monitor and follow up as needed.  
14 Well, we know that didn't happen.

15 Now, you also heard Ms. Henderson, again, who  
16 has no knowledge of this case testify about what's  
17 required of CNAs. In addition to charting once per  
18 shift, she acknowledged that they have an obligation  
19 to chart every shift the level of assistance offered  
20 to residents. But, ironically, despite having  
21 participated in therapy, despite having gone to the  
22 dining hall, despite having what appears to be a  
23 relatively normal, full day, there's not a single  
24 notation in this patient's chart about the level of  
25 assistance provided by staff on the afternoon of the



1        2nd in the following categories: Walks in corridor,  
2        no assistance provided; locomotion on unit, how did  
3        she get to the therapy room? What did she do in  
4        therapy? How did she get to the dining hall? No  
5        assistance provided. Locomotion off unit, no  
6        assistance provided.

7                Now, ladies and gentlemen, 8 means activity did  
8        not occur. Did she walk in a room? Did she walk in  
9        the corridor? They document that she didn't. And  
10       maybe she didn't, even though she allegedly  
11       participated in all that stuff, including 150  
12       minutes of therapy. But we know that she locomoted,  
13       if that's a word, on the unit. Now is she walking  
14       by herself?

15               So they made a big deal out of Ms. Hill  
16       O'Neil's deposition and the fact that she said that  
17       this patient was ambulating at the time of the fall.  
18       But what are they documenting? They're documenting  
19       that she's locomoting on the unit on July 2nd with  
20       no assistance. Now, again, we know what happened,  
21       because the nursing staff told the EMTs when they  
22       came to pick her up. They said patient was found on  
23       the floor in the room. That's really what happened,  
24       probably. They don't have any reason to make things  
25       up.

1           Now, why do these details matter? You know, so  
2           what? So what about these -- we looked at a bunch  
3           of inconsistencies in the chart, in assessments,  
4           about gate, about vision, about all sorts of  
5           conditions. And, ladies and gentlemen, you can go  
6           through the chart and you'll find -- we showed you  
7           just a couple examples. You can go through and in  
8           one day admission, you will find a multitude of  
9           inconsistent assessments that relate to this  
10          patient.

11          The defendants want you to believe that, so  
12          what, we got the end score right, why does it  
13          matter? Well, according to the vice president of  
14          Agape Nursing, as well as Agape Management, he  
15          testified, did he not, that if the numbers are  
16          wrong, then they don't mean anything. And, ladies  
17          and gentlemen, I agree. I agree they don't mean  
18          anything. Now, the question is why are they wrong  
19          in this case? That's the question.

20          Now, as you know, this patient was transferred  
21          after her fall to Lexington Medical Center. And  
22          there, it was discovered that she had a right neck,  
23          hip fracture, and that she required surgery. And  
24          she underwent that surgery on July 3rd of 2014 and  
25          remained hospitalized there.

1           Now, the defendants will have you believe that  
2           at the end of this hospitalization, that this  
3           patient was somehow better off than she was before  
4           she came to them, based off the fact that it's  
5           documented in one of those charts that she walked  
6           120 feet. Now, ladies and gentlemen, if any of  
7           y'all believe that a resident is better off because  
8           they have a second hip fracture, does that make  
9           sense?

10           Now, they take a big issue with the fact that  
11           this ER doc documents no pain. Well, ladies and  
12           gentlemen, you'll have the opportunity to look at  
13           the hospital records. You'll have the opportunity  
14           to see what sort of pain level that this patient was  
15           in throughout her admission at the hospital. You'll  
16           also have the opportunity to see what kind of  
17           medications they were providing her.

18           So there are instances, I'm sure, when her pain  
19           medication is effective. That's what's supposed to  
20           happen. You provide it to try to deal with the pain  
21           that she had. You also saw in the orthopedist's  
22           record that when the hip was held in a certain way,  
23           that there would be relief of pain.

24           So to suggest that this resident was not in  
25           pain after she's documented as being in pain by the

1 nurses who assessed her after finding her on the  
2 floor, after she's documented as being in pain after  
3 she was assessed by the EMTs who came to pick her  
4 up, who is documented as being in pain by the  
5 orthopedist who is assessing her prior to being in  
6 surgery, and you've heard testimony over and over by  
7 family members that this woman was in excruciating  
8 pain as a result of this fracture. She's still  
9 healing from a prior fracture. This is outrageous.

10 Now, you'll have the operative report that  
11 describes what actually happens when a patient has  
12 their hip pinned, how the drill forces screws into  
13 the hip to secure that fracture, how the bone is  
14 hollowed out, drilled out, before these screws go  
15 in. And, ladies and gentlemen, this is the result.  
16 And that will remain with this woman the rest of her  
17 life. And the fact that she already had one is of  
18 no consequence.

19 Now, why did this happen? Ladies and  
20 gentlemen, we contend that fracture and the  
21 accompanying arm that followed was the direct result  
22 of the defendants, both defendants, the licensee as  
23 well as the management company's ordinary negligence  
24 as well as their professional negligence.

25 And the judge is going to explain what all this

1 means to you. But ordinary negligence is simply the  
2 duty of reasonable care. All of us have a duty of  
3 reasonable care to conduct ourselves in a manner so  
4 as to prevent harm to others. This does not require  
5 specialized knowledge or training or expertise.  
6 This is within the purview of your own experiences  
7 to make an assessment of.

8 Again, it includes administrative or  
9 operational acts whose performance requires no  
10 professional knowledge, skill, or expertise. It's a  
11 subject matter within the ambit of common knowledge.

12 Now, ladies and gentlemen, examples that we  
13 contend that ordinary negligence are in this case  
14 include inadequate education. You heard me ask  
15 Ms. Henderson, well, ma'am, you'd agree, wouldn't  
16 you, that you could have training materials, but  
17 unless they're taught appropriately, they're not  
18 effective? The materials are only as good as the  
19 teacher; right? And she took issue with that. She  
20 said, well, no, sometimes it's the students' fault.  
21 Well, the students are the employees of the nursing  
22 home, ladies and gentlemen, so it's either the  
23 teacher or it's the student. But own up, accept  
24 some responsibility.

25 Inadequate training, inadequate and unqualified

1 staff. You've got a two-month nurse responsible for  
2 caring for this patient, and who knows how many  
3 others, who's clearly not able to keep her eyes on  
4 the patient, because it's an unwitnessed fall.  
5 Inadequate policies and procedures, and if not  
6 inadequate, certainly inadequate enforcement of  
7 those, as well as insufficient safety equipment and  
8 general culture of indifference to the safety of  
9 residents within this facility.

10 We've also asserted claims of professional  
11 negligence. These are those that require  
12 specialized knowledge. It's the failure of the  
13 healthcare provider to exercise the degree of care  
14 or skill which is ordinarily employed by the  
15 profession generally under similar conditions and  
16 like circumstances. This is what folks in nursing  
17 homes are supposed to do when treating a patient  
18 like Ms. Shealy. That's the standard.

19 Now, the breaches in standard of care that we  
20 contend were met here include the failure to provide  
21 an accurate and appropriate assessment of Ms.  
22 Shealy, the failure to perform appropriate nursing  
23 diagnoses, the failure to provide adequate and  
24 appropriate care plans, the failure to provide  
25 adequate and appropriate interventions, the failure

1 to timely evaluate and re-evaluate the effectiveness  
2 of those interventions, and the failure to document  
3 and ensure an accurate medical record in conformity  
4 with appropriate practice standards.

5 We contend all of these steps that Ellen Lewis,  
6 our expert, told you about were breached. And, as  
7 you know, Ms. Lewis is an expert witness. The  
8 defendants do not have one. They could have easily  
9 gotten one. Generally, you heard Ms. Lewis testify,  
10 there is a countervailing expert. I think it's fair  
11 to assume that no expert was able to support the  
12 conduct of the defendants in this case.  
13 Emory-trained, RN, nurse practitioner, and certified  
14 nurse practitioner.

15 She described a host of interventions that  
16 would have made a difference in this case. And I'm  
17 not going to go through every single one of them.  
18 You've heard testimony about them all. And, ladies  
19 and gentlemen, do not, do not be confused. Many of  
20 these do not require a doctor's order. You've also  
21 heard the testimony by Ms. Henderson, the only  
22 witness for the defendants, that it's not hard to  
23 get a doctor's order. You pick up the phone and you  
24 say, hey, I think we need this to keep this resident  
25 safe, and they say, do it; I'll send over an order.

1 Engage the family. This family was with this  
2 resident every day that she was within this  
3 facility. There's nothing to suggest that someone  
4 would not come, had the nursing home said, hey, we  
5 need some help. They did it the night before and  
6 the family was willing to be there after midnight.  
7 Call the doctor, round frequently, round -- take her  
8 with you as you round, engage a sitter, engage a  
9 volunteer, toilet -- put her on a toileting  
10 schedule, make sure she's being toileted. We know  
11 that was not happening.

12 Look at the records. Listen to the testimony  
13 about the conditions she was in when she got to the  
14 ER. Put a better chair alarm in. Yeah, it needs an  
15 order. This doctor has already said she's a huge  
16 fall risk. She was already in the chair alarm in  
17 the hospital. There's nothing to suggest that if  
18 it's what was necessary to keep this patient safe,  
19 that this doctor wouldn't have gotten it.

20 Frequent assessment. Monitor her medication,  
21 put her in a group setting, give her an activity to  
22 keep her busy, put her in a gerichair, use a pommel,  
23 use a Lap Buddy, use that dropped wheelchair seat  
24 cushion, put some nonskid socks on her, use a hip  
25 pad if she's prone to falls, give her an emergency



1 pendant light.

2 But, ladies and gentlemen, the obvious, the  
3 easiest intervention in this case, the one that the  
4 therapist said she needed, was keep her in line of  
5 sight, put her somewhere when they can see, where  
6 they can see when she's trying to get up or  
7 agitated, they can go over and say, now,  
8 Ms. Shealy, you need to sit down; is there something  
9 I can help you with? Ms. Shealy, come on, let's go  
10 for a walk. Ms. Shealy, you want to call your  
11 daughter? It's not hard. It's what they said they  
12 could do.

13 Now, these failures not only breached the  
14 standard of care, but they violated provisions of  
15 both state and federal law, as well as their own  
16 policies and procedures. And at least as it relates  
17 to the law, ladies and gentlemen, you're going to  
18 hear an instruction by the judge that if you find,  
19 upon your review of one of these statutes, that they  
20 were breached, that that is negligence per se, that  
21 you have met that requirement of finding negligence.

22 Now, Agape had a code of conduct handbook that  
23 states, quote: All Agape employees must be  
24 cognizant of all federal and state laws and  
25 regulations that apply and affect Agape's

1 operations. Ignorance is no excuse. They have to  
2 know what the laws are. Each and every employee has  
3 an obligation to familiarize himself or herself with  
4 all such applicable laws and regulations and to  
5 adhere, at all times, to the requirements thereof.

6 It continues, quote: Failure to observe the  
7 provision of this code can result in serious  
8 consequences to the employee such as dismissal and  
9 criminal charges, and to Agape Senior, the  
10 defendants in this case, such as criminal  
11 prosecution, substantial monetary fines and  
12 penalties, and substantial damages to its  
13 reputation.

14 Ladies and gentlemen, the defendants were on  
15 notice that if they didn't provide the care that was  
16 required as mandated by the laws, that they could be  
17 here today. And they knew that there is the  
18 potential of a significant monetary penalty for  
19 their noncompliance. This is not a surprise to  
20 them. They should have anticipated this.

21 Now, the federal regulations that we contend  
22 were violated include those related to dignity, to  
23 resident's environment, to appropriate assessments,  
24 to the accuracy of those assessments, to the quality  
25 of care, to activities of daily living, to mental

1       and psychosocial functioning, to accidents, nursing  
2       services, administration, and clinical records.  
3       And, ladies and gentlemen, you'll have these in  
4       evidence to review and make a determination,  
5       yourselves collectively, as to whether or not these  
6       were violated.

7               There's also applicable state laws including  
8       the DHEC regulations that mirror many of the same  
9       federal regs, the South Carolina Bill of Rights for  
10      Residents of Long-Term Care Facilities, as well as  
11      the Nurse Practice Act. Again, we contend many of  
12      those provisions were also disregarded in this case.

13             Now, as to the policies, you'll have those as  
14      well, and we've looked at a few, but admissions,  
15      care plans, charting, charting errors, administering  
16      medications, documenting medications, PRN orders,  
17      accidents, nursing services, staffing, resident  
18      rights, supervision of residents, managing falls,  
19      and assessing falls and their causes, we contend  
20      they were all violated in this case.

21             Now, these defendants also have a handbook, and  
22      in that handbook it states: All employees must take  
23      steps to ensure the safety of themselves and their  
24      residents. This is the duty of the facility when it  
25      accepts patients. They are the insurer of their

1 safety. That's what they say they do.

2 Now, I anticipate the defendants will attempt  
3 to make some distinction between the two entities  
4 that are in this case. And you've already heard  
5 their motivation. As you know, this skilled nursing  
6 facility has been sold. If you load up on them,  
7 it's of no consequence; they don't exist anymore.  
8 But, ladies and gentlemen, the evidence in this case  
9 is overwhelming that these Agape Nursing & Rehab  
10 Center and Agape Management Service in effect are  
11 one and the same. They are treated by the  
12 companies, by the owners, as simply a vehicle  
13 through which to do business.

14 Now, agency is one of the theories that  
15 Plaintiffs have pled to hold them as one and the  
16 same. That theory is defined as when defendants act  
17 as an agent for one another and ratify or authorize  
18 the acts or omissions of each other.

19 Another theory that Plaintiffs contend -- or in  
20 support of this allegation, you heard about Team  
21 Agape. She says -- you saw the marketing materials,  
22 you can see how they hold themselves out as one and  
23 the same. It says: Team Agape oversees the  
24 integrated network including assisted living  
25 physician services, therapy services, and skilled

1 nursing facilities. They want to blame a doctor who  
2 they employ for not putting in an order. He's an  
3 agent of the management, as is every CNA, as is  
4 every nurse, as is every therapist.

5 Another theory that the plaintiffs contend that  
6 the defendants acted one and the same is alter ego.  
7 This is where the defendants conduct their business  
8 of the entities including the facility as if, one,  
9 by commingling them on an interchangeable basis for  
10 confusing separate properties, records, or control.

11 You saw Agape Senior records throughout that  
12 chart. You'll see every other document stamped with  
13 Agape Senior. This is supposed to an independent  
14 stand-alone facility with an administrator and a DON  
15 who are calling the shots. That's what you're  
16 supposed to believe. That's not what happened.  
17 Management and operation of this facility was so  
18 assimilated within the defendant that Agape Nursing  
19 & Rehab Center was simply a name through which Agape  
20 Senior, Agape Management Services, Inc., did  
21 business. They're one and the same, ladies and  
22 gentlemen.

23 Joint venture and amalgamation of interests.  
24 This is the third legal theory that Plaintiffs  
25 contend applies to make Agape Nursing & Rehab equal

1 to, the same as, as if they were the same, as Agape  
2 Management Company. Under that theory of law,  
3 that's when you have a blurring of corporate  
4 entities through an integrated enterprise or a joint  
5 venture in the establishment, operation management,  
6 and control of the facility.

7 Who's calling the shots? The regional  
8 president, the owner, or Scott Smith who'd never  
9 been a DON, never had any experience as one, who had  
10 only been there a couple months and who was only  
11 there six months and been the third DON in less than  
12 a year?

13 Now, this is the agreement under which these  
14 services were provided. Is it five percent? Is it  
15 seven percent? You heard the testimony of  
16 Mr. Middleton. We don't even know. Is it January  
17 sometime or December? I don't know. We know it was  
18 signed by Gregory A. Middleton as a vice president  
19 and again by Gregory A. Middleton as vice president  
20 for both companies though.

21 Question: If they wanted to go out and use a  
22 different management company other than Agape, would  
23 they be able to do that? Would the administrator be  
24 able to say, hey, you know what, these services  
25 you're offering, I don't find them up to par, or,

1       you know, I really don't think that what you're  
2       doing here warrants this five or seven percent of  
3       our total -- of our gross revenues. That's steep  
4       for the crappy IT system that doesn't even stamp  
5       records right. Let's do something else. I think  
6       I'm going to -- I think I'm going to try to  
7       negotiate with another -- no. Scott Middleton, no  
8       discretion. This administrator couldn't do that.  
9       He's calling the shots; he's setting the rates.

10               Greg Middleton, in the lease, \$5,000 a month,  
11       why the change? No explanation. \$120,000 a year,  
12       well, I guess I hadn't raised it in a while. Signed  
13       by the same person on behalf of both companies.  
14       There's a lot of negotiation there. No, I think  
15       that increase is a little steep for this year. How  
16       about \$5,000 this year? Nah.

17               Ladies and gentlemen, it's not just the  
18       landlord; it's not just the management company.  
19       You'll see the cost report. You'll see all these  
20       related parties that are siphoning money out of this  
21       facility. You'll see them all: Pharmacy services,  
22       medical equipment, vehicles, management, real  
23       estate, doctors, insurance, ambulance, assisted  
24       living. This is a cash cow for the owner of all of  
25       these companies, which happens to be sitting here in

1       this courtroom today.

2               Now, ladies and gentlemen, you remember this  
3       management agreement; right? And they're going to  
4       say, well, all we really do is provide financial  
5       services, human resources services, IT services, and  
6       legal. Well, how good did they do with that in this  
7       case? Financial services, we got broken  
8       wheelchairs, broken beds, and a host of other  
9       problems. Human resources, how about those trained  
10      nurses and staff who leave a resident at risk for  
11      falls out of line of sight so that she can be  
12      discovered on the floor for some period of who knows  
13      how long?

14             IT. Well, how about that IT system, guys?  
15      Isn't it to their benefit that that IT system is  
16      unexplainable? That's a great recordkeeping system,  
17      isn't it? And then the legal services, well,  
18      they're certainly doing a good job of ensuring  
19      compliance with all those laws and regulations that  
20      you all have seen. Every element failed.

21             Now, there's a reason, ladies and gentlemen,  
22      and that's because of corporate malfeasance. And we  
23      contend that there's a direct correlation between  
24      the cause and effect at issue here. The  
25      defendants -- Plaintiffs have pled -- this is an



1       underlying theory of our case that you all need to  
2       be made aware of: We have pled that the defendants  
3       have made operational, budgetary, and administrative  
4       decisions determined more by the financial needs and  
5       goals of this defendant than by the facility  
6       residents, including Ms. Shealy.

7               We contend that they entered into a continuing  
8       course of neglect, a continuing course of negligent  
9       conduct, and implemented dangerous operational  
10      practices which deprive residents, including      Ms.  
11      Shealy, of safe, adequate, and essential care. We  
12      contend that they breached their duty of failing to  
13      allocate sufficient resources to meet their needs.  
14      Those funds being paid by the federal government,  
15      they failed to utilize those to provide care, but  
16      instead diverted those at the expense of these  
17      residents. The effect: Ongoing, repeated neglect  
18      of residents, including Ms. Shealy.

19             And, ladies and gentlemen, this is not a single  
20      incident; this is not a one-time event; this is not  
21      an accident. This is exactly what had been  
22      occurring in this facility in the year before and  
23      continued after her discharge and affected many,  
24      many, many people.

25             Now let's look at this training that Agape

1 offers. Remember what they do when they're being  
2 investigated by the State, when the surveyors are in  
3 the building? What do they teach their staff? What  
4 have you heard here in this courtroom? Don't give  
5 them the whole cow if they ask for the foot. Now,  
6 ladies and gentlemen, do y'all feel like maybe  
7 that's happened here in this courtroom? Answer  
8 questions with yes or no, do not offer or provide  
9 more information than what they ask for.

10 Less is best. Who did we hear from? Who is  
11 the one witness the defendants called? A regional  
12 president who disclaimed any knowledge of the facts  
13 of this case. Now, why would your sole witness be a  
14 regional president that knows nothing about the case  
15 at issue? Because less is best, skip the details,  
16 and any staff member who will come into contact with  
17 a surveyor must be coached.

18 Now, ladies and gentlemen, I have a strong  
19 suspicion, and I'll explain why in a moment, that we  
20 saw some of this in this courtroom. And y'all will  
21 be the judge of that. Y'all will be the judge of  
22 whether or not they're applying their own tactics in  
23 an effort to make their case here. This is their  
24 own depiction. This is what they're telling their  
25 people to do when confronted by a surveyor who is

1       there to find out the truth.

2               Now, you may wonder why there's a photograph of  
3       Ronald Reagan in my presentation. And I had this  
4       very same thought when I heard Dee Dee Henderson  
5       testify that Ronald Reagan fell too. Ladies and  
6       gentlemen, you saw the statistics, most people over  
7       the age of 65 are going to fall within the year. It  
8       happens. It does happen. It's going to happen  
9       to -- some of you-all may have experienced that.  
10      This is -- this is -- that was nothing more than  
11      what's called a red herring. That's nothing more  
12      than some overt attempt to, I don't know, appeal to  
13      the jury venire that may be conservative and a  
14      Ronald Reagan fan. I have no idea what that was.

15             The city of Charlotte? What does  
16      Ms. Henderson's trip-and-fall where she broke her  
17      ankle have anything to do in this case? Do we know  
18      the circumstances of that fall? Did she explain  
19      what she was doing when she did? Do we know whether  
20      she had been out on Broad Street all night long?  
21      Who knows? And you know what? It's totally  
22      irrelevant. But she told us.

23             And we know why that is; right? Do y'all  
24      remember? Because they prefer stories over facts.  
25      That's what she said they train their staff when

1       dealing with surveyors. They're going to distract  
2       you with irrelevant information with the hopes that  
3       you forget what this case is about. This case is  
4       about Ms. Shealy and their lack of care. That's  
5       what this case is about.

6               Now, ladies and gentlemen, you're going to have  
7       to find that the defendants' conduct caused injury.  
8       Okay? That's one of the requirements for us to  
9       prevail in this case. That -- but what that means,  
10      it's not necessary for a plaintiff to demonstrate.  
11      The defendant should have foreseen the particular  
12      event which had occurred which, here, they certainly  
13      should have. It simply requires that the defendant  
14      foresee that its negligence could result in harm.

15             Well, ladies and gentlemen, this is an easy  
16      case, because we know, in this instance, that if  
17      they don't do their fall prevention interventions,  
18      that harm will result. Their care plan says you got  
19      to do these things to prevent a fall. So they know.  
20      There's a causal link right there. It's proximately  
21      caused. If you don't do the interventions as  
22      required, they're going to fall. That's exactly  
23      what happened. All that we have to show is that  
24      there was a change of events which, in the end,  
25      brought about injury.

1           Ladies and gentlemen, there's no clearer case  
2 of proximate cause. There's no doubt these folks  
3 are on notice of what happens if they don't provide  
4 appropriate fall precaution interventions. Now, to  
5 prevail, the plaintiff must prove only that some  
6 injury from the defendant was foreseeable. Their  
7 own documents show this. Look at their training  
8 materials.

9           There's also something called the burden of  
10 proof that applies in this case. This is not a  
11 criminal case; this is a civil case. That means  
12 that the burden of proof is lessened. The burden of  
13 proof is simply a preponderance of the evidence,  
14 that means 50.1 percent. All we have to do is show,  
15 by a preponderance of the evidence, that the facts  
16 slightly, however slight, tip, ever so slightly in  
17 our favor. Often you see the description of the  
18 balanced scales of justice. A feather falls from  
19 the sky and lights into one of those little cups and  
20 just ever so slightly tilts. That's all we have to  
21 prove; that's it. That's all we have to prove.  
22 50.0000001 percent, and the plaintiffs prevail.  
23 That's what the law requires. And we contend that's  
24 been satisfied here.

25           Now, there are two types of damages that we're

1       going to seek in this case. The first is  
2       compensatory damages, and they are what they sound  
3       like. They are to compensate Ms. Shealy for her  
4       loss. And this is relatively -- one portion of this  
5       damage is easy to calculate; that's the medical and  
6       rehabilitation expenses that flow as a direct result  
7       of her harm.

8               What medical expenses and rehabilitation  
9       expenses did she incur as a result of the fall?  
10      Well, she went to the hospital; she had to have her  
11      hip fixed; she had to pay a doctor to do that; she  
12      had to pay the hospital for the bills. She had to  
13      pay whatever other ancillary providers, whether it  
14      be radiologists and that sort of thing to -- and the  
15      bills are about 50 grand.

16             The much harder part, ladies and gentlemen,  
17      that you have to make a determination on is the  
18      compensation for her pain and suffering flowing from  
19      the defendant's neglect. Now, they want to make it  
20      sound, again, like this lady was fine. That, you  
21      know, yeah, she -- well, actually, they don't even  
22      acknowledge that she suffered pain even though their  
23      own records document that she did. They want to  
24      focus on some ER record that was improperly done and  
25      they want to use that as a distraction. And we

1 don't even know if it was improperly done. We don't  
2 know what -- you can look and try to determine  
3 whether she'd been given pain medications by the  
4 nursing home before they sent her out or whether  
5 they -- the EMTs gave her pain medications. I think  
6 they did, actually. You can look at that report.

7 But I assure you, look at the rest of the  
8 records. It's clear that this woman was in pain and  
9 it's clear that she had a dramatic decrease in her  
10 cognitive effect as a result of the second surgery.  
11 They want to make light of that fact because there's  
12 some mention that she's returned to baseline.  
13 Return to baseline? Their only measure is what her  
14 baseline was in the hospital before, which was  
15 really bad. She had a really bad adverse outcome of  
16 the anesthesia, and she had it again.

17 And you heard the testimony of these staff  
18 members -- I mean, of these family members who cared  
19 for this woman for the next several years of their  
20 life. She never regained her functioning; not just  
21 her physical functioning, her mind was not able to  
22 sustain the assault of the medication and the trauma  
23 associated with this fracture. She was never the  
24 same.

25 Now, the defendants can make light of that and

1 try to call our clients out as being untruthful by  
2 pointing to some record or some statement. But do  
3 these people know their mom? You would know if your  
4 own mother had a change such that that's what family  
5 can recognize. Okay? They're the ones who know  
6 best. You've heard from them. There's no reason to  
7 believe that they've made this up in some effort to  
8 try to -- it's not the lottery, ladies and  
9 gentlemen. They know what their mom suffered.

10 This is their mom's claim. They're here only  
11 in her capacity. This is if Utricia Shealy was  
12 sitting here. Because her mom named her  
13 administrator over her estate does not mean -- she  
14 doesn't want to be here. This is not easy for her  
15 to hear this. \$1,038, that's what this nursing home  
16 charged for the one day, the one day that our  
17 resident was there, one day. One day of services,  
18 \$1,038.

19 Ladies and gentlemen, our client lived the rest  
20 of her life, which was another 1,081 days, feeling  
21 the effects of the defendants' negligence. She had  
22 three bolts in her leg for the rest of her life as a  
23 consequence of this. She, in effect, lost her mind  
24 because of the anesthesia effect. Let's -- if you  
25 evaluate it the same as they evaluate their day,



1       that's a million -- over a million dollars that they  
2       would have gotten paid if she stayed in their  
3       facility at the rates that they charged. Is she not  
4       entitled to the same worth and value that they would  
5       have been compensated?

6               If she did lose her mind as an effect, as a  
7       result of this, that's a million and a half minutes  
8       of lost time for this woman to wander this world  
9       away from her god, not knowing her family for a  
10      million and a half minutes, and they couldn't keep  
11      an eye on her for 115.

12             Now, in addition to compensatory damages, there  
13      are punitive damages. And the intent of those is to  
14      punish and deter. Now, the defendants may say,  
15      well, this company is out of business, they're just  
16      winding down. Well, then it shouldn't be hard to  
17      award a huge number, should it? We can worry about  
18      that, but, certainly, their conduct has warranted  
19      punitive damages in this case. Their conduct has  
20      been reckless, you heard it from the expert. Their  
21      conduct exhibits a wantonness, a conscious  
22      indifference to exercise due care.

23             Now, recklessness signifies a conscious failure  
24      to exercise due care. It's a conscious indifference  
25      to the rights of the plaintiff or a reckless

1       disregard for her rights. This resident has rights,  
2       you've seen them, they're protected by law. These  
3       people disregarded them without effect. They did  
4       not -- it's clear that they were not at the top of  
5       their priority list. Recklessness is an awareness  
6       of a wrongful conduct and a continuation to act.

7               The defendants had knowledge of Ms. Shealy's  
8       risk for the injuries described and they failed to  
9       take appropriate precautions. They had knowledge of  
10      a risk for injuries described and they failed to  
11      properly train and supervise their staff. Further,  
12      the repeated notice of ongoing violations of the  
13      standards of care experienced by similarly situated  
14      residents was inextricably intertwined and connected  
15      to the defendants' neglect and it is directly  
16      relevant to their knowledge, indifference, and  
17      willful and wanton conduct at issue in this case.

18             You've seen the pattern of misconduct, you have  
19      them before you, the poor surveys showing repeated  
20      violations of the egregious conduct at issue in this  
21      case, substantial fines, significant fines levied  
22      against this facility for noncompliance, payment  
23      denials, meaning Medicare says we're not paying you,  
24      your care sucks so bad. We're not paying you,  
25      payment denied, clean your act up; continuous

1 turnover of management, multiple DONs, multiple RNs.  
2 You'll see it in the licensure file we have to  
3 identify these changes over and over and over again.  
4 Why can't anyone stay there? Are they not willing  
5 to do the bidding of the defendant?

6 In the months prior to Ms. Shealy's admission,  
7 Agape was cited by DHEC for multiple directly  
8 relevant violations: Failure to provide care and  
9 services, failure to provide an environment free  
10 from accidents, failure to provide appropriate  
11 treatments, failure to provide a drug regiment free  
12 from unnecessary drugs.

13 Look at the five-star survey, ladies and  
14 gentlemen. They're restraint-free; do you remember  
15 that? Restraint-free, they say. Their use of  
16 medications chemically -- that are found to be  
17 chemical restraints is significantly higher than  
18 state and national averages, significantly. What  
19 they did -- what they do is they say, oh, well,  
20 we're restraint-free; we'll medicate them; we'll  
21 overmedicate them such that they're confined to  
22 their rooms or chairs.

23 You'll see how they got one star in quality and  
24 all the problems that flow from chemically  
25 restraining residents. Overall score, 1, 20 --

1 lowest 20 percent. Much below average. Not just  
2 passing grade, not just standard of care C; F.  
3 Quality measures, that's what we're here about,  
4 okay, quality of care. One star, much below  
5 average, F.

6 You know, I had saw this little thing here,  
7 emblem, and I saw that Latin phrase and I said, oh,  
8 I wonder what that means. I looked it up and it  
9 made me sick because it means to achieve excellence.  
10 Ladies and gentlemen, if this is the definition of  
11 excellence, if the care and the treatment and the  
12 manner in which business is conducted is excellence,  
13 then we are all in a heap of trouble.

14 Ladies and gentlemen, you have a very unique  
15 opportunity today. You get to decide how excellence  
16 is defined. You get to decide what the standard of  
17 care is in Lexington County for caring for your  
18 elderly folks. You do. You decide; you set that  
19 bar. Don't let these folks set the bar. This is  
20 not excellence. This is not -- this is not -- this  
21 is egregious; this is reckless.

22 Now, ladies and gentlemen, at the end of this,  
23 when we're finished here, you're going to have the  
24 opportunity -- bear with me -- to fill out what is  
25 called the verdict form. Help me out, Mona. There

1 we go. And it's a little bit confounding, so I want  
2 to have the opportunity to walk y'all through it.  
3 Okay?

4 Ladies and gentlemen, you'll be asked the  
5 question first, A: On the claims of Plaintiff  
6 against Defendant Agape Nursing & Rehab Center for  
7 Ms. Shealy's injuries, we, the jury, in the  
8 above-referenced case. I submit the appropriate  
9 answer is find in favor of the plaintiff.

10 On the claims against Agape Management  
11 Services, Inc., for Ms. Shealy's injuries, we, the  
12 jury, in the above-referenced case find. Again, I  
13 submit the appropriate answer is, in favor of the  
14 plaintiff. There's instructions then: If you found  
15 for the plaintiff above, proceed to B and C.

16 B says: If you found in favor of Plaintiff,  
17 what is the total amount of damages to be awarded?  
18 There's two lines. One of those lines is for  
19 compensation for Ms. Shealy's medical expenses and  
20 other economic damages; that's one category of  
21 damages. The other is for her physical and mental  
22 pain and suffering, her apprehension of shock, her  
23 fright and emotional upset, her humiliation,  
24 anxiety, loss of enjoyment of life, disability,  
25 disfigurement, and other noneconomic damages.

1 Ladies and gentlemen, that is the space where I  
2 would hope that you have found significant damages  
3 in this case.

4 Next, if you found for the plaintiff against  
5 only one defendant, go to D; however, if you found  
6 against both, proceed to C. C is the question about  
7 whether or not you find that these businesses were  
8 engaged in a joint venture, a joint enterprise, or  
9 were amalgamated or agents of one another. I  
10 contend the evidence overwhelmingly suggests that  
11 they were.

12 The answer [sic] then asks: If you answered  
13 yes to the above, what percent of your total  
14 damages -- up here -- are attributable to the  
15 defendant's ordinary negligence? That's how they  
16 operate their business; that's how they train their  
17 staff; that's how their aides watch their patients;  
18 that's how they manage their facility from a  
19 corporate level and its impact on resident care.

20 The question about the professional negligence  
21 deals specifically with the nursing interventions  
22 that were in place in this case. Were they  
23 sufficient? Did Ms. Lewis define for you those  
24 deficiencies that required the exercise of  
25 professional judgment? Is it 50/50? Is it 75/25?

1       Is it 25/75? That's within your discretion, but,  
2       certainly, there's shared responsibility here. The  
3       total between those numbers must be equal to 100.  
4       Therefore, there needs to be a -- if you find 90 and  
5       10, however, 50/50, 40/60, it has to total 100.

6             If you answered no to whether or not they were  
7       a joint venture amalgamation of interests or joint  
8       enterprise, if you answer no to the question, then  
9       you have to attribute fault between the two, meaning  
10      you're viewing them as standalone defendants and  
11      you're saying Agape Rehab, the licensee, is  
12      X-percent at fault for the above damages and the  
13      management company is Y-percent at fault for the  
14      damages. That's if you find no agency, no  
15      amalgamation of interest.

16            I contend there was agency; I contend there was  
17      amalgamation of interests; I contend there was joint  
18      venture. But if you disagree collectively, then you  
19      answer this question and allocate the percent  
20      between the defendants as far as their  
21      responsibility. In that instance, the total must  
22      equal 100.

23            If you do -- again, do not find agency  
24      amalgamation or joint venture, you move on to the  
25      next questions which say, okay, well, as to the

1 negligence of the defendant that you put 50 percent  
2 on, what percent of the damages above do you  
3 attribute to ordinary negligence and professional  
4 negligence? You have to answer those two questions.  
5 And you have to do the same again for Agape  
6 Management Services.

7 Ladies and gentlemen, I contend you will not be  
8 answering any of these questions because your answer  
9 to the question above was yes and then you'd  
10 allocate your percent of damages.

11 At the end, regardless of the questions asked,  
12 so long as you've found for the plaintiff on a  
13 single count, you go to section D: Do you find, by  
14 clear and convincing evidence, that the actions or  
15 omissions of the defendant were reckless and a  
16 conscious disregard of Ms. Shealy's condition? I  
17 think the evidence is undisputedly yes in this case.

18 The next question, if you answered yes: Did  
19 you find that at the time of Ms. Shealy's injury the  
20 defendants had an intent to harm and their conduct  
21 did, in fact, harm Ms. Shealy? Ladies and  
22 gentlemen, I contend the answer to this question is  
23 yes. You've seen the evidence; you've seen the  
24 conduct in this case. You've seen that this is  
25 foreseeable conduct if they do not take appropriate



1 steps, and you've seen the repeated pattern of  
2 neglect. Very specific intent in this case.

3 When you're done, sign and date the form, and  
4 you've returned your verdict. Ladies and gentlemen,  
5 thank you for your time. Thank you for your  
6 sacrifice in being here today. Again, this is an  
7 important service and it means a lot to everyone in  
8 this room that you're here and willing to serve. So  
9 thank you again. I won't have another opportunity  
10 to speak to y'all. I've thoroughly enjoyed being in  
11 your presence. Thank you so much.

12 THE COURT: Ladies and gentlemen, now we'll  
13 hear closing argument from the defense.

14 MR. BLAKE: Thank you, Your Honor. May it  
15 please the Court?

16 THE COURT: Yes, sir.

17 MR. BLAKE: Ladies and gentlemen, it's been a  
18 long week. I appreciate your attention, your  
19 patience with us. You've been outstanding in  
20 locking in on all of the issues and watching the  
21 witnesses and doing what I asked you to do on  
22 Monday, which was to pay attention, listen to the  
23 testimony, and do the hard job, which is sorting  
24 through what evidence was presented in this case  
25 that matters to the real questions that you have to

1       answer on that verdict form, and what information  
2       really doesn't have a bearing on the important  
3       question in this case, which is what caused Utricia  
4       Shealy to fall?

5               Was it a breach of a standard of care or was it  
6       a natural disease process? Was it an accident that  
7       happens quite often to a very large percentage of  
8       our elderly population, just as it happened to Ms.  
9       Shealy a week before she came to Agape?

10              And, ladies and gentlemen, you've seen a lot  
11       information about time periods for companies that  
12       are no longer operating. You've heard from  
13       employees that have moved on with their lives and  
14       work in other places doing other jobs that were  
15       called here to testify without being paid to be here  
16       to talk about something that happened a long time  
17       ago.

18              And I wish that we all had perfect memories. I  
19       wish that I could remember what I was doing in July  
20       of 2014. But none of us have perfect memories. And  
21       it's challenging for professionals like the nurses  
22       that you saw here, Ms. McDaniel, Ms. Vaughn,  
23       Mr. Smith, to give us all precise details of what  
24       happened on July of 2014. I think that they  
25       testified truthfully and I hope that you found them

1 to be testifying truthfully. Ultimately, y'all will  
2 make that decision. Y'all weigh the credibility of  
3 the witnesses and find whether or not you believe  
4 that what they said up there was heartfelt and true.

5 There was a question raised -- several  
6 questions raised as to why the defendant didn't  
7 present more people to talk. I hope it's not  
8 surprising to you that -- well, one, whenever the  
9 plaintiff calls in their case the employees who were  
10 actually involved in the day in question, we might  
11 not necessarily need to recall them again during our  
12 defense case. I hope that seems reasonable and  
13 logical to y'all.

14 The other question that was raised was why  
15 wouldn't the defendant hire an expert? Why wouldn't  
16 the defendant hire an expert to come debate with  
17 Ms. Lewis and see who can come up with better paid  
18 testimony for y'all to weigh? And I'm just going to  
19 answer that question directly before I go any  
20 further and then I'll kind of show you why as we  
21 walk through my closing. You know, the problem with  
22 paid experts is they're paid to testify about facts.  
23 They're paid to believe, to pick and choose facts.  
24 And it's not always credible; it's not always  
25 something that should be given particular weight or

1 particular value, particularly in a case like this  
2 when the expert just has a couple pieces of paper  
3 describing an event from which they have to  
4 extrapolate an opinion, a long list of opinions,  
5 with broad, sweeping consequences that talk about  
6 egregious breaches of the standard of care,  
7 according to her testimony, and violations of state  
8 and federal law.

9 Now, you heard her. I asked her, if she really  
10 believed that, did she believe that any of these  
11 professionals needed to be reported, for example, to  
12 their licensures board. She wasn't willing to go  
13 that far. Once we took it out of the realm of  
14 hypothetical, once we took it out of the realm of  
15 the opinions she was paid to give, when I asked her,  
16 let's be real, are these professionals really liable  
17 for all these things you've accused them of, she  
18 dialed it back real quick. She dialed is back real  
19 quick.

20 So, no, they're exactly right; we did not ask  
21 an expert to come here today to look over the few  
22 scant records that talk about that fall, and from  
23 that, try to extrapolate a big long list of opinions  
24 and spend a week of y'all's time or more talking  
25 about that. We're just letting the records speak

1       for themselves and trusting y'all to not have  
2       checked your common sense at the door, and to have,  
3       ultimately, throughout the week, gotten a sense for  
4       what's credible evidence and what's not.

5               And the judge is going to charge you on the  
6       law. I'm not going to spend a bunch of time putting  
7       up law to y'all and try to tell you what it means.  
8       That's his Honor's job. But I will say one of those  
9       charges is going to tell you expert witness  
10      testimony is no different than any other evidence.  
11      You can choose to accept it or you can choose to  
12      ignore it.

13             We have been accused -- these professionals  
14      were accused of breaking a lot of laws as it relates  
15      to assessments. And as we went through the evidence  
16      this week, I just want to remind you that during the  
17      27 hours or so that Ms. Shealy was at the facility,  
18      she was repeatedly assessed. And y'all have a box  
19      of records. I don't know how much y'all will feel  
20      the need to dig through there. We've put a lot of  
21      them up this week and we talked about them.

22             But she was assessed by a nurse named Donna  
23      Shafer who performed a detailed assessment. She was  
24      assessed by Nurse Vaughn, who y'all did get  
25      testimony from. She came here and testified about

1 the assessment she performed. She was assessed by a  
2 CNA Ms. Holland who is in the CNA records they  
3 produced. Neither side called a CNA to testify this  
4 week..

5 She was assessed by Ms. Murray. She was  
6 assessed by a therapist named Norma Ambert. She was  
7 assessed by a physical therapist Stephanie Bond, and  
8 she was assessed, on multiple occasions, by Nurse  
9 McDaniel. She was also assessed by a doctor,  
10 Dr. Margalit. And for a day in the facility, that  
11 is a lot of assessments.

12 To suggest that she was not assessed in this  
13 facility and that there are not dozens and dozens of  
14 detailed assessments, fall-specific assessments,  
15 performed by these professionals is just simply  
16 inaccurate.

17 What they really mean, what they really mean  
18 when you dig down to it -- and I pressed Ms. Lewis  
19 on this. I pressed her, what are really the errors  
20 in the assessments? Let's not talk about it  
21 abstractly; let's talk about what are the real  
22 errors in the assessments. And I asked my law  
23 partner Jenkins Mann here to help me just briefly --  
24 and I know y'all have seen this, but I just want to  
25 talk about it for a moment.

1           This first error pointed out is this error of  
2           assessing the gate. And, as you see, there are four  
3           boxes checked. But what impact does that have on  
4           the ultimate question in this case, why did she  
5           fall? There's been no evidence that she was up  
6           walking at the time she fell. I asked Ms. Lewis  
7           about that, y'all remember. I told her, Ms. Lewis,  
8           when I took your deposition, the initial breach of  
9           the standard of care you identified was that she was  
10          walking down the hall unattended by a person and  
11          fell. When I asked her, do you still believe that's  
12          your opinion? No. No, I don't believe so.

13          So, again, surely there's a documentation  
14          error. We can see that that box is checked and that  
15          box is checked and that box is checked and those  
16          appear to be inconsistent. Neither party was able  
17          to have a witness here this week to talk about how  
18          that old electronic medical records system generates  
19          written documents. Neither party presented evidence  
20          on it. We know, from the testimony of the nurses  
21          that actually did come and testify, they didn't fill  
22          stuff out on the paper form. They answered  
23          questions in an electronic system that were then  
24          printed out for this lawsuit. I can't explain why  
25          those boxes are all checked. What I can tell you is

1       that it's a smoke and mirror. It has no impact on  
2       the question that matters in this case, which is why  
3       she fell. Was it a breach of the standard of care?  
4       No question that she wasn't walking.

5               The next error that she pointed out is that  
6       requires use of assistive devices, cane, walker,  
7       wheelchair, wasn't selected. And you heard me ask  
8       her, well, ma'am, was she in a wheelchair? Yes.  
9       Did she have a wheelchair while she was in the  
10      facility? Yes. Was she in the wheelchair at the  
11      time she fell? Yes. So can you honestly believe  
12      that whether or not that box was checked has any  
13      bearing on the question that matters, why she fell?  
14      It doesn't.

15             More importantly, this is a long assessment.  
16      This assessment, as you'll see if you dig through  
17      those papers, goes on for pages. That question gets  
18      asked in other places. And I don't know why the box  
19      gets printed, generated, checked in some and not in  
20      others, but there is no doubt that when asked  
21      elsewhere in the assessment, when the form says,  
22      does the resident use assistive devices, wheelchair  
23      is checked. I don't know why it prints out the way  
24      it prints out. It's not that she wasn't assessed  
25      for not having a wheelchair. Everyone knew she had



1 a wheelchair. She, in fact, had a wheelchair. It's  
2 just smoke and mirrors.

3 The next one that she identified was pain and  
4 that there was a failure to assess her as being a  
5 person in pain. And the basis of that opinion  
6 Ms. Lewis gave you was that both the no pain  
7 reported and the stabbing pain boxes that occurs  
8 daily are checked. And, I'm sorry, I just have a  
9 fundamental disagreement with the parties on this.

10 And I think Mr. Connor actually addressed it in  
11 his closing quite well. You can both not report  
12 pain at a particular point in time, as he  
13 referenced. Maybe the ER doctor got it right.  
14 Maybe Ms. Lewis got the ER doctor's getting it  
15 wrong, wrong. Maybe at the time somebody asked  
16 Ms. Lewis this question, she did not report pain.  
17 But we know, because when she came to our facility,  
18 we have a stack of hospital records that she has  
19 daily stabbing pain, and that's not a surprise to  
20 any of us. That's common sense. She's got a broken  
21 hip; she's in the process of healing. Again, I  
22 can't imagine how that little box-checking issue has  
23 any real bearing on a question that's in front of  
24 this jury today.

25 Then they've pointed to an issue with a score.

1 And this scratch-out upset Ms. Lewis. And I'll  
2 agree with one thing: If my client ever came to me  
3 and said, should this be initialed, I'd be like,  
4 sure, you should initial that; we want perfect  
5 records. I would love if every record in every case  
6 I ever had to deal with had perfect records in it.  
7 I want that initialed; I want to know who did it; I  
8 want to know the time.

9 But this is a living document. You heard Scott  
10 Smith testify that it's a living document. You  
11 heard Javan Vaughn say that it's a living document.  
12 You see that there are write-ins. They're supposed  
13 to be changed. There's nothing nefarious about a  
14 change from 15 to 17; at least no one has  
15 articulated one for you in this case. There's no  
16 doubt that that 17 is the same as the fall-risk  
17 score that Donna Shafer's assessment had up on July  
18 1st. Again, maybe someone just did their math wrong  
19 and wrote down a 5 and meant to write down a 7, once  
20 they re-added up the totals on the side. We don't  
21 know because, unfortunately, none of these people  
22 remembered what happened four years ago when they  
23 were filling out the paperwork. But, again, it's  
24 smoke and mirrors. It has no impact on the care  
25 that was provided, and even Ms. Lewis couldn't

1       dispute that.

2               The threshold of the facility was if that  
3       number is higher than a 10, you treat them like a  
4       high fall risk. So I don't know why these types of  
5       documentation errors need to be the focus of your  
6       consideration. Do they show less than ideal  
7       recordkeeping? Most certainly. But that happens.  
8       That happens in every job, in every profession.  
9       Ms. Lewis agreed that nurses and doctors and anyone  
10      else that she's accused in this trial of keeping  
11      poor records, that they're just people and they make  
12      mistakes.

13              But to have an error, a technical error, in the  
14      documentation of a record, does that rise to a  
15      violation of law and an actionable breach in the  
16      standard of care such that these companies are  
17      legally liable for monetary damages? I feel that  
18      that is a stretch. I feel that that is asking a bit  
19      much.

20              There have been some other concerns about the  
21      documentation raised. They asked about -- or they  
22      talked about in detail with Ms. McDaniel why there  
23      wasn't an entry on the MAR, the medical  
24      administration record, that Ativan had been given.  
25      And she agreed that box, that should have been

1       checked. And I'm sorry it wasn't. It was a breach  
2       of the standard of care. She knows she should have  
3       checked that box. It's not that it wasn't  
4       documented in her medical record though. Okay? It  
5       wasn't documented on that form in her medical  
6       record, but it was documented by her in this medical  
7       record. There's no dispute about that.

8               So, again, yeah, there's a box that wasn't  
9       checked. I'm not sure that the standard of care  
10      requires anything more than it be documented in the  
11      record, but y'all are the judge of that. But what  
12      you can't doubt is what even Ms. Lewis conceded, is  
13      that even if that's a breach of the standard of  
14      care, it didn't cause Ms. Shealy to fall. I asked  
15      her, point blank, did the failure to document that  
16      in the MAR cause her to fall? She said, no, the  
17      only way it could have, is if time had passed and  
18      someone hadn't known that she, in fact, had gotten  
19      the Ativan and then gave her another Ativan, and  
20      then she was over-drugged, essentially, and fell,  
21      then that would absolutely be a breach of the  
22      standard of care that caused her to fall. But  
23      Ms. Lewis didn't say that happened; she confirmed it  
24      didn't.

25             So even that breach of the standard of care

1 doesn't amount to liability in this case because  
2 it's not enough for the plaintiffs to come up and  
3 nit-pick the documentation of this closed-down  
4 company and come back with rearview and say, well, I  
5 can find dozens of mistakes in your paper records;  
6 therefore, you're liable. No. The essential  
7 question is: Did it cause the damages that are  
8 being sought? And a failure to document that MAR,  
9 by their own expert testimony, did not cause the  
10 damages.

11       There is absolutely problems with this record  
12 and the time stamps on it. There's no denying that.  
13 Those medical records have incorrect times. If you  
14 believe the time line that the plaintiffs have  
15 presented you this morning, then you have absolutely  
16 checked your common sense at the door. There is no  
17 doubt that Ms. McDaniel does not have psychic  
18 ability. There's no doubt that that ER note was not  
19 created at 3:22, four hours before the fall. To buy  
20 the time line posted up there absolutely defies  
21 reason. It's just an error.

22       Plaintiffs could have hired somebody from that  
23 company to come in here and explain the -- the  
24 electronic records company to explain how that box  
25 gets generated and the forms are printed. They

1 chose not to. Why? Because it's not material.

2 It's just not material. There's no evidence that  
3 says that those time stamps have any bearing on the  
4 treatment that she received or that they caused her  
5 to fall. It's just a sideshow.

6 There are -- one other documentation error that  
7 I want to talk about before I just move on, and that  
8 is the allegations about these -- the work that the  
9 two CNAs did, the two CNAs that Plaintiffs did not  
10 subpoena to come in here and testify, Ashley Holland  
11 and Shander Murray.

12 You heard testimony from Ms. Henderson about  
13 how all the Agape nursing homes were on 12-hour  
14 shifts, and that was a 7 A to 7 P. You heard  
15 Ms. McDaniel testify to the same thing: Twelve-hour  
16 shift, I run 7 A to 7 P. Okay? And I did this with  
17 one of our witnesses, you'll recall. Common sense  
18 tells you that all the acts that are described in  
19 this record were not all performed within one day.

20 What's obviously happening is someone is  
21 documenting once per shift. You've heard repeated  
22 testimony that that's not a breach of the standard  
23 of care; that regulations, CMS regulations, require  
24 less documentation than that; that that's a policy  
25 that it's documented once per shift.

1           You've seen no law, their expert can identify  
2           no regulation, that requires CNAs to do anything  
3           different than document ADLs once per shift. So  
4           this repeated suggestion that from this time, being  
5           the time that Ms. Holland documented her ADLs  
6           performed between 7:00 A and 2:19 PM, to say that  
7           that means that she didn't perform anything after  
8           that time, it's just wrong. It's an incorrect  
9           inference to draw. All this means is that between  
10          7:00 AM and 2:19 PM, she performed all of those and  
11          she had no duty to document anymore.

12           And you know other stuff happened. You heard  
13          Ms. Koon testify that she received aid from someone  
14          in the building to toilet Ms. Shealy at a time other  
15          than 2:19 or 2:20 PM on July 2nd. It was between  
16          10:30 and noon that morning. That's not in the  
17          record, but that doesn't mean it didn't happen.

18           You heard the plaintiff testify that her mom  
19          was going to dinner on the way out when she left at  
20          5:00 or so the afternoon that she fell on July 2nd.  
21          Plaintiff's counsel asked this morning, where's  
22          dinner? Well, it's not in the record, but that  
23          doesn't mean she didn't eat. The whole family  
24          testified she was going to go get dinner. She ate.  
25          It's not in the record, but that's okay because

1       they've shown you no way that that's a breach of the  
2       standard of care.

3             The other one that concerned me that I did want  
4       to address with you briefly was this other CNA form  
5       that was shown to Ms. Henderson during her  
6       examination yesterday. And you'll recall that the  
7       fact that there's no second number was something  
8       that she was asked questions about. Unfortunately,  
9       she wasn't shown the third page of that document  
10      that says that an 8 means the activity did not  
11      occur.

12            If the activity did not occur, obviously  
13      there's no need to document the level of support  
14      provided because, again, it means it didn't occur.  
15      So it should be no surprise that CNA Holland didn't  
16      say how much she helped Ms. Shealy walk in her room  
17      or walk in the corridor or locomote off the unit.  
18      It should be no surprise because the activity didn't  
19      occur. So I can't think of a better example of  
20      smoke and mirrors than to ambush Ms. Henderson with  
21      a part of a record without reminding her of the  
22      explanation code two pages later that says, no,  
23      there's no required documentation there for the  
24      level of assistance provided because the coding  
25      that's on the page suggests the activity did not



1 occur.

2 We have a lot of other assessments that were  
3 done in this case, as I've said. Norma Ambert,  
4 Stephanie Bond, Ebonie McDaniel, I'm not even going  
5 to walk through them -- just for the sake of time,  
6 I'm not going to walk through them all.

7 Dr. Margalit -- Dr. Margalit did a very  
8 important assessment that I would like for you to  
9 consider. Okay? You heard testimony the doctor  
10 doesn't have to come to the building for the first  
11 30 days to see a particular resident. And because  
12 of the condition that this resident was in, a nurse  
13 met with Dr. Margalit and disclosed this about  
14 Ms. Shealy. Now, this appears to me it's 8:45 in  
15 the morning -- 8:45, that's during Ms. McDaniel's  
16 shift: Per nurse, the patient is confused and  
17 agitated. It's another assessment done by Ebonie  
18 McDaniel in response to the plaintiff's condition.  
19 She brings the doctor in on the first day to see  
20 this particular patient, has the doctor assess her  
21 and make orders. That is the nursing process. That  
22 is, yes, we have a care plan from yesterday. Yes,  
23 the rules don't require us to have a doctor see her  
24 until the first 30 days is about to be up, but let's  
25 get the doctor in on the first day, have the patient

1       assessed, see what the doctor wants to do about it.

2               Confused and agitated, the same condition she  
3       was in when she fell later the same day, the same  
4       condition. The doctor was more than aware of the  
5       fact that the patient was confused and agitated. He  
6       was aware that she was a huge fall risk, that she  
7       was so upset the night before, that she said she  
8       wanted to die.

9               And I hate that for Ms. Shealy, I do. I hate  
10       that. No one in this room has any ill-will towards  
11       the plaintiff, to their family. No one wants to see  
12       their loved one go through that. And it's a  
13       difficult job that y'all have because as jurors  
14       you're required to check your passions and your  
15       prejudices at the door and to objectively weigh  
16       evidence.

17              And we all sympathize with Ms. Shealy. We all  
18       sympathize with her family. I've seen nothing in  
19       this case other than proof that her children and her  
20       family, her brother, her sister-in-law are dutiful  
21       family members; they cared about her. They're not  
22       on trial here. Okay? We're just asking that you  
23       take an objective look at the facts and give them  
24       the weight that they're entitled.

25              And what the facts show is that there was a

1 physician that evaluated her the day she fell and  
2 that that physician knew her condition, knew she was  
3 a huge fall risk, knew that she was in a bad state  
4 of mind, and chose an intervention to be provided to  
5 her. He was armed with a doctor's order that came  
6 the previous day, which I've shown y'all and I'm not  
7 going to dig back out, from Lexington Medical  
8 Center. He knew that she had been taking Ativan for  
9 20 years and because of that order, she was at least  
10 entitled to get Ativan one time a day. He said, I'm  
11 going to up that to four times a day. And that was  
12 the intervention that he put in place.

13 And I think it really gets to -- the  
14 fundamental question is, well, should he have  
15 ordered something else? Right? Should he have  
16 ordered something else to keep her from falling?  
17 And when I asked Ms. Lewis, when I got down to the  
18 nuts and bolts of it, when I got down to the  
19 ultimate question that mattered in this case, when I  
20 asked her the open-ended question and gave her the  
21 chance to tell you the answer to the ultimate  
22 question in this case, which she did not do until I  
23 asked her, which is, ma'am, how did she fall, why  
24 did she fall? Okay? When asked that question, she  
25 didn't cite to all these technical document errors.

1       She didn't cite to staffing ratios or survey results  
2       or any of the other corporate documents or yearlong  
3       history or who-knows-how-long history of this  
4       corporation or companies. She looked at a very  
5       defined window, the time between 5:30 PM and the  
6       time of the fall, which you've been reminded this  
7       morning with a lot of lungs was about a hundred or  
8       so minutes, 115 minutes. And she agreed that the  
9       provision of the Ativan was the proper intervention  
10      to do. The doctor had ordered it, doctor said  
11      particularly in the afternoon -- at least Lexington  
12      Medical Center said in the afternoon she sundowns;  
13      she's going to get more agitated; make sure she gets  
14      her Ativan.

15             Dr. Margalit agreed, said give her the Ativan.  
16      Ms. Lewis said that was within the standard of care,  
17      that's what you should do. Then I asked her, well,  
18      Ativan takes time to get in the body; correct? And  
19      we've seen this board with the nursing circle on it,  
20      how that has to -- you have to give the  
21      intervention. You have to have time to assess it.  
22      You have to evaluate whether it's working. If it's  
23      not working, then you put in another intervention;  
24      correct? That's the real issue here, is in response  
25      to the Ativan, it didn't work. Okay? Well, she

1       agreed with me that Ativan takes time. It takes an  
2       hour to even get to efficacy -- full efficacy in the  
3       body. So surely, she agreed with me, that it's not  
4       that you had to do something at that time period  
5       because nurses following the nurses process are  
6       supposed to wait for an intervention to take its  
7       place, see if it's working, assess it; if it's not,  
8       come up with a new plan.

9               Well, Ms. McDaniel gave us a timeline in her ER  
10       note of what happened, says she was given the  
11       Ativan, time passed, about an hour, and it wasn't  
12       effective. She became -- she was still agitated.  
13       Another intervention got put into place; she got  
14       moved to the nurses station. You've heard testimony  
15       that that's where they do their shift change.  
16       That's where they are when it's the most busy.  
17       You've heard that the shift change is at 7:00 PM or  
18       so, so she gets taken out to the busiest spot in the  
19       nursing home for observation.

20               You heard Ms. Henderson testify that nurses  
21       station is about 10 to 12 feet from where the record  
22       shows she fell. And there's been this question  
23       raised about whether she really fell in the room.  
24       Ms. Lewis didn't even buy that theory. I asked  
25       Ms. Lewis where did she fall and she said outside

1 the PT room. She couldn't say with a straight face  
2 that she believes that the word room being typed  
3 into the EMS driver's report really indicates where  
4 she really fell. Ms. Lewis didn't assume that, she  
5 didn't believe that, and I don't think that you  
6 should either.

7 When I asked Ms. Lewis if moving this  
8 resident to the nursing home was the right  
9 intervention -- I mean, sorry, to the nurses station  
10 was the right intervention, was it the right thing  
11 to do, was it a breach of the standard of care, she  
12 agreed that it was the right thing to do. I said,  
13 okay, Ms. Lewis, how long was she there before she  
14 fell? And we don't know. Out of those 115 minutes  
15 that they've chalked away on this board this  
16 morning, Ms. Lewis could not tell us how long she  
17 was at the nurses station.

18 And that is fundamental, I believe, ladies and  
19 gentlemen, to the decision that you have to make  
20 because we know that these interventions are  
21 supposed to be given time to work. Okay? And if  
22 moving this person to the busiest spot in the  
23 nursing home where they'll be in the line of sight  
24 of this staff is the standard of care, then it's  
25 reasonable for the nurses or the CNAs that are there

1       to give her some time to be observed before they  
2       call the doctor and try to do what Ms. Lewis said  
3       the doctor would do to restrain her, because  
4       restraints are very serious.

5                You've heard the CMS regulations, you've heard  
6       testimony about it from everybody, and Ms. Lewis  
7       agreed that all those things that she initially said  
8       should have been an additional intervention, the Lap  
9       Buddy, the belt, the deep-seated cushion, she agreed  
10      that every single one of those things that she said  
11      the nurses should have done first would require a  
12      doctor's order. And thank goodness it does. Thank  
13      goodness it does, because nobody wants to go back to  
14      the time when loved ones were sent to nursing homes  
15      and restrained without someone else checking behind  
16      to make sure it's the right thing to do. And I know  
17      that the plaintiff's family would not have wanted  
18      that for Ms. Shealy either. None of us in the room  
19      want to go back to a time where that was what was  
20      happening in a nursing home. What you've heard is  
21      that it's dangerous to restrain those people. It's  
22      dangerous; they can get hurt. What's not being  
23      shown is that a restraint was ever warranted in this  
24      case.

25               And we know what CMS says about that.

1 Ms. Lewis and Ms. Henderson agree on this: Falls do  
2 not constitute self-injurious behavior or medical  
3 symptom that warrants the use of a physical  
4 restraint. Although restraints have been  
5 traditionally used as a fall-prevention approach,  
6 they have major serious drawbacks and contribute to  
7 serious injuries. There's no evidence that the use  
8 of physical restraints including but not limited to  
9 side rails will prevent or reduce falls.  
10 Additionally, falls that occur while a person is  
11 physically restrained often result in more severe  
12 injuries such as strangulation and entrapment.

13 So Ms. Lewis' real answer to what is the breach  
14 of the standard of care that caused her to fall,  
15 call the doctor, get an order, have a restraint  
16 done. Tell me this, ladies and gentlemen: If falls  
17 are not a reason for the doctor to be allowed to use  
18 restraints, how is it a breach of the standard of  
19 care for the nurses to have failed to call the  
20 doctor to get an order that there's no evidence that  
21 the doctor would have ever given it? I don't think  
22 it can be. And they may come back up and tell you,  
23 no, we don't know what the doctor would have done.  
24 But we do, but we do, because the doctor had already  
25 seen her. The doctor had already seen her confused



1       and agitated and talking about wanting to die and he  
2       put in place the intervention that he thought was  
3       appropriate, which was medication. And then,  
4       they're correct, one of our therapists said, she  
5       needs to be closely monitored. And we did that too.  
6       We took her to the nurses station where she could be  
7       closely monitored.

8               The only other suggestions that Ms. Lewis could  
9       come up with was, well, the family could have been  
10      called; maybe she could have been taken to a  
11      distracting activity like bingo. And the family had  
12      just recently left, you heard the testimony from the  
13      plaintiff. And, who knows, maybe if she had sat up  
14      there at the nurses station long enough, that would  
15      have been the next intervention. But nurses are  
16      allowed time for that nursing process to work. It's  
17      not a breach of the standard of care to see if the  
18      time at the nurses station calmed her down before a  
19      call was made.

20             And so, ultimately, at the end of the day,  
21      Ms. Lewis, despite doing her best effort to earn the  
22      fees that she's been paid in this case, failed to  
23      identify a breach of the standard of care that  
24      caused Ms. Shealy to fall. And I believe that Mr.  
25      Smith, Scott Smith, the nurse that was the director

1 of nursing, put it well. I mean, remember, Scott  
2 Smith is one of our people that got called by the  
3 plaintiff during their case, Scott Smith, not paid  
4 to be here, Scott Smith who has, you know, been  
5 attacked for never being a director of nursing  
6 again. Somehow he's still qualified to be an ICU  
7 nurse. So now he's able to work in the highest  
8 level of care that exists in our medical system.  
9 His testimony, to me, rung true, which is falls  
10 happen, even in hospitals where staffing ratios are  
11 one nurse for every two people. Falls still happen  
12 and it's unfortunate, but we balance in our society  
13 dignity versus the risk of falls.

14 And as you've heard from the regulations, as  
15 you've heard from the guidance that CMS sends out  
16 those people, those surveyors that have given Agape  
17 the F-tags in the past that have been brought up  
18 during this trial, those people by CMS the same  
19 thing that I'm telling you, which is that falls and  
20 the risk of a fall is still not an excuse to take  
21 every action that you can to prevent somebody from  
22 falling, including a restraint.

23 I do need to talk -- I would be remiss to  
24 talk or not to talk -- I -- to me, that ends the  
25 inquiry, ladies and gentlemen. If there's not a

1 breach of the standard of care that caused her to  
2 fall, the case is over. I mean, when you get on the  
3 verdict form, you don't need to get past the first  
4 page. You can say I rule in favor of the defendant,  
5 and then, Mr. Foreperson, you'd sign the last page.

6 But I do want to discuss, briefly, the damages  
7 that are being claimed by the plaintiff. And,  
8 again, you have to look at these damages. You have  
9 analyze them; you have to think about them. You  
10 need to remember things like argument by counsel  
11 isn't evidence. Remember, their opening argument,  
12 there was some discussion about a lost home, a lost  
13 home that no evidence was ever entered into the  
14 record on in this case.

15 If you're looking at the damages, look at them  
16 closely. There's medical bills in here. I believe  
17 when you analyze those medical bills, if you get to  
18 that point, you'll see that there's bills that are  
19 also related to the treatment of the hip that was  
20 not broken when she came to Agape for which they're  
21 asking you to award damages on. But when you're  
22 looking at all this damages evidence, I do want you  
23 to remember the condition of Ms. Shealy before she  
24 came to the facility on July 1st and then how it  
25 progressed. And, again, I want to say this out of

1       the gate: I'm not in any way being degrading to the  
2       patient's family, because I can completely  
3       sympathize with what living with a loved one with  
4       dementia is like. And I understand that this fall  
5       happened years ago and she lived for, as you saw,  
6       over a thousand days, and so the memory gets skewed  
7       looking backwards.

8               So the reason why I want you to see these  
9       records is because they are, in fact, a  
10      contemporaneous recording by an objective medical  
11      professional telling you the condition that she was  
12      actually in, not testimony by family looking  
13      backwards through years of admitted heartbreak and  
14      emotion over losing their mother and their sister  
15      who had Alzheimer's. Okay.

16             Whenever she came to the hospital, no one  
17      disputes this fact, she had dementia. She had a  
18      history of dementia. She was not as ambulatory, I  
19      believe -- I believe if you compare the objective  
20      medical evidence to the recollection of the family,  
21      records show she's not as ambulatory, able to walk  
22      around, as the family recalls her being. While they  
23      don't recall saying this to the doctors, the doctors  
24      recorded family reporting that she did use a cane,  
25      but she probably needed a walker before she fell the

1 first time.

2 After her fall, she suffered encephalopathy  
3 with agitation following that first surgery. And  
4 that's documented in the record. We know that. We  
5 know that she suffered with increased agitation. We  
6 know that she suffered with considerable confusion.  
7 We know it was so bad in the hospital they, in fact,  
8 chose to restrain her and she struggled with that.  
9 Since postop, she's had considerable confusion as  
10 well as agitation with restraints, which, by the  
11 way, is kind of the point. Right? If you know  
12 someone gets agitated when you're going to restrain  
13 them in their chair, is it safer to restrain them or  
14 safer not to?

15 She doesn't know where she's at, doesn't know  
16 why she's there. She can't describe her  
17 surroundings. And Ms. Lewis confirmed  
18 periventricular white matter changes indicate  
19 Alzheimer's, dementia progression. We know that's  
20 her condition before she came to Agape. And while I  
21 hate the fact that that disease progressed after she  
22 left, there's a giant gap in the evidence that the  
23 plaintiff has to show you to meet their burden --  
24 their burden of proof in this case. And that is  
25 that whatever mentation changes she suffered in the

1 thousand days that followed her leaving Agape are  
2 somehow causally connected to that fall. Where are  
3 the doctors that are treating her? Where are the  
4 nurses? Where are the people doing the follow-up on  
5 her psych evals? Where are any of her healthcare  
6 providers from the thousand days following the fall  
7 here to tell you, ladies and gentlemen, that the  
8 decline in mentation she suffered, the memory she  
9 lost, the time she's lost, that that is in any way  
10 causally connected to the fall that she had on July  
11 2nd versus the fall she had on July 22nd versus the  
12 progression of Alzheimer's before she came to us?  
13 Where are those medical professionals? Where are  
14 those medical records? Where in the records have  
15 you seen is there even a single opinion by any  
16 provider saying that the 1,000-plus days of life she  
17 had following that fall were worse because of that  
18 fall?

19 No one here sitting at my table, Mr. Middleton,  
20 his daughter Sara, those providers that got called  
21 in here from their other jobs this week to testify,  
22 no one here really believes that she wasn't in pain  
23 right after she fell. That wasn't even the point of  
24 that conversation. The point with Ms. Lewis about  
25 the accuracy of medical records, I'll go to this

1 more, the Lexington medical records, in a moment.

2 We don't dispute that she was in pain after she  
3 fell. We've showed you records about her condition  
4 following our fall just so that you'll understand  
5 that perhaps the medical records don't document the  
6 same recollection that the plaintiff's family has.

7 So following the fall -- well, actually, right  
8 before she was left to us, this was her ability to  
9 ambulate on July 1st, the day she came to Agape's  
10 nursing home: Two people assisting, walking 60  
11 feet. This is from Lexington Medical Center on July  
12 1st. She has a fall where she undoubtedly is in  
13 pain. But what happens next? What's the course of  
14 the medical treatment for her ability to ambulate  
15 and her mentation?

16 Let's look at those together. Following the  
17 surgery, they say there are no complications.  
18 Contrast that with the first hospital stay where she  
19 did have acute encephalopathy. Okay? At least  
20 postoperatively there's not a record that says she's  
21 having additional post -- acute encephalopathy, but  
22 there was some other surgical complication that  
23 arose during the course of the surgery. Certainly  
24 she's still confused, but that confusion never  
25 resolved from the first surgery.

1           Five days after the fall at Agape's nursing  
2           home, she's awake and alert. She has mild baseline  
3           confusion, baseline. Baseline. During the  
4           plaintiff's opening, that term baseline was somehow  
5           suggested that the defendants are misusing it in  
6           looking at the wrong baseline. That's not our  
7           record. We're not here to tell you that that's her  
8           baseline before 7/1, before 6/22. We don't know  
9           which baseline they're referring to, other than it's  
10          before her fall at Agape. I don't know how far back  
11          before her fall at Agape that medical provider,  
12          Dr. Dedmond, is saying the baseline should be  
13          measured from. We don't know because Plaintiff  
14          never got Dr. Dedmond to come explain that to you.  
15          They didn't meet their burden of proof to establish  
16          what her baseline was before and after.

17               And if you believe the suggestion that we're  
18               here trying to play hide the ball by saying less is  
19               more, that sword cuts both ways because it would be  
20               great to have heard from these medical providers  
21               that treated Ms. Shealy for years following this  
22               fall as to how that actual disease progressed. But  
23               we know here, five days after the fall, this is what  
24               an objective medical professional assessed her to  
25               be: Awake, alert, back at her mild baseline and not



1 agitated, capable of walking 18 feet with one  
2 person, not two people like she was the day she came  
3 to Agape. That's the 7th. Let's go to the 8th.

4 Now, on July 8th, following a fall on July 2nd  
5 and a hip surgery on July 3rd, 110 feet with one  
6 person aiding. During the hospitalization, there  
7 were not additional medical issues. Where is the  
8 evidence of this lifelong negative impact of  
9 anesthesia given during the second surgery? Where  
10 is it? I haven't seen it the whole trial.

11 I haven't heard a single doctor or anyone come  
12 here, any neurologists, any of the treating  
13 physicians she had come here to explain to us how  
14 anesthesia given in the second surgery resulted in  
15 lifelong medical issues when during the  
16 hospitalization itself where the care was provided,  
17 there were not additional medical issues. That  
18 doesn't meet the burden of proof, ladies and  
19 gentlemen.

20 She had mild post-op confusion, but it's the  
21 chronic kind, the kind that she's always had, and  
22 she's back to her baseline dementia. Again, I don't  
23 believe the family was here trying to mislead  
24 anybody. It's just hard when you're looking  
25 backwards and trying to remember these things. It's

1       important, ladies and gentlemen, whenever y'all are  
2       back there deliberating, if you get to the point of  
3       discussing damages, that you look at the objective  
4       evidence as to what her condition was before you  
5       decide that the defendants are liable for \$1,000 a  
6       day for a thousand days because of conditions that  
7       the plaintiffs have failed to provide any medical  
8       evidence or medical causation evidence, because none  
9       of us are doctors; at least I don't remember any of  
10      y'all being doctors during our voir dire. None of  
11      us are doctors. None of us are able to connect  
12      those medical links. That requires someone who  
13      knows more certainly than me. We didn't hear it at  
14      this trial.

15             Let's look at that August 28th note. There was  
16      a little bit of question with Ms. Lewis. I asked  
17      her and she didn't really want to commit to whether  
18      or not the plaintiff had Alzheimer's. She  
19      definitely agreed it was dementia, sometimes thinks  
20      the terms are used interchangeably. Certainly there  
21      in Lexington Ortho's records, certainly there on  
22      August 28th, 2014 there was no doubt that she  
23      suffered from Alzheimer's disease. There's  
24      certainly no doubt there.

25             Like I said, it's difficult to rely, as a

1 plaintiff, on paid expert testimony because experts  
2 are only worth the opinions that they're paid to  
3 provide. And I think that when you go to judge  
4 Ms. Lewis' credibility, you'll have reasons to doubt  
5 the reliability of the opinion that she was paid to  
6 provide you.

7 Let's look at a couple other documents that I  
8 just feel that Ms. Lewis really should have dug into  
9 with us. I asked her, like I would ask any  
10 healthcare provider, well, she fell a week before,  
11 can you tell us why that fall happened? You're here  
12 getting paid to tell us why this fall happened. Can  
13 you tell us why the one the week before happened?  
14 You would think that maybe she would dig into this  
15 patient's history. Right? Dig into the cause of  
16 why she fell. Usually when you go to the doctor,  
17 they say, tell me about your physical history.  
18 Well, we know Ms. Lewis didn't consider this. Not  
19 only did she not consider the fall from June 22nd,  
20 did we hear any testimony from Ms. Lewis on the  
21 hemorrhage in the brain that she suffered in 2008  
22 when she suffered a fall and had a closed head  
23 concussion? Why did Utricia Shealy fall in 2008,  
24 six years before she came to Agape, a fall serious  
25 enough to cause her to have a hemorrhage in the

1 brain? Why did that fall occur?

2 Ms. Lewis wasn't paid to give us an opinion on  
3 that. She got asked a lot of questions and read a  
4 lot of regulations during examination, a lot of  
5 things to busy y'all's mind with, a lot of things  
6 that don't answer questions that are really  
7 pertinent to this case. But something like why she  
8 fell in 2008 and suffered a brain bleed, we never  
9 heard the first bit of testimony from her on that.  
10 It's in the records she received. She testified  
11 that she received the Lexington records, same  
12 records we all received in this case, same records  
13 that have been shown. You'll see, if you dig into  
14 these Lexington records from this fall -- again,  
15 this is the fall that occurred -- this is a note  
16 from the fall that occurred at Agape buried in those  
17 same records. So we know she saw them. This was a  
18 very serious fall and we didn't hear the first ounce  
19 of testimony on it from this paid expert.

20 What else? This was telling to me: July 2nd,  
21 the day she left our facility, 2130, 9:30, a nurse  
22 at Lexington Medical Center says that patient is out  
23 of the room getting a CT and X-ray at this time.  
24 Okay? They're looking at her hips and there's a  
25 doctor named Dr. Krusling who is evaluating her at

1       this time.

2               And I asked Ms. Lewis about Dr. Krusling's  
3       notes, I asked her what she thought, and all she  
4       could tell is that he made some mistakes; there were  
5       errors. Took her a while to get to the fact that  
6       maybe she thought they were a breach in the standard  
7       of care. Took me asking her the question three  
8       times because she wasn't paid to come here and blame  
9       Lexington Medical Center for something.

10              So I asked her, was it a breach in the standard  
11       of care? She said error. I said, I hear that, but  
12       was it a breach in the standard of care? She said  
13       error. The third time she conceded, yeah, his  
14       mistakes are a breach of the standard of care.  
15       She's never talked to him. I asked her had she  
16       talked to any of the treating physicians. No. But  
17       she's willing to look at his notes also and say he  
18       breached the standard of care. Let's look at his  
19       notes.

20              I asked her about this injury where it says  
21       the -- and I'm just going to leave it and see if it  
22       focuses for a second. I think it's the other way.  
23       I asked her, well, Dr. Krusling saw her that very  
24       same night in the ER and said the severity of pain  
25       is no pain. And they continued to say, on the next

1 page -- where is the next page? Oh, here we go --  
2 that she's orientated to person, place, and time,  
3 she's well-developed, she shows no sign of distress,  
4 she has normal range of motion, she has a normal  
5 mood and affect, her behavior is normal, she's  
6 well-developed, A&O times 3. That's what  
7 Dr. Krusling said about her.

8 Now, that's gotten turned around somehow this  
9 morning into being argued that the defendants are  
10 saying that she wasn't in pain. We're not saying  
11 that she's not in pain. We're not saying she wasn't  
12 in pain. Obviously our records say she's in pain.  
13 We don't dispute she was in pain. That's not the  
14 point. The point is the doctors that are treating  
15 her in real time say she's not in pain.

16 Ms. Lewis, because that doesn't fit her  
17 narrative that she was paid to come here to say,  
18 jumps to the conclusion of, well, that's not wrong,  
19 that's -- that's not right; that's wrong; that's  
20 erroneous. She never talked to this guy. She  
21 didn't see anything. She made no observations. Her  
22 opinions are only as good as the facts she's paid to  
23 believe. So she has to disregard this to give you  
24 her opinions, doesn't she? She has to disregard all  
25 that. Dismisses it out of hand, even though she

1       wasn't there and we never got to hear from him on  
2       this.

3               But what really I found surprising about her  
4       opinion that she was willing to address with us is  
5       the fact that there's no way she could have been  
6       alert and oriented times 3; there's no way she  
7       couldn't have been in pain. But what about this  
8       finding by Dr. Krusling: Diagnosis. He's evaluated  
9       her July 2nd, 10:30. Diagnosis: She suffered a  
10      fall, had a bruise on her face, left the ER in good  
11      condition. Where is the mention of the broken hip  
12      at all?

13             Remember a moment ago that she's out getting  
14      X-rays done, right, at 9:30? Doctor looks at those  
15      X-rays. Per my read of the C-spine and hip X-rays,  
16      they're negative. Dr. Krusling looks at the X-rays  
17      and says no broken hip. Now, are we saying that she  
18      didn't have a broken hip? She obviously had a  
19      broken hip at some point. And we don't know because  
20      we don't have a person in this courtroom that has  
21      any recollection of the medical care that she  
22      received on July 2nd or that has an independent  
23      recollection of a fall. All anyone in this case has  
24      to go off to, unfortunately -- or go off of,  
25      unfortunately, are the medical records. Okay?

1           My point on this is not that she didn't have a  
2 broken hip. My point on this is that the paid  
3 expert ignores statements by doctors that say after  
4 she left Agape, she didn't have a broken hip. She  
5 ignores it. She doesn't talk about it. She doesn't  
6 even address it. Plaintiffs had these records.  
7 They're the ones that gave her the records. They  
8 didn't ask her about it and yet Agape is the one  
9 hiding the ball today because they didn't call a  
10 paid expert of its own, because they didn't pay  
11 someone else to pick and choose what records they  
12 were going to find compelling and to tell you a  
13 story.

14           Ladies and gentlemen, Agape wasn't required to  
15 do that. We're not required to pay somebody to come  
16 up here and make up a story and argue with  
17 Ms. Lewis about it. The records are what they are.  
18 I don't believe that any expert could look at that  
19 record and offer an opinion to a reasonable degree  
20 of medical certainty that somebody did something  
21 wrong that caused her to fall when there's not a  
22 record of how she fell and there's not a record of a  
23 person who witnessed it. Okay? So -- and, oh,  
24 there was no expert testimony provided. We agree  
25 with that completely. Not willing to pay for



1 someone to do it on this scale. But Agape doesn't  
2 bear the burden of proof. That's the difference.

3 Agape does not bear the burden of proof in this  
4 trial; the plaintiff does. The plaintiff has to  
5 bear the burden of proof. They have to show by the  
6 preponderance of the evidence that these defendants  
7 are responsible for the millions of dollars of  
8 damages that they're claiming are due from this  
9 fall, from a broken hip that, while painful, she was  
10 actually up and moving better five days later.  
11 Okay? And we're not saying that that means falls  
12 don't matter, that she's better off with a broken  
13 hip. No one is saying that. We're just saying that  
14 as drastic as it was in the family's mind, the  
15 medical records don't show that it resulted in a  
16 thousand days of problems. There's no medical  
17 testimony here to make that connection for you.

18 Finally, I want to address, briefly, two other  
19 points -- three other points. We've seen a lot of  
20 training materials in this case and I believe that  
21 we've spent a lot of time watching videos, going  
22 through records. There's a box full of training and  
23 inservice records in there. Agape Management  
24 Company is -- has a contract that's in that box, in  
25 the file, and it's a contractor that's providing

1 specific services, training services, legal  
2 services, IT, HR, and Plaintiff takes an independent  
3 contractor and tries to make them liable in every  
4 way in the world that they can for some alleged  
5 negligence by one of these nurses.

6 Listen closely to the charge, ladies and  
7 gentlemen. I just don't believe it's the law. I  
8 don't believe that the facts in this case require a  
9 contractor to be responsible for people that they  
10 didn't employ or their negligence. And you've heard  
11 testimony that they're asking for -- you've heard  
12 argument that they're asking for punitive damages in  
13 this case. And what didn't get discussed with you  
14 during Plaintiff's opening is that punitive damages  
15 require something more than just tipping of the  
16 scales. It's not just the preponderance of the  
17 evidence. It's clear and convincing evidence. And  
18 the judge will charge you that that is a higher  
19 standard of the burden of proof than even the  
20 negligence standard and professional negligence  
21 standard. It's much more than just ever so slightly  
22 tipping the scales. And the judge will charge you  
23 on the law on that, but you never get to the issue  
24 of punitive damages, I believe, because I don't see  
25 how the paid testimony of Ellen Lewis was sufficient

1       for you to find any negligence, any negligence at  
2       all, any conduct that rose to the breach of the  
3       standard of care that actually caused her to fall  
4       and that actually caused her damages.

5               The rest of it, ladies and gentlemen, I believe  
6       is smoke and mirrors, an attempt to inflame your  
7       passions over other things about this company that  
8       really have no bearing on this fall. So I respect  
9       you; I respect your opinion, however you choose to  
10      make it. I trust that you'll do the right thing. I  
11      just ask that when you look at the form, that you  
12      answer both questions in favor of the defendant on  
13      the first page and then, Mr. Foreperson, that you  
14      sign the last.

15             Thank you for your attention. This is the last  
16      time I get to speak to you today or this trial.  
17      You've been a fantastic attention-holding group and  
18      we really do appreciate it because that's how this  
19      justice system works.

20             THE COURT: Rebuttal?

21             MR. MCALISTER: Ladies and gentlemen, I'll be  
22      brief. We wanted to have an opportunity to respond  
23      to some of the arguments that you've heard from  
24      defense counsel. And we anticipated many of those  
25      arguments. We knew that they were coming. And

1 earlier in this trial, my co-counsel, Mr. Connor,  
2 told you to watch out for red herrings; watch out  
3 for distractions. And that's exactly what every one  
4 of those arguments was about. I took notes through  
5 the entire balance of that argument.

6 We've got a fall from 2008? What does that  
7 have to do about this case? We have an ED doctor  
8 who misdiagnosed an X-ray. We know she fractured  
9 her hip at Agape. They performed surgery on her the  
10 next day. Use your common sense. Did she really  
11 get better once she had her second hip fracture  
12 because she was able to ambulate a little further?  
13 We know one thing: She never went home. She  
14 remained in a nursing home the rest of her life.

15 Their own materials tell us that falls can  
16 result in functional disability, issues with your  
17 mentation in addition to your loss of physical  
18 ability. They know that. That's why they're on  
19 notice that falls are dangerous to the elderly.  
20 That's why they're there, to protect. You've heard  
21 a lot about paid testimony. Well, here's the dirty  
22 little secret. Yes, we had to pay an expert. We're  
23 required to, by law, to bring a professional  
24 negligence lawsuit. The law requires us to pay an  
25 expert to bring the complaint. Yes, we paid her.

1           We brought the best we can find because it's  
2           important to us, it's important to this community,  
3           and it's important to the 12 people sitting in this  
4           box that you can hear from an expert who can look at  
5           medical records, scant medical records. Scant,  
6           that's the term. I wrote on here and circled it.  
7           Scant medical records. So scant that he also  
8           testifies that we don't know -- we don't know what  
9           happened. Well, we do know what happened. They  
10          failed to apply interventions allowing Ms. Shealy to  
11          fall and break her hip. That's a breach of the  
12          standard of care. Pretty simple.

13                I told you earlier that I grew up in a family  
14          of a football coach. I played at Presbyterian  
15          College. I've been around a lot of football coaches  
16          in my life. I've heard a lot of lines. And one  
17          thing that just kept sticking out to me that I heard  
18          all through college are excuses are contagious.  
19          Ladies and gentlemen, there was an epidemic of  
20          excuses running rampant at Agape.

21                Now, with coaching, if you're really trying to  
22          achieve excellence, you try to maximize the ability  
23          and potential of your team. You try to instill the  
24          values that you believe in. And the whole goal is  
25          to work towards a positive outcome. Now, you just

1 heard a lot of evidence about things that don't  
2 really matter. Here are a few: Agape didn't do it;  
3 Dr. Margalit did. He could have ordered an  
4 intervention, but he didn't. We heard that. The  
5 disease process, we heard that, that Ms. Shealy is  
6 to blame because her mind was diseased and it was a  
7 continual progression. Well, did they get her in a  
8 condition that was better or worse? They can't have  
9 it both ways. Dr. Krusling missed it on the X-rays.  
10 We know she had hip surgery. We don't have to bring  
11 an expert in here to talk about what Dr. Krusling  
12 did wrong. That's not Ellen Lewis' job. She was  
13 transferred to Agape due to a fall that resulted  
14 from the breach of the standard of care at their  
15 nursing home.

16 Got a record, scant record, nothing to see  
17 here. Well, the law requires that records be  
18 accurate and complete. We know that wasn't the  
19 case. And, yeah, we were nit-picky and we showed  
20 you quite a few documents that were suspect. But  
21 that goes to the culture, the indifference. And  
22 that's what's important in this case. They showed  
23 you records and talked about her records at  
24 Lexington Extended Care, blamed them, wasn't our  
25 fault. We have blamed IT and printing issues that

1 the time stamps are wrong because technology in our  
2 computer didn't apply it the right way. What is  
3 that? That doesn't make any sense. The records are  
4 skewed because when we printed them for this  
5 lawsuit, the Xs were in the wrong box. Are you  
6 kidding me?

7 Ms. Utricia Shealy, she had a fall in 2008, had  
8 a fall at home. It's her fault, not our fault.  
9 Shealy family, they don't know what they're talking  
10 about. She was fine. Her mentation didn't  
11 decrease. They didn't see her in pain, but you  
12 heard the testimony that they did. Let's blame the  
13 students. Is the training adequate? Is it the  
14 teacher? No, it's the students.

15 There's one common denominator in every bit of  
16 that, and that's the defendant sitting at that table  
17 right there. That's the one common denominator.  
18 Now, excellence in coaching, you don't blame your  
19 students; you don't blame your players; you take  
20 responsibility for your actions. Now, we've heard a  
21 lot about the facts; stories, not facts. We want  
22 facts. Facts are a thing that are indisputably in  
23 the case. Reality, actuality, certainty, those are  
24 synonyms for facts.

25 The facts that we heard in this case, Agape

1       took Ms. Shealy as their patient. They accepted her  
2       under their care. They have a duty to protect her.  
3       They accepted her with her lower cognition, they  
4       accepted her with her prior hip fracture, and they  
5       promised to take care of her. We know that at 8:45  
6       in the morning on July 2nd, Dr. Margalit told them,  
7       huge fall risk. Did they take precautions after  
8       that? No.

9               We know the PT staff and the OT staff said she  
10       needs constant supervision. Now, you've heard from  
11       the defendants there were no interventions that  
12       could be applied that would keep her from falling.  
13       Well, I got one: Keep your eyes on her. That's all  
14       they had to do. You know, you heard testimony that  
15       she was 12 feet from the nurses station. That's a  
16       corporate representative who has no idea anything  
17       about this case. You didn't hear them ask  
18       Ms. McDaniel, the caretaker, how far it was from the  
19       nurses station to where she fell. Twelve feet, are  
20       you kidding me? We want facts. And the fact is at  
21       5:30 PM, she was given Ativan. She was agitated;  
22       she was confused. At some point, they pulled her  
23       towards the nurses station, so the records say,  
24       which are totally unreliable. That's assuming that  
25       the narrative in the record is actually accurate.



1       They pulled her to the nurses station and she was  
2       found on the floor.

3               Does it matter if she was walking? Does it  
4       matter if she was pulling herself up on the crown  
5       molding? No. It matters that she was found on the  
6       floor and there was no one there to witness it.  
7       That's the one intervention. Eyes-on care. All you  
8       have to do is keep tabs on her.

9               Ladies and gentlemen, this isn't a complicated  
10       case, but that doesn't mean you're not going to have  
11       difficult decisions when you go back in that jury  
12       room. Use your common sense. Use your common  
13       judgment. And I think the evidence that's been  
14       presented is overwhelming, and we believe that Ms.  
15       Shealy is entitled to a substantial verdict. Thank  
16       y'all.

17              THE COURT: All right. Ladies and gentlemen,  
18       it's now time for me to charge you on the law in  
19       this case. However, we're going to take a very  
20       short break before we do that. I'm going to send  
21       you back to your jury room. Please don't discuss  
22       the case. I'll have you back out here in a few  
23       minutes to get started with the charge. Thank you.

24              (The jury exits the courtroom at 11:36 AM.)

25              THE COURT: We'll bring them back in about

1 eight to ten minutes.

2 (Brief recess.)

3 (The jury enters the courtroom at 11:47 AM.)

4 THE COURT: Mr. Foreman, members of the jury,  
5 it's now my duty as the trial judge to instruct you  
6 on the law applicable to this case. And in that  
7 regard, it is your duty as jurors to accept and  
8 apply the law as I now state it to you.

9 Furthermore, it is your exclusive duty to decide all  
10 of the issues of fact in this case and to determine  
11 the effect, value, weight, and truth of the  
12 evidence. All the parties have the right to expect  
13 that you will carefully consider and evaluate the  
14 evidence and apply the law of this case to it so  
15 that in the end, all the parties receive a fair and  
16 impartial trial.

17 During this trial, you and I have had separate  
18 duties to perform. As the trial judge, it is my  
19 responsibility to preside over this trial and to  
20 rule on the admissibility of evidence offered during  
21 the trial. In that regard, you're to consider only  
22 the evidence before you. Thus, you're to consider  
23 only the testimony which has been presented from the  
24 witness stand together with any exhibits admitted  
25 into the record of this case.

1           Furthermore, I have the additional duty to  
2 charge you on the law applicable in this case and in  
3 that regard, it is your duty to accept and apply the  
4 law as I now state it to you. If you have any  
5 preconceived ideas of what the law is or what you  
6 think the law ought to be and it does not agree with  
7 what I tell you the law is, you're obligated under  
8 your oath to abandon these preconceptions because  
9 you are sworn to accept the law as I now state it to  
10 you.

11           In this trial, you're the sole and exclusive  
12 judges of the facts. Do not infer that I have an  
13 opinion about the facts in this case from anything  
14 that I have said or done during the course of this  
15 trial. In this regard, the law simply does not  
16 permit me to have an opinion about the facts. As  
17 jurors, it is your duty alone to determine the  
18 effect, value, weight, and truth of the evidence  
19 presented during the course of this trial.

20           It is your job as jurors to determine the  
21 credibility or believability of the witnesses who  
22 have testified in this case. You must evaluate the  
23 evidence and determine which evidence convinces you  
24 of its truth.

25           In determining the believability of witnesses

1       who have testified in this case, you may believe one  
2       witness over many or many over one; you may believe  
3       a part of the testimony of a witness and reject the  
4       remaining part; you may believe the testimony of a  
5       witness in its entirety or reject it in full; you  
6       may consider whether the witness has an interest in  
7       the result of the trial, whether the witness was  
8       prejudice towards either party, the opportunity to  
9       have seen matters or things about which the witness  
10      may testify, and the way the witness acts on the  
11      witness stand.

12               Furthermore, I will talk about direct and  
13      circumstantial evidence. Evidence may be direct or  
14      circumstantial. Direct evidence is testimony by a  
15      witness about what the witness personally saw,  
16      heard, or did. Circumstantial evidence is indirect;  
17      in other words, it is proof of one or more facts  
18      from which one can find another fact. You may  
19      consider both direct and circumstantial evidence  
20      equally.

21               What is not evidence? The following things are  
22      not evidence and you must not consider them as  
23      evidence in deciding the facts of this case: One,  
24      statements and arguments of the attorneys; two,  
25      questions and objections of the attorneys; and

1       three, testimony that I instructed you to disregard.

2               While argument of counsel is a beneficial part  
3 of every trial, you should remember that statements  
4 made by counsel are not evidence. In presenting  
5 arguments, counsel have often referred to evidence;  
6 however, you should base your verdict on the  
7 evidence as you remember it. Therefore, if there  
8 are any conflicts between recollection of counsel  
9 about the evidence and your own recollection, you  
10 should rely on your own in understanding the  
11 evidence.

12              Objections. Attorneys are officers of the  
13 court. Attorneys have the absolute duty to bring  
14 matters to the attention of the Court by way of  
15 objection. Do not inferentially or otherwise become  
16 upset or disturbed by counsel by virtue of an  
17 objection. Our trial procedures includes the  
18 objection process as a means to control the  
19 evidence; in other words, letting in the proper  
20 evidence and keeping out the improper evidence.

21              Counsel, by objecting, are simply performing  
22 their role in the trial of the case. Once the Court  
23 makes a ruling on an objection, the jury is bound by  
24 that ruling. If the objection is sustained, then  
25 the question is improper. If the objection is

1       overruled, the question is proper.

2               In that regard, the jury must not under any  
3       circumstances derive any inference from any ruling  
4       made by the Court on objections as to any opinion  
5       the Court may have on the case. The Judge does not  
6       have an opinion on the evidence and is not entitled  
7       to an opinion under the law. The Judge is  
8       performing his role in the trial of this case. As  
9       to any questions which an objection was sustained,  
10      you must not speculate as to what the answer might  
11      have been or as to the reason for the objection.

12             The burden of proof in this case is by a  
13      preponderance of the evidence. Preponderance of the  
14      evidence simply means the greater weight of the  
15      evidence. It is evidence which, as a whole, shows  
16      that the fact sought to be proved is more likely  
17      true than not true. This can be illustrated by  
18      imagining a set of scales. When the case begins,  
19      the scales are even. After all of the evidence has  
20      been presented, if the scales remain even or tip  
21      even slightly in favor of the defendant, then the  
22      plaintiff has failed to meet their burden of proof  
23      and would not be entitled to recovery in this case.  
24      If, on the other hand, the scales tip evenly in  
25      favor of the plaintiff, the plaintiff will have met

1       their burden of proof and you should return a  
2       verdict for the plaintiff.

3               The preponderance of the evidence is not  
4       determined by the number of witnesses. Instead, it  
5       must be determined by the greater weight of all the  
6       evidence. Now, during the trial of this case, we've  
7       had deposition -- we've had testimony by way of  
8       depositions of witnesses taken outside of the  
9       courtroom. The depositions were taken in a manner  
10      prescribed by law, and you will consider the  
11      testimony from that deposition just as if the  
12      witnesses were here on the stand testifying.

13             You take this deposition testimony in  
14      connection with all other testimony and you assess  
15      the credibility of that witness from anything that  
16      is on the record that will aid you in doing so. You  
17      consider that deposition evidence along with the  
18      testimony of witnesses who have appeared in person  
19      and you determine from all the evidence in the case  
20      whether by witnesses present or by deposition or  
21      whether by exhibits in the case what the truth of  
22      this controversy is according to the facts as you  
23      find them to be and then apply the law as I give it  
24      to you.

25             The rules of evidence ordinarily do not permit

1 witnesses to testify to opinions or conclusions. An  
2 exception to this rule exists for witnesses we call  
3 expert witnesses. A witness who, by education and  
4 experience, has become an expert in some art,  
5 science, or profession may give opinion as to the  
6 subject the witness claims to be an expert in and  
7 may also give the reasons for the opinion.

8         You should consider any expert opinion given by  
9 a witness like any other evidence. Give it the  
10 weight you think it deserves. If you decide that an  
11 expert witness' opinion is not based on sufficient  
12 education and experience or if you decide that the  
13 reasons given in support of the opinion are not  
14 sound or that the opinion is outweighed by other  
15 evidence, you may disregard the opinion entirely.  
16 On expert witness testimony, it is -- an expert  
17 witness' testimony is to be given no greater weight  
18 than that of other witnesses simply because the  
19 witness is an expert and you do not have to accept  
20 an expert's opinion. Lastly, when the opinions of  
21 medical experts are relied upon to establish causal  
22 connections of negligence to an injury, the proper  
23 test to be applied is that the expert must, with  
24 reasonable certainty, state that in his or her  
25 professional opinion, the injuries complained of



1 most probably resulted from the alleged negligence  
2 of the defendants.

3 Now, ladies and gentlemen, under the  
4 constitution of this state, the jury verdict must be  
5 unanimous. Unanimity is mandated. Every single  
6 juror must agree on the jury verdict. There cannot  
7 be any divided vote in any form or fashion such as  
8 11 to 1 or 10 to 2, 9 to 3. Every single juror must  
9 agree on this jury verdict. When the foreperson  
10 writes the verdict and signs the name as the  
11 foreperson, that assures the Court that the jury  
12 verdict is unanimous.

13 Agency. A principal is responsible for the  
14 acts of his or her authorized agent when such agent  
15 is acting within the scope and course of his or her  
16 agency. In this case, the defendants are  
17 corporations. Under our law, a corporation is  
18 treated as if it were a person. It can sue and be  
19 sued in a court of law. Furthermore, a corporation  
20 may be liable for the wrongful acts or omissions of  
21 its officers, agents, or employees if they're acting  
22 within the scope of their employment or the  
23 course -- excuse me -- acting under the scope of  
24 their authority or within the scope of their  
25 employment. This is true even where the agent

1 serving the employee may be acting against the  
2 instructions of the corporate authority.

3 The corporation may also be liable for third  
4 persons for concealment, negligence, and other  
5 malfeasance and omissions of duty of the agent  
6 acting within the scope of the agency although the  
7 corporation did not authorize, participate in, or  
8 know of such misconduct. A principal is presumed to  
9 have knowledge of any and all material facts which  
10 its agents receive notice of while acting within  
11 their scope of their job duties.

12 Joint enterprise or joint venture. The  
13 plaintiff claims that the defendants were engaged in  
14 a joint venture or a joint enterprise with respect  
15 to the operation, management, or control of a  
16 nursing home. A joint venture or joint enterprise  
17 is where two or more persons combine their money,  
18 property, or time for a particular purpose and agree  
19 to share jointly in proportion to what each  
20 contributed in their profits and losses. To  
21 constitute a joint venture or joint enterprise, the  
22 defendants must have a common or joint purpose and  
23 must be acting towards the accomplishment of that  
24 purpose when they enter into the relationship. If  
25 you find that the defendants were engaged in a joint

1       venture or joint enterprise, each person or entity  
2       involved in the operation, management, or control of  
3       the nursing home is responsible for the negligence  
4       of one of the defendants in the managing of -- in  
5       managing the joint venture or joint enterprise.

6               Amalgamation of interest. The plaintiff  
7       contends that the defendants are amalgamated, that  
8       the legal distinctions between the entities are  
9       blurred, that they are, in effect, one and the same  
10      as far as their representation and operation of the  
11      nursing home and that the actions of one should  
12      apply to the other.

13             Negligent supervision. An employer can be  
14      liable for negligent hiring and employment by  
15      failing to select an employee fit or competent to  
16      perform the services of employment. The basis of  
17      responsibility under the negligent hiring doctrine  
18      is the master's own negligence in hiring an  
19      incompetent servant who the master or employer knew  
20      or should have known by the exercise of reasonable  
21      or ordinary care should have known was incompetent  
22      or unfit, thereby creating an unreasonable risk of  
23      harm to another.

24             If an employer is in some way negligent in  
25      hiring, supervising, retaining, or assigning of an

1 employee or agent with the knowledge that the  
2 employee or agent is in some way unfit, incompetent,  
3 or unworthy to perform the work of the employer, or  
4 if the employer fails to use the same degree of care  
5 that normally would be required to discover this  
6 unfitness, such as negligent supervision or  
7 negligent hiring, constitutes an independent basis  
8 for liability of the master if it is shown by the  
9 greater weight of the evidence.

10 Negligence. The plaintiff claims that the  
11 defendants were negligent and should compensate the  
12 plaintiff -- excuse me. The plaintiffs claim the  
13 defendants were negligent and should compensate the  
14 plaintiff for injuries that the plaintiff suffered  
15 as a result of the defendant's negligence.

16 A plaintiff's right of recovery may not rest on  
17 the mere fact that an accident or injury occurred.  
18 Instead, in order to prove that the defendants were  
19 negligent, the plaintiff must prove by a  
20 preponderance or greater weight of the evidence the  
21 following things: First, the plaintiff must prove  
22 by a preponderance or greater weight of the evidence  
23 that the defendants owed the plaintiff a duty of  
24 care. This is a question of law which I decide, and  
25 I decide that there was a duty of care. You must

1       now decide the remaining questions. The first of  
2       these is whether the plaintiff has proven by a  
3       preponderance or greater weight of the evidence that  
4       the defendants breached the duty of care by  
5       negligence act or omission.

6               Negligence means a person has done something  
7       that a reasonable person would not have done or has  
8       failed to do something that a reasonable person  
9       would have done in the same situation. The  
10      plaintiff must also prove by the preponderance or  
11      greater weight of the evidence that she suffered  
12      damages as a result of the defendant's breach of  
13      duty.

14             Finally, the plaintiff must prove by a  
15      preponderance or greater weight of the evidence that  
16      the damages were proximately caused by the  
17      defendant's breach of duty. There's no  
18      countervailing burden on the defendants to prove  
19      that their negligence did not cause the plaintiffs  
20      injuries. Proximate cause is something that  
21      produces a natural chain of events which, in the  
22      end, brings about the injury. It is the direct  
23      cause of the injury.

24             To prove that the defendants' negligence  
25      proximately caused the plaintiff's injury, the

1 plaintiff must first prove causation in fact. This  
2 is proven by showing that the injury would not have  
3 occurred but for the defendant's negligence. The  
4 plaintiff must also prove legal cause. Legal cause  
5 is proven by showing that the injury was  
6 foreseeable. This means that the injury occurred is  
7 a natural and probable consequence of the  
8 defendants' negligence. The plaintiff must prove  
9 that some injury from the defendants' negligence was  
10 foreseeable, but it does not have to prove that the  
11 particular injury that occurred was foreseeable.  
12 However, the defendants cannot be held responsible  
13 for things that could not be expected to happen.

14 Proximate cause does not mean the only cause.  
15 The defendants' act can be a proximate cause of the  
16 plaintiff's injury if it was at least one of the  
17 direct and concurring causes of the injury.  
18 However, the real cause of the claimed injury or  
19 damage is left in doubt by the testimony --  
20 correction: However, if the real cause of the  
21 claimed injury or damage is left in doubt by the  
22 testimony, the plaintiff has not met her burden of  
23 proof.

24 I charge you that when the cause of plaintiff's  
25 injuries may be reasonably attributed to an act for

1       which the defendants are not liable as to one for  
2       which they are liable, the plaintiff has failed to  
3       carry the burden of establishing that her injuries  
4       were the proximate result of defendants' negligence  
5       and the verdict must be for the defendants.

6               Professional negligence. In addition to  
7       ordinary negligence, ordinary negligence in this  
8       case, we're dealing with a special type of  
9       negligence. It is professional negligence. So  
10      you'll take the general definition of negligence or  
11      carelessness and put it into the proper perspective  
12      as I specifically now define for you and give you  
13      the law as it relates to professional negligence.

14             Professional negligence is a particular form of  
15      negligence that consists of not applying to the  
16      exercise of the practice of nursing care that that  
17      degree of care and skill which is ordinarily  
18      employed by the profession generally under similar  
19      circumstances -- under similar conditions and under  
20      like surrounding circumstances.

21             In a case of this nature, professional  
22      negligence is a failure to do that which an  
23      ordinary, careful, prudent, skilled nursing home  
24      would do under the circumstances shown by the  
25      evidence to have existed at the time in question or

1       it is the doing of that which an ordinary, careful,  
2       and prudent skilled nursing home would not have done  
3       under the existing circumstances.

4               To recover from professional negligence, the  
5       plaintiff must show a failure by a nursing home to  
6       exercise that degree of care and skill. A  
7       professional negligence case must involve charges of  
8       deviation from the standard of care. I charge you  
9       that professional negligence on the part of a  
10      nursing home facility is not presumed but must be  
11      affirmatively proven. I told you earlier that the  
12      burden of proof is on the plaintiff to prove the  
13      case by a preponderance or the greater weight of the  
14      evidence.

15             In the absence of evidence from the contrary,  
16      it will be presumed that the nursing home has  
17      discharged its duty in full to the patient,  
18      including the exercise of reasonable care in skill  
19      and treatment. If the opinions of experts are  
20      relied on to establish proximate cause, the expert  
21      must state with reasonable certainty that, in his or  
22      her professional opinion, the plaintiff's injuries  
23      most probably resulted from the negligence of the  
24      defendants. It is not necessary that the expert use  
25      the words most probably, but is enough for the



1 expert to state that it is the expert's professional  
2 opinion that the defendants' negligence was most  
3 likely among the possible causes of the plaintiff's  
4 injuries.

5 Because many professional negligence suits  
6 involve ailments and treatments outside the realm of  
7 ordinary lay knowledge, expert testimony is  
8 generally necessary under our law. A witness who  
9 has special knowledge, skill, experience, training  
10 in a particular field, profession, or occupation may  
11 give his or her opinion as an expert once that  
12 expert has been qualified as an expert.

13 The general rule is that the expert testimonies  
14 require the professional negligence in a case to  
15 show the defendant failed to conform to a required  
16 standard. There is an exception to the expert  
17 testimony requirement in situations where the common  
18 knowledge or experience of laymen is extensive  
19 enough to recognize or to infer negligence from the  
20 facts.

21 Accordingly, in a professional negligence case,  
22 the plaintiff must establish by expert testimony  
23 both the required standard of care and the  
24 defendant's failure to conform to that standard,  
25 unless the subject matter lies within the ambit of

1 common knowledge or experience so that no special  
2 learning is needed to evaluate the defendants'  
3 conduct. When the expert testimony is the only  
4 evidence of proximate cause relied upon, it must  
5 provide a significant causal link between the  
6 alleged negligence and the plaintiff's injuries  
7 rather than a tenuous or hypothetical connection.

8 You must determine the standard of  
9 professional, learning, skill, and care required of  
10 the defendants only from the opinions of the  
11 witnesses who have testified as expert witnesses as  
12 to such a standard. You must not attempt to  
13 determine this question from any personal knowledge  
14 you have where the plaintiff is required to use  
15 expert testimony to establish, recognize practices  
16 and procedures if the matter is within special  
17 knowledge or expertise of medical practitioners.

18 The words recklessness, willfulness, and wanton  
19 are synonymous. The terms are used to describe a  
20 conscious failure to exercise and observe reasonable  
21 or due care. Recklessness implies that doing a  
22 negligent act knowingly. When a person acts  
23 negligently and he realizes that he's acting  
24 negligently, the law says he's reckless, willful,  
25 and/or wanton, whichever term you prefer. They all

1 mean the same thing, that it is a conscious failure  
2 to exercise due care. Recklessness is distinguished  
3 from negligence.

4 Negligence is failure to use due care.  
5 Negligence is carelessness. Negligence is failure  
6 by omission or commission to exercise due care as a  
7 person of ordinary reason and prudence would  
8 exercise in the same circumstances. Recklessness is  
9 a higher degree of culpability and responsibility.  
10 Recklessness signifies a conscious failure to  
11 exercise due care. Recklessness is a conscious  
12 indifference to the rights of the plaintiff or  
13 reckless disregard for the rights of the plaintiff.  
14 Recklessness is an awareness of wrongful conduct and  
15 a continuation to act regardless of the  
16 consequences.

17 In other words, while a negligent person is one  
18 who acts carelessly, a person whose behavior is  
19 reckless and willful or wanton is not only careless  
20 of his or her actions, but is also aware that he or  
21 she is careless. The test for determining whether a  
22 tort may be deemed reckless, willful, or wanton is  
23 whether it is being committed in such a manner and  
24 under such circumstances that a person of ordinary  
25 reason and prudence would have been conscious of it

1 as an invasion of a person's rights as the injured  
2 party.

3 Negligence per se. Where a duty arises from a  
4 statute and regulation, the plaintiff shows that the  
5 defendants violated the statute or regulation, the  
6 violation is negligence per se. The violation of  
7 any of the provisions of a statute is negligence per  
8 se. That is negligence in and of itself.  
9 Negligence is a matter of law.

10 Negligence per se simply means you, the jury,  
11 do not decide if the defendants acted as what a  
12 reasonable person would in the circumstances. The  
13 statute fixes the standard of conduct required of  
14 the defendants, leaving you merely to decide whether  
15 the defendants breached the statute. If they did,  
16 their failure to take due care is established as a  
17 matter of law. The only issue then left for you to  
18 determine is whether the defendant's conduct in  
19 violation of that statute or regulation proximately  
20 caused damage to the plaintiff.

21 Accordingly, proof of a violation of a statute  
22 or regulation is, in fact, proof of negligence so  
23 that your only concern -- your only concern then  
24 would be whether such a violation of the statute was  
25 the proximate cause of the injury and damage. The

1 violation of a statute or regulation in support of  
2 recovery of damages if such a violation proximately  
3 caused or proximately contributed to the injuries or  
4 damages complained of.

5 During the trial you have heard and read  
6 various statutes, rules, and regulations that you  
7 may consider in evaluating whether a particular  
8 statute, rule, or regulation was violated by the  
9 defendants. Rather than reading them to you one by  
10 one, they will be provided in the evidence being  
11 sent to the jury room with you.

12 Standard of care of a nursing home. Nursing  
13 homes owe their residents ordinary care and protect  
14 residents from any danger or injury which might  
15 reasonably -- be reasonably anticipated. As to  
16 dangers reasonably to be anticipated from acts of  
17 others, persons under the facility's control,  
18 reasonable care and attention must be exercised for  
19 the safety and well-being of the facility's  
20 residents if a portion of the circumstances and the  
21 resident's ability to look after their own safety.

22 A nursing home is required to assess and  
23 exercise that degree of skill and learning which is  
24 ordinarily possessed and exercised by nursing homes  
25 practicing in the same or similar circumstances and

1 the failure to perform their duty and either of such  
2 constitutes negligence. Where there is greater  
3 danger of hazard, there must be a corresponding  
4 exercise of attention for the purpose of preventing  
5 injury to another to exercise ordinary care.

6 The standard of care expected of a nursing  
7 professional is based on a national standard, not a  
8 local standard. It's the standard of care of the  
9 nursing profession generally which is broader than  
10 the degree of care and skill ordinarily employed by  
11 the profession in the immediate locality.

12 Since the locality rule does not apply, an  
13 expert witness giving testimony in a nursing home  
14 abuse and neglect case does not need to have  
15 personal knowledge of the standards of practice in  
16 the community where the alleged negligence occurred.

17 Violations of industry standards. Defendants'  
18 violation of an industry standard may be considered  
19 as evidence of negligence as such violations may be  
20 relevant on the issue of the defendants' failure to  
21 exercise due care and may form a determination as to  
22 what was reasonable under the circumstances.

23 Here, Plaintiff contends the defendants  
24 violated industry standards. In such a case, you  
25 may consider the industry standard, the purpose for

1       which the standard was developed, and the  
2       defendants' compliance or lack of compliance for the  
3       standard.

4               Violations of policies and procedures. A  
5       defendant's violations of its own internal policies,  
6       procedures, and rules may be considered as evidence  
7       of negligence as such violations may be relevant to  
8       the issue of a defendant's failure to exercise due  
9       care and may inform your determination as to what  
10      was reasonable under the circumstances. In such a  
11      case, you may consider the policy, procedure, or  
12      rule, the purpose for which it was developed, and  
13      the defendant's compliance or lack of compliance  
14      with the policy, procedure, or rule.

15             Violation of statute, ordinance, or regulation.  
16      Plaintiff claims that the defendants failed to  
17      follow the nursing home laws and regulations. The  
18      violation may be considered in connection with all  
19      other facts and circumstances surrounding the case  
20      in determining whether the defendant has been  
21      negligent, including reckless, willful, or wanton  
22      conduct.

23             Violation of a rule or regulation which is  
24      designed primarily for the safety of nursing home  
25      residents will constitute ordinary negligence if the

1 violation proximately results in the injury.

2 Negligence, unavoidable accident. An injury  
3 may be caused by an unforeseen mishap that is not  
4 caused by or contributed to by the negligent conduct  
5 of a person. Such a mishap is called an unavoidable  
6 accident and any loss or injury that results from  
7 it, no matter how grievous, must be allowed to  
8 remain where it has fallen. There can be no  
9 recovery of damages from an unavoidable accident.

10 To constitute an unavoidable accident, the  
11 event must have occurred without negligence of any  
12 party to the accident or if either the plaintiff or  
13 the defendant or persons whose negligence will be  
14 imputed to you. An unavoidable accident is an  
15 occurrence which was not intended and could not have  
16 been foreseen, prevented, or avoided by the exercise  
17 of reasonable caution and ordinary care.

18 An unavoidable accident is the happening of an  
19 event free from human agency such as an act of God  
20 or it may be the happening of an event where a human  
21 agency is present and, in which case, if the human  
22 acts were not negligent acts, then it is regarded in  
23 the law as unavoidable accident.

24 Any unforeseen event, loss, act, or omission  
25 resulting solely from the operations of the human



1       agency which is not caused by negligence or  
2       misconduct may be defined as an unavoidable  
3       accident. The burden is upon the plaintiff to show  
4       that the injuries she complains of were not the  
5       result of an unavoidable accident. The mere fact  
6       that an accident happened standing alone does not  
7       permit you to assume that someone may have caused  
8       it.

9               Actual damages. If you decide that the  
10       plaintiff is entitled to a verdict, your next step  
11       would be to decide how much money the defendants  
12       should be required to pay. Actual damages are to  
13       compensate the plaintiff for the plaintiff's  
14       injuries or loss and to put the plaintiff in as near  
15       as possible or the same position that the plaintiff  
16       was in before the incident occurred.

17       In other words, actual damages would be the  
18       actual losses and expenses which the plaintiff has  
19       suffered because of the defendant's negligence. In  
20       personal injury actions, the general rule is that  
21       the plaintiff may recover the necessary and  
22       reasonable expenses caused by the injury such as the  
23       amounts necessarily incurred for medicine, medical  
24       services, hospital expense and care, and nursing. A  
25       person who suffers personal injuries because of the

1 negligence of another is entitled to recover the  
2 reasonable value of the medical care and expenses  
3 incurred for the treatment of the injuries to the  
4 time of trial as well as the costs of those  
5 reasonably certain to be incurred in the future.

6 Accordingly, a plaintiff may recover amounts  
7 incurred for past and future medical care, including  
8 hospital, physician, and other nursing care costs,  
9 medicine and other out-of-pocket and anticipated  
10 expenses such as vocational, physical, and other  
11 rehabilitation efforts. Recovery from medical  
12 expenses is controlled by what the services rendered  
13 were reasonably worth, not by what was actually paid  
14 or contracted to be paid.

15 You determine from the evidence under the law  
16 as I have instructed you that the plaintiff is  
17 entitled to recover damages, including medical,  
18 hospital, or other healthcare costs, and the  
19 plaintiff can only recover such sums you determine  
20 from the evidence to be both reasonable and  
21 necessary. While the amount actually charged or  
22 incurred may be considered by you, you're not bound  
23 by that amount. You must find only such sum as is  
24 reasonable and necessary to recover future medical  
25 expenses. The plaintiff must prove such expenses

1 are reasonably certain to result in the future from  
2 injury giving rise to the lawsuit.

3 Pain and suffering. Pain and suffering  
4 compensates the plaintiff for the physical  
5 discomfort and emotional response to the sensation  
6 of pain caused by the injury itself. There's no  
7 definite standard by which to compensate the  
8 plaintiff for pain and suffering. You have the  
9 authority to determine the amount, if any, to be  
10 allowed for pain and suffering using calm and  
11 reasonable judgment to ensure that the damages are  
12 just and reasonable in light of the testimony and  
13 evidence in this case.

14 Mental suffering. Mental suffering,  
15 apprehension, shock, fright, emotional upset,  
16 humiliation, and anxiety either present or expected  
17 in the future can also be properly considered as an  
18 element of damages. The amount of damages for  
19 mental suffering cannot be exactly measured.

20 Loss of enjoyment of life compensates the  
21 plaintiff for limitations in the plaintiff's ability  
22 to participate in and derive pleasure from the  
23 normal activities of daily life.

24 Punitive damages. If you award actual damages,  
25 you may also consider an award for punitive damages.

1 Punitive damages are intended to punish a defendant  
2 for extraordinarily or outrageous misconduct and to  
3 prevent a defendant and others from committing  
4 similar acts in the future. Punitive damages can  
5 only be awarded when the conduct of a defendant is  
6 something more than mere negligence. The evidence  
7 must establish that the defendant's acts were  
8 reckless, willful, and wanton, meaning there was a  
9 conscious failure to exercise due care or a  
10 conscious indifference to the rights and safety of  
11 others or reckless disregard thereof.

12 If you find that the defendant's conduct was  
13 willful, wanton, or reckless, you may award the  
14 plaintiff punitive damages. To support an award for  
15 punitive damages, the plaintiff must prove by clear  
16 and convincing evidence that the conduct complained  
17 of included a consciousness of wrongdoing at the  
18 time of the conduct.

19 Clear and convincing is more than just a  
20 preponderance or greater weight of the evidence  
21 which requires only proof that persuades you that a  
22 party's claim is more likely than not true. On the  
23 other hand, clear and convincing evidence proof is  
24 not as high as the standard of the burden in  
25 criminal cases which is proof beyond a reasonable

1       doubt. Clear and convincing proof leaves no  
2       substantial doubt in your mind. It means that the  
3       evidence is not indigenous, doubtful, equivocal, or  
4       contradictory. Convincing means persuaded by proof  
5       or argument causing one to believe the truth of what  
6       is asserted. Clear and convincing proof establishes  
7       in your mind not only that the fact is probable,  
8       but, in fact, that it is highly probable.

9               Depending on whether or not you find that the  
10       plaintiff is owed punitive damages, you may have one  
11       or more jury deliberation after this one. I will  
12       not tell you which verdict will render the need for  
13       one -- one -- the need for another jury  
14       deliberation.

15              Preexisting condition. The fact that a person  
16       is more susceptible to injury or death because of a  
17       preexisting condition does not serve to excuse an  
18       otherwise negligent defendant who has caused the  
19       injury or allowed the injury to happen when there is  
20       a duty to act to prevent it. A negligent defendant  
21       takes his or her plaintiff as he finds them, whether  
22       the plaintiff be in perfect health or poor health or  
23       somewhere in between. An injured person is entitled  
24       to recover all damages caused by a defendant's  
25       negligence.

1           When the plaintiff's preexisting physical or  
2           mental condition is aggravated or activated by a  
3           subsequent act, the defendant is liable to the  
4           extent that his or her wrongful act proximately and  
5           naturally aggravated or activated the plaintiff's  
6           preexisting condition. A defendant who causes  
7           injuries to a plaintiff with a preexisting condition  
8           must take the plaintiff as he or she finds them.  
9           Although not responsible for the preexisting  
10          condition itself, he's liable for any exacerbation  
11          of it caused by his tortious conduct.

12          A plaintiff can recover for preexisting  
13          injuries only to the extent that they were  
14          aggravated by the defendant's actions. Any portion  
15          of the injuries which is not caused by an act or  
16          omission on the part of the defendant is not  
17          compensable. You can award damages for any  
18          aggravation of any preexisting condition not from  
19          the original injury itself.

20          If you find that the plaintiff received an  
21          injury as a result of the negligence of the  
22          defendant so that he is entitled to recover for said  
23          injuries, the fact that he had a preexisting defect  
24          would not defeat his recovery.

25          It is the law of this state that one who

1 negligently inflicts personal injury on another is  
2 responsible for all ill effects which in considering  
3 the condition or health in which the plaintiff was  
4 when he received the injury naturally and  
5 necessarily follow such injury. Hence, the  
6 defendant's liability is in no way lessened or  
7 affected by reason of the fact that the injury would  
8 not have resulted had the plaintiff been in good  
9 health or that they were aggravated or rendered more  
10 difficult to cure by reason of the fact that she was  
11 not in good health. In other words, if the presence  
12 of a disease or existing physical condition  
13 aggravates or prolongs the injury and  
14 correspondingly increases the damages, such  
15 increased or added damages may be recovered.

16 The collateral source rule provides that  
17 compensation received by an injured party from a  
18 source wholly independent of the wrongdoer will not  
19 reduce the amount of damages owed by the wrongdoer.  
20 In other words, under the collateral source rule, if  
21 an injured plaintiff receives compensation for her  
22 injuries from a source wholly independent of a  
23 defendant, the payment should not be deducted from  
24 the damages which she would otherwise collect from  
25 the defendant. A defendant is not entitled to have

1 the damages for which the defendant is liable  
2 reduced by proving the plaintiff has received or  
3 will receive compensation or indemnity from the loss  
4 of a collateral source wholly independent of the  
5 defendant. A defendant may not benefit from the  
6 fact that a plaintiff has received money from other  
7 sources as a result of the defendant's wrongful  
8 conduct. The only requirement for qualification as  
9 a collateral source is that the source be wholly  
10 independent of the wrongdoer. A source is wholly  
11 independent of the wrongdoer when the wrongdoer has  
12 not contributed to it and when payments to the  
13 injured party were not made on behalf of the  
14 wrongdoer.

15 In applying the collateral source rule, South  
16 Carolina allows the plaintiff the benefit of both  
17 gratuitous benefits and nongratuitous benefits  
18 arising from employment, insurance, and other  
19 contractual agreements. A benefit directed to an  
20 injured party should not be shifted so as to result  
21 in a windfall for the wrongdoer. The wrongdoer may  
22 not be benefited by collateral payments made to the  
23 person he has wronged. It is the wrongdoer's  
24 responsibility to compensate the injured party for  
25 all the harm that he causes, not the net loss the



1       injured party receives. A defendant cannot take  
2       advantage of payments or services rendered by a  
3       collateral source for the plaintiff's benefit,  
4       irrespective of whether the source is an insurance  
5       company, an employer, family member, or other  
6       source. A negligent defendant is not entitled to  
7       enjoy the fruits of fortuitous circumstances,  
8       employer generosity, or diligent effort on the part  
9       of an injured plaintiff.

10             The fact that the plaintiff received gratuitous  
11       medical care, continued salary or wage payments,  
12       proceeds from insurance policies, welfare and any  
13       pension benefits will not be taken into account when  
14       computing damages.

15             In closing, let me say something about your  
16       deliberations. Deliberation is defined as careful  
17       consideration, weighing up with a view to decision.  
18       The genius of our jury system is that it allows 12  
19       good men and women from 12 different backgrounds,  
20       life experiences, and perspectives to consider the  
21       evidence, talk about it, and ultimately reach a  
22       verdict.

23             We call them deliberations for a reason.  
24       You're to consider the evidence in this case  
25       carefully and deliberately and discuss it in a calm,

1       thorough, and courteous manner. Listen to the views  
2       of all your fellow jurors, consider other people's  
3       points and points of view, talk and talk through and  
4       discuss the evidence. And, remember, if you are  
5       doing something deliberately, you are not in a big  
6       hurry. You should not be put in a hurry here. This  
7       case is very important to both sides and this is  
8       their only day in court.

9               When you retire to the jury room, you should  
10       discuss the case with your fellow jurors to reach  
11       agreement, if you can do so. Your verdict must be  
12       unanimous. Each of you must decide the case for  
13       yourself, but you should do so only after you have  
14       impartially considered all the evidence, discussed  
15       it fully with your other jurors, and listened to the  
16       views of your fellow jurors.

17              Do not be afraid to change your opinion if the  
18       discussion persuades you that you should, but do not  
19       come to a decision simply because other jurors think  
20       it is right. It is important that you attempt to  
21       reach a unanimous verdict but, of course, only if  
22       each of you can do so after having made your own  
23       decision. Do not change an honest belief about the  
24       weight -- an honest belief about the weight of the  
25       evidence simply to reach a verdict. In other words,

1 do not change your opinion solely for the sake of  
2 reaching a unanimous verdict.

3 Ladies and gentlemen, your verdict must be a  
4 unanimous one. Mr. Foreperson, when the jury agrees  
5 on a verdict, you will write the verdict on the  
6 verdict form and sign your name as foreperson. Then  
7 knock on the jury door and inform the bailiff that  
8 you've reached a verdict. At that time, we'll  
9 receive you back in the courtroom. I will give you  
10 a copy of these instructions in written form.  
11 During your deliberations, you may refer to the  
12 instructions to guide your decisionmaking. You must  
13 consider the instructions as a whole and not follow  
14 some any more than others. Please return the  
15 instructions to the Court at the time your verdict  
16 is reached.

17 Ladies and gentlemen, at this point I'm going  
18 to ask you to go back to your jury room and not  
19 discuss the case. I have a few things that I have  
20 to -- I have to just make sure I haven't said  
21 anything wrong in my instruction to you with  
22 attorneys. But after that, momentarily, I expect  
23 that we'll get you the evidence, the verdict form,  
24 and all the materials you need to begin your  
25 deliberations. But at this time, I'd ask you to

1 return to your jury room and please do not discuss  
2 the case yet. Thank you.

3 (The jury exits the courtroom at 12:29 PM.)

4 THE COURT: Since we agreed on the charge  
5 yesterday, I don't expect an objection, but I  
6 thought I'd say that out of an abundance of caution.

7 MR. BLAKE: You had one misread that's somewhat  
8 substantial. You had a misread that even slightly  
9 in favor of the defendant came out evenly.

10 MR. CONNOR: It's under preponderance of the  
11 evidence.

12 THE COURT: All right. I mean --

13 MR. CONNOR: Just recharge them on it.

14 THE COURT: Preponderance of the evidence, the  
15 whole charge?

16 MR. MCALISTER: Second to last paragraph of  
17 page 5.

18 MR. CONNOR: You said, if, on the other hand,  
19 the scales tip -- you said evenly in favor instead  
20 of even slightly.

21 THE COURT: Okay. All right. Thank you for  
22 catching it.

23 Okay. Bring them back in, please.

24 (The jury enters the courtroom at 12:31 PM.)

25 THE COURT: Ladies and gentlemen, I did misread

1 a portion of one of the charges, so I'm going to  
2 read it to you again. I will charge you now on  
3 preponderance of the evidence.

4 The burden of proof in this case is by a  
5 preponderance of the evidence. A preponderance of  
6 the evidence simply means the greater weight of the  
7 evidence. It is evidence which, as a whole, shows  
8 that the fact sought to be proved is more likely  
9 true than not true. This can be illustrated by  
10 imagining a set of scales. When the case begins,  
11 the scales are even. After all of the evidence has  
12 been presented, if the scales remain even or if they  
13 tip even slightly in favor of the defendant, then  
14 the plaintiff has failed to meet the burden of proof  
15 and would not be entitled to recover in this case.

16 If, on the other hand, the scales tip even  
17 slightly in favor of the plaintiff, the plaintiff  
18 will have met the burden of proof and you should  
19 return a verdict for the plaintiff. The  
20 preponderance of the evidence is not determined by  
21 the number of witnesses; instead, it must be  
22 determined by the greater weight of all of the  
23 evidence.

24 Ladies and gentlemen of the jury, at this time,  
25 I'll send you back to your jury room. Thank you.

1 (The jury exits the courtroom at 12:33 PM.)

2 THE COURT: Thank you both for bringing that  
3 up. All right. Anything else before we -- at this  
4 point, I've got the verdict form, the charge I just  
5 read, and the box of evidence. That's it; right?

6 MR. CONNOR: Yes, sir.

7 MR. BLAKE: Yes, sir.

8 MR. CONNOR: Just don't forget about the  
9 alternate.

10 THE COURT: Oh, yeah. Let's bring the  
11 alternate back in.

12 (Alternate Juror enters the courtroom at 12:33  
13 PM.)

14 THE COURT: We're at the point now where the  
15 jury is about to begin their deliberations.  
16 Fortunately or unfortunately, depending on how you  
17 feel at this point, you have served your duty as an  
18 alternate juror. And at this point, we've used one,  
19 but we didn't need the second, so you're free to go  
20 at this time. You're free to stay and watch.  
21 You're free to stay in the courtroom. You're free  
22 to speak to the attorneys on either side, if you  
23 wish. If you don't wish to do that, that's totally  
24 okay too. We all want to thank you for your service  
25 this week. We know it's been a long week. It means

1 a lot that you were here and we thank you very much.  
2 But you're free to go any time you'd like.

3 (Alternate Juror excused.)

4 THE COURT: All right. Y'all come make sure we  
5 have all the exhibits in order.

6 (The jury begins deliberations 12:40 PM - 2:53  
7 PM.)

8 THE COURT: All right. So the question I've  
9 received from the jury states: Why is it necessary  
10 to distinguish between ordinary or professional  
11 negligence? That's it.

12 I'll mark it as an exhibit. I want to just --  
13 frankly, read the charge. I don't want to -- I  
14 think we can take a notepad and we can write  
15 something out and I can answer it to them in the  
16 room or I can bring them in here, if you prefer.

17 MR. CONNOR: Whatever Your Honor --

18 THE COURT: Let's agree on something in writing  
19 and then put it on the record and I'll walk back  
20 there and state it and walk away.

21 MR. BLAKE: That's perfect.

22 THE COURT: Let's go off the record for a  
23 minute, please.

24 (Off-the-record discussion.)

25 (Brief recess 2:54 PM - 3:07 PM.)

1           THE COURT: I've just met with the attorneys  
2           regarding Court's response to question 1. I typed  
3           up, with input from both attorneys, the response to  
4           Jury Question 1 which provides: Plaintiff has  
5           asserted claims of both ordinary and professional  
6           negligence. Your job is to consider the evidence,  
7           and if you find that liability is warranted under  
8           both claims, then you must allocate the portion of  
9           damage between ordinary and professional negligence.  
10          And that ends it. Okay?

11          All right. I'm going to take the note to the  
12          jury. The attorneys can come with me to listen to  
13          me read it to them.

14          (The Court and both Counsel exit the courtroom  
15          at 3:13 PM.)

16          (The Court and both Counsel enter the courtroom  
17          at 3:14 PM.)

18          THE COURT: All right. I have read my response  
19          to the jury. We'll continue to hang out.

20          (The jury continues deliberations 3:14 PM -  
21          4:41 PM.)

22          THE COURT: All right. Ladies and gentlemen,  
23          I'm informed we have a verdict. Is that correct?  
24          All right. Bring the jury in.

25          THE COURT: Mr. Foreman, good afternoon. I



1 understand you have reached a verdict.

2 THE FOREMAN: Yes, sir.

3 THE COURT: Is your verdict unanimous?

4 THE FOREMAN: Yes, sir.

5 THE COURT: Please hand your verdict form to  
6 the bailiff.

7 Madam Clerk, please publish the verdict form.

8 THE CLERK: 2016-CP-32-950, Amy S. Davis as  
9 Personal Representative for the Estate of Utricia  
10 Shealy vs. Agape Nursing & Rehabilitation Center,  
11 Agape Management Services, John Doe, Richard Roe,  
12 Jane Doe, and Mary Doe Corporation. A, on the  
13 claims of Plaintiff against Defendant Agape Nursing  
14 & Rehabilitation Center, Inc., for Ms. Utricia  
15 Shealy's injuries, we the jury in the  
16 above-referenced case find in favor of the  
17 plaintiff.

18 On the claims of Plaintiff against Defendant  
19 Agape Management Services, Inc., for Ms. Utricia  
20 Shealy's injuries, we the jury in the  
21 above-referenced case find in favor of the  
22 plaintiff.

23 If you found in favor of the plaintiff, what is  
24 the total amount of damages to be awarded? \$47,500  
25 as compensation for Ms. Shealy's medical expenses

1 and other economic damages, \$250,000 as compensation  
2 for Ms. Shealy's physical and mental pain and  
3 suffering, apprehension, shock, fright, emotional  
4 upset, humiliation, anxiety, loss of enjoyment of  
5 life, disability, disfigurement, and other  
6 noneconomic damages.

7 Do you find the defendants were engaged in a  
8 joint enterprise/joint venture or agents of one  
9 another or were amalgamated? The jury checked yes.

10 If you answered yes as to the above damages,  
11 what percentage of damages do you attribute to  
12 Defendants' ordinary and professional negligence?  
13 65 percent for ordinary negligence, 35 percent for  
14 professional negligence. Total must equal 100  
15 percent.

16 Section D: Do you find by clear and convincing  
17 evidence that the actions or omissions of Defendants  
18 were reckless or in conscious disregard of Ms.  
19 Shealy's condition or medical needs? The jury  
20 checked no. The verdict form is signed and dated by  
21 the jury foreperson.

22 THE COURT: Thank you, Madam Clerk.

23 Anything from counsel?

24 MR. CONNOR: Nothing from the plaintiff, Your  
25 Honor.

1           THE COURT: Ladies and gentlemen, I want to  
2           thank you for your service this week and this  
3           afternoon during your deliberations. Your service  
4           is absolutely vital to our civil justice system. I  
5           speak on behalf of the attorneys, the parties, the  
6           bailiffs, the clerks, and everyone in the  
7           courthouse, we thank you for your service here this  
8           week. At this point, your service has been rendered  
9           and is much appreciated and you're free to go at  
10          this time.

11          I will ask that you go back to your jury room  
12          so I can come speak to you momentarily. Thank you.  
13          One other thing I should have said: Obviously now  
14          you may talk about the case. And some of the  
15          attorneys may or someone may contact you to speak  
16          about the case. Whether you talk to them or not  
17          talk to them, that is entirely up to you. You may  
18          do so if you choose. Thank you.

19          (The jury exits the courtroom at 4:49 PM.)

20          THE COURT: Assuming everybody was okay with  
21          it, I'm just going to speak to them and shake their  
22          hands on the way out.

23          MR. CONNOR: We do have another motion, Your  
24          Honor.

25          THE COURT: Okay.

1           MR. CONNOR: At this time, Plaintiff moves for  
2 attorney's fees in accordance with Section  
3 15-35-400. And February 1st of 2017, Plaintiffs  
4 offered -- or filed an offer of judgment pursuant to  
5 that Statute 15-35-400 in an amount of \$150,000.  
6 The defendants had 20 days to respond to that offer  
7 and failed to do so. That should be on record with  
8 the court, but I would like to attach it as an  
9 exhibit to today's proceedings.

10           THE COURT: Very well.

11           MR. CONNOR: And then I'd seek 30 days to file  
12 a formal motion, if that's acceptable.

13           THE COURT: Certainly.

14           MR. BLAKE: For the record, he said attorney's  
15 fees. I think he means costs.

16           MR. CONNOR: No. It's for fees and costs.  
17 It's a --

18           MR. BLAKE: It's not fees under that statute;  
19 it's just costs.

20           THE COURT: I don't have the statute in front  
21 of me.

22           MR. CONNOR: Well, for whatever relief is  
23 permissible under the rule, Your Honor.

24           THE COURT: All right.

25           MR. BLAKE: Your Honor, we have ten days to do

1 post-trial motions?

2 THE COURT: The Court will allow ten days for  
3 post-trial motions and you're obviously allocated  
4 time to supplement the offer of judgment you just  
5 discussed.

6 MR. CONNOR: Yes, sir. Thank you.

7 THE COURT: Anything else?

8 MR. BLAKE: That's it, Your Honor.

9 THE COURT: I compliment the counsel on a tough  
10 trial and a long week. I thought both sides did a  
11 good job. And to the family, best of luck to you in  
12 the future. And we're adjourned.

13 -- END OF TRANSCRIPT OF RECORD --

14

15

16

17

18

19

20

21

22

23

24

25