1 THE STATE OF OHIO,)
) SS: WILLIAM J. COYNE, J.
2 COUNTY OF CUYAHOGA.)

3 IN THE COURT OF COMMON PLEAS

4 CIVIL BRANCH

5 ESTATE OF LEONA MAXIM BY)
CHRISTINE GUEST, EXECUTOR,)
6)
Plaintiff,)
7)
-v-) Case No. CV 15 845038
8)
)
9 KINDRED NURSING & REHAB -)
STRATFORD, et al.,)
10)
Defendants.)
11
- - - o0o - - -
12 TRANSCRIPT OF PROCEEDINGS
- - - o0o - - -
13
Whereupon the following proceedings
14 were had in Courtroom No. 3-A, Lakeside
Courthouse, Cleveland, Ohio, before the
15 Honorable William J. Coyne, commencing on
Tuesday, October 11th, 2016, upon the
16 pleadings filed heretofore.

17 APPEARANCES:

18 SPANGENBERG, SHIBLEY & LIBER, L.L.P., by;
WILLIAM B. EADIE, ESQ.,
19 MICHAEL A. HILL, ESQ.,

20 on behalf of the Plaintiff;

21 BONEZZI, SWITZER, POLITO & HUPP CO., L.P.A., by;
PAUL W. McCARTNEY , ESQ.,
22 JENNIFER R. BECKER, ESQ.,

23 on behalf of the Defendants.

24 Angela R. Cudo, RPR/CRR
Official Court Reporter
25 Cuyahoga County, Ohio

1 ought to care for somebody. Those are
2 questions you're going to decide. It's the
3 type of case that I think you'll understand
4 once you've seen the evidence and heard the
10:38:57 5 testimony is the type of case where I have to
6 ask for a lot of money, and at the conclusion
7 of this trial I'm going to ask you to return a
8 verdict of $9 million. Thank you.
9 THE COURT: Ladies and
10:39:18 10 gentlemen, I'm going to give you about a
11 ten-minute recess at this time. Once the
12 defense lawyers start I don't want to
13 interrupt his argument, either, so we'll go
14 for the morning recess. Approximately
10:39:32 15 10 minutes.
16 Everybody rise while the jury leaves
17 the courtroom. Don't discuss the case with
18 anyone. Don't let anybody discuss the case
19 with you.
10:39:40 20 - - - oOo - - -
21 (Thereupon, a recess was had.)
22 - - - oOo - - -
23 THE COURT: Counsel may
24 proceed with your opening statement.
10:55:10 25 DEFENDANTS' OPENING STATEMENT

1 MR. McCARTNEY: Thank you, Your
2 Honor.
3 Good morning. Responsibility. You
4 heard a lot in questions in voir dire and also
10:55:23 5 from Mr. Eadie about responsibility and
6 accepting responsibility.
7 On behalf of my clients, Kindred
8 Healthcare Operating, Inc., and Kindred
9 Transitional Care & Rehabilitation -
10:55:35 10 Stratford, we accept responsibility for the
11 fall. We accept responsibility that the fall
12 should not have happened. We accept
13 responsibility that because of the fall,
14 Mrs. Maxim sustained a right femur fracture.
10:55:49 15 We accept responsibility that because of that
16 she had pain and suffering; that she incurred
17 medical bills. We have accepted
18 responsibility that it did impact her life for
19 a little over two months.
10:55:59 20 However, there are some things that
21 we don't agree with and we don't accept
22 responsibility for. One is, Leona Maxim was
23 not rolled out of bed on June 3rd of 2013.
24 She was not rolled out of bed. How do we know
10:56:14 25 that? We know that from this note. These are

1 the nurse's notes that were put into the
2 system on June 3rd both by Crystal Brown, the
3 nurse caring for Mrs. Maxim that day, and also
4 Jose Giner, the director of nursing.
10:56:30 5 I blew these up because I knew you
6 were not going to be able to read that small
7 print. Crystal Brown's notes go up, so this
8 is an earlier note than this. Crystal Brown
9 writes at 10:15 a.m. this nurse was notified
10:56:40 10 that while resident, abbreviation res,
11 received a.m. care when turned, resident begun
12 to slide out of bed. Resident's STNA stated
13 she lowered resident to floor. Resident did
14 not hit her head. Resident did hit her knee.
10:56:58 15 Resident complains of pain to right knee.
16 This nurse assessed resident's vital signs.
17 Within normal limits. Family notified and
18 doctor notified with new order for x-ray right
19 knee and will continue to monitor resident.
10:57:10 20 Jose Giner, the director of nursing,
21 did an investigation looking into what
22 happened. One of the things he did was he
23 went and talked to Leona Maxim, and he
24 describes what his conversation was with
10:57:23 25 Leona Maxim. Met with resident to discuss

1 what happened earlier in the day. Resident
2 stated that she was on right side. Her leg
3 started to slide out of the bed and the STNA,
4 nursing aide, that stands for state tested
10:57:37 5 nurse assistant, came over to the other side
6 of the bed and assisted her to the floor
7 because she was sliding out of bed.
8 Now, in nursing home parlance, this
9 constitutes a fall. That's why it's going to
10:57:52 10 be described as a fall. But not a fall that
11 lay people typically would think of where
12 someone just falls hard to the ground. If you
13 find a resident on the floor for unknown
14 reasons, that is considered a fall. If the
10:58:04 15 resident falls in a more lay person parlance,
16 that is a fall. If a resident is assisted to
17 the floor by an aide or staff member, that is
18 considered a fall.
19 This is not a rolling out of bed.
10:58:19 20 This is not someone coming tumbling off the
21 bed and hitting the ground hard. That is what
22 happened on June 3rd, not a rolling out of
23 bed.
24 Now, it doesn't really matter because
10:58:32 25 my clients accept responsibility for that. So

1 the questions are why are we here then today?
2 Well, we are here to determine what amount
3 would fairly compensate Leona Maxim's family
4 for Leona Maxim's pain and suffering and
10:58:48 5 medical bills prior to death. And there's a
6 disagreement as to what that is.
7 We're also here to decide whether her
8 death two plus months later from aspiration of
9 pneumonia is related.
10:59:01 10 Now, we've looked at this case. You
11 heard Mr. Eadie talk about all he did to look
12 at this case. We pursued the same kind of
13 exercise in investigating the case, having
14 medical experts look at this case, reviewing
10:59:12 15 the medical records from Hillcrest right after
16 the fall, the Kindred - Stratford records from
17 June, July and August, and also the Ahuja
18 Medical Center records. We also looked at the
19 Death Certificate and we went out and met with
10:59:28 20 the coroner to decide whether or not we agreed
21 with the coroner's conclusion that the death
22 was related. Not because we're not willing to
23 accept responsibility and not because of any
24 kind of ill will or nefarious purpose. We
10:59:42 25 disagree the death is related.

1 Now, obviously we were not able to
2 reach a conclusion as to that, Plaintiff and
3 my clients, so that is partly why we're here.
4 If you decide the death is unrelated,
10:59:56 5 you will not be rewarding any damages to
6 Leona Maxim's family for the death or any
7 suffering they occurred, the mental anguish,
8 the loss of her society. However, if you
9 decide that damages are warranted because the
11:00:11 10 death is related, you are to award fair and
11 reasonable damages, and what you decide my
12 clients will accept. Because if you decide
13 the death is related to the fracture, we
14 accept your judgment.
11:00:27 15 With that said, let's learn a little
16 about Leona Maxim. She was a widower with
17 four adult children and grandchildren. She
18 was loved by the family. And we are not at
19 any point in time going to suggest she wasn't
11:00:42 20 loved by her family; that this was not a
21 loving and caring family; that this was not a
22 family that was involved with her mother. But
23 she wasn't only loved by her family. She was
24 loved by the staff at Stratford.
11:00:52 25 She had been a resident at Stratford

1 since July 1st of 2007. She was there longer
2 than most of the staff. She was there when a
3 different company operated the facility. She
4 was there before most of the staff joined
11:01:08 5 Stratford. She was so loved by the facility,
6 one of the nurses who you will hear from went
7 to Ahuja Medical Center after she was
8 transferred out from Stratford to visit her.
9 And you will hear the staff talk about how
11:01:23 10 much they loved her. One of the things they
11 really liked about her was she called them all
12 by name. She knew who they were. It wasn't
13 just saying you, or nurse, or aide. She would
14 call them by their name. Whether it was
11:01:34 15 Wendy, Mercedes, Latricia, she called them by
16 name.
17 It's important, though, also to know
18 about Leona Maxim to really understand what
19 her medical conditions were and what that
11:01:47 20 meant for what her life was like. She had a
21 condition called COPD. That's short for
22 chronic obstructive pulmonary disease. One of
23 the diseases under that umbrella is called
24 emphysema, which many of you have probably
11:02:03 25 heard of. COPD means you can't really

1 exchange air properly and you have trouble
2 breathing. And because of the COPD, you are
3 on supplemental oxygen, as was Leona Maxim.
4 She had a stroke. She had a stroke
11:02:17 5 back in 2006, 2007. And it was actually that
6 stroke that led her to be admitted to
7 Stratford in the first place. She was living
8 with her daughter Jackie in Arizona when she
9 had the stroke, and because of the distance
11:02:31 10 from the rest of the family a decision was
11 made that she should return to the Cleveland
12 area and she entered Stratford.
13 She had seizures, and because she had
14 seizures she was on anti-seizure medication.
11:02:45 15 She had scoliosis. That means a
16 curvature of the spine. You'll hear how she
17 tended to lean to one side when she was in the
18 wheelchair because of the scoliosis. You look
19 at a normal spine, that is straight. It will
11:02:59 20 sort of hook and do like an S instead.
21 She had GERD. That is short for
22 gastroesophageal reflux disease. We've all
23 heard of reflux. That's where your stomach
24 contents come up into your esophagus and
11:03:12 25 causes that burning pain.

1 She had Parkinson's Disease. The
2 important thing about Parkinson's Disease is
3 it's a chronic condition. It's a degenerative
4 condition, meaning it's not going to get any
11:03:22 5 better. In fact, over time it's going to get
6 worse, meaning that Leona Maxim's function was
7 going to decline over the years and never get
8 better. You never would expect that on
9 January 1st she had the same level of function
11:03:34 10 that she did the prior January 1st.
11 She had hyperlipidemia, which means
12 fat in the blood.
13 She was depressed. She had been on
14 anti-depressant medication for years.
11:03:48 15 She had dysphagia. That's probably
16 what causes her gastroesophageal reflux
17 disease. What dysphagia means is she had
18 trouble swallowing. There's a valve there
19 that is supposed to prevent food from coming
11:04:02 20 up and everything doesn't work correctly.
21 When you have dysphagia what that does is put
22 you at risk for aspiration pneumonia. And
23 aspiration pneumonia is when contents in your
24 stomach are aspirated and come up and go into
11:04:14 25 your lungs. We all think and talk about how

1 we swallowed wrong and you get that feeling of
2 food going into your lungs or liquid going
3 into your lungs. Well, someone with dysphagia
4 is going to be in such a state that they're
11:04:27 5 going to have that coming up and potentially
6 go into their lungs.
7 She also had a cognitive decline, not
8 a significant cognitive decline to the point
9 of she didn't know anything that was going on.
11:04:38 10 But she was 73 years old, and she had a
11 cognitive decline that was consistent with her
12 age and probably more advanced than most 73
13 year olds.
14 You can see this going back
11:04:51 15 February 14th of 2013. This is one of the
16 nursing progress notes. Resident is alert and
17 oriented with minimal confusion. And the
18 nurse goes on -- This is actually a social
19 worker, she scored a 7 on her BIMS assessment.
11:05:08 20 What you will learn through the evidence in
21 this case is that means she had significant
22 cognitive impairment at least at the time this
23 assessment was done.
24 What you really see with her
11:05:18 25 cognitive impairment it wasn't this was her

1 level at all times. She would go up and she
2 would go down. She would wax and she would
3 wane. Some days and some times she would be
4 more cognizant than others, and others she
11:05:31 5 might not know where she was or what time it
6 was. It was consistent with her age that she
7 had these cognitive issues.
8 So what was the impact on her
9 capabilities and function as a result of all
11:05:43 10 these what we call comorbid conditions? She
11 had been in a nursing home since 2007, meaning
12 she entered when she was 67 years old. Only
13 67 years old she entered the facility. She
14 was nearly or completely dependent on staff
11:05:58 15 for what we call activities of daily living;
16 things such as dressing, grooming, hygiene,
17 things such as getting in and out of bed,
18 those kinds of things. Those are activities
19 of daily living. She was almost completely
11:06:12 20 dependent on the staff for all of those kinds
21 of activities.
22 She had been bedbound or wheelchair
23 bound since 2010, and she required a Hoyer
24 lift with transfers. She spent her day either
11:06:27 25 in bed or in her wheelchair. She was not able

1 since 2010 to ambulate, walk, by herself. And
2 it was so bad and she had such limited
3 physical capabilities they had to use this
4 device called a Hoyer lift. What a Hoyer lift
11:06:44 5 does is while are you in bed or the chair,
6 they, the staff, would slide a sling
7 underneath her, slide a sling underneath her,
8 and basically wrap around her body, then a
9 machine would lift her up and they would take
11:06:57 10 the arm, if it was from the chair move her
11 over to the bed, or vice versa, from the bed
12 over to the chair. That would require two
13 people to assist her. And that was the only
14 way she could go from bed to chair and chair
11:07:10 15 to bed.
16 She had left side weakness, probably
17 due to the stroke, and also the general
18 weakness that she would have secondary to her
19 Parkinson's Disease.
11:07:20 20 We mentioned already she had
21 supplemental oxygen because of her COPD,
22 meaning she had that little tube under her
23 nose all the time requiring oxygen. And she
24 required breathing treatments and medications.
11:07:31 25 Often you'll see people with asthma that have

1 a little inhaler. Well, she would get
2 treatments periodically to help with her
3 breathing to open her bronchioles so she could
4 breathe better. And what that meant, with the
11:07:41 5 COPD requiring supplemental oxygen and
6 breathing treatments and medications, what
7 that meant was she wasn't physically really
8 fit; that she wasn't someone that was able to
9 go in her wheelchair and propel herself all
11:07:56 10 over the facility for hundreds and hundreds of
11 feet.
12 By April of 2012 her health was such
13 that her ability to propel herself in the
14 wheelchair through the facility was somewhere
11:08:07 15 between 25 feet and 100 feet depending on the
16 time. And it wasn't a fast pace. It was a
17 very slow pace that she would go, probably
18 because she had the weakness on the left side.
19 And most of the time when she moved from her
11:08:21 20 room to go to an activity the staff was the
21 one that got her to the activity. She wasn't
22 going on her own.
23 She had a PEG tube. That's a tube
24 they put in through your stomach, create a
11:08:36 25 hole in your abdomen and stick a tube in

1 through your stomach and they can then put
2 medication, fluid, and food through that PEG
3 tube in order to feed you. Since 2010 she was
4 NPO. NPO is shorthand for a Latin term
11:08:53 5 meaning nothing by mouth. From 2010 until
6 March of 2013 she was taking nothing by mouth
7 for three years. And the speech therapist at
8 Stratford, despite three years of not being
9 able to do anything, continued to work with
11:09:10 10 her, continued to evaluate her to see if it
11 would be possible for her to get anything by
12 mouth.
13 And because they worked with her, by
14 March she was being moved off the PEG tube
11:09:21 15 even though she still required supplements
16 through the PEG tube. And what happened?
17 Well, at the end of April, April 29th, she was
18 diagnosed with an aspiration pneumonia. She
19 had to be sent to Hillcrest Hospital for three
11:09:34 20 days because she had this aspiration pneumonia
21 where the contents in her stomach had come up
22 and gone into her lungs and her lungs had
23 become infected. And this wasn't the first
24 time. The records are replete with references
11:09:47 25 that she had a history of aspiration

1 pneumonias. And in the elderly any pneumonia
2 is always a major threat to their survival.
3 Pneumonia has been described as death's best
4 friend. One of the leading causes of deaths
11:10:04 5 in elderly is they develop a pneumonia and
6 because of their condition they cannot fight
7 it off.
8 She also had edema; a fancy word for
9 swelling. Her extremities were swollen. She
11:10:16 10 had a device, an apparatus, called TENS hose
11 put on her legs to try to compress the edema
12 in her legs. She required anti-diuretic
13 medication, Lasix, medication that are given
14 to try to take water off the body.
11:10:31 15 She had all of these conditions
16 before June 3rd of 2013, and all of these
17 conditions put her at substantial risk for a
18 sudden acute event to take her life.
19 So what actually happened in this
11:10:46 20 case? Well, I mentioned already that in April
21 of 2013 she had this aspiration pneumonia.
22 She goes to the hospital at that time for
23 three days.
24 Now, you heard Mr. Eadie say to you
11:10:59 25 that Stratford took all the orders off that

1 day. They did. How a nursing home works, the
2 system that works in a nursing home, is when a
3 patient is discharged, they don't know if the
4 resident is ever coming back, and they don't
11:11:16 5 know what the condition the resident will be
6 in when he or she does come back. So when a
7 resident is discharged, all the orders are
8 discontinued. That's not just something that
9 happens at Kindred - Stratford. That is
11:11:29 10 something that is done at any kind of nursing
11 home, any kind of hospital. When you
12 discharge a resident, the orders are
13 discontinued because you don't know if they're
14 coming back and you don't know what condition
11:11:41 15 or what their needs will be when they come
16 back.
17 So when she's readmitted they have to
18 get new orders. One of the things you will
19 see, you'll see a sheet from Hillcrest that
11:11:51 20 has the orders that they recommend for her
21 when she comes back over. It includes the
22 medication, also includes a variety of other
23 things beyond medication that Hillcrest
24 Hospital's recommending that Leona Maxim
11:12:04 25 needs.

1 Unfortunately, one of the things that
2 Hillcrest did not put on that sheet, and
3 sometimes they're called mission orders or
4 continuity of care forms, they did not include
11:12:17 5 the requirement that Leona Maxim needed a
6 two-person assist when being provided a.m.
7 care in bed that required position change.
8 That order was not on it.
9 So when she comes back, the nurses --
11:12:31 10 then the admitting nurse duly transcribes the
11 orders. Ordinarily what happens is once the
12 orders are entered into the record a couple
13 days before the end of the month, a printed
14 out version of doctor orders is sent out two
11:12:46 15 or three days in advance so the nursing staff
16 can look at it, take them off and also get the
17 physician to sign off on them.
18 This is the one that was done shortly
19 before the end of April in 2013, the May 1st
11:12:58 20 to May 31st one. I have it up here because
21 it includes -- This is just the first page of
22 it just to give you an example of what it
23 looks like. When she comes back, they
24 handwrite the orders in before the unit clerk
11:13:14 25 puts all the orders in.

1 So for the month of May when she
2 returned on May 2nd, here's the admission
3 date, May 2, these are what the orders look
4 like, this handwritten version. And the nurse
11:13:24 5 takes all these orders off and then she calls
6 the doctor, Dr. Umapathy, calls the doctor and
7 says here are the orders we received from
8 Hillcrest Hospital, will you verify these
9 orders so we can put them on and start using
11:13:38 10 them and are there any other orders you need?
11 One of the other things the nurse
12 would have done and should have done was check
13 to see whether there were any things that were
14 missing from these orders from the other
11:13:50 15 orders that already existed. And some things
16 were picked up that were not included.
17 Unfortunately, the nurse did not pick up the
18 two-person assist for a.m. care in bed that
19 required a position change. She did not pick
11:14:04 20 that up. That was a mistake. And for that,
21 my clients are responsible. Stratford is
22 responsible. We're not going to argue with
23 that. It wasn't some nefarious purpose. It
24 was simply a human mistake. And when you're
11:14:17 25 dealing with humans, you're never going to

1 design a system that is perfect that can
2 overcome human error.
3 So the June orders then that came out
4 towards the end of May and the TAR - TAR is
11:14:35 5 shorthand for Treatment Administration Record.
6 I'll show you one of those in a minute - did
7 not include that requirement for two-person
8 assist.
9 However, when she came back on
11:14:46 10 May 2nd, rather than writing out all the
11 orders that would go on the Treatment
12 Administration Record, the staff looked and
13 said why should we write these all out, we
14 had, just like the orders, this Treatment
11:14:59 15 Administration Record for the month of May
16 that was printed out before she was sent to
17 Hillcrest Hospital.
18 They used this form. You see this
19 says treatment record. In the industry it's
11:15:08 20 called Treatment Administration Record, TAR.
21 This is the one that is from May 1st to
22 May 31st. You see they crossed out May 1st
23 and put in May 2nd.
24 One of the things on these Treatment
11:15:20 25 Administration Records, because it had been

1 printed out before she had been sent to
2 Hillcrest Hospital, was this requirement for
3 two-person assist for all care given in bed
4 that requires a position change. And the
11:15:30 5 staff was going ahead and doing that all
6 through the month of May, charting that they
7 were using two persons all through the month
8 of May. But, unfortunately, on the June
9 orders, when the June TAR came out, that was
11:15:43 10 no longer there. That order wasn't in place.
11 That order, which did not require a physician
12 to discontinue it because all orders as a
13 matter of course are discharged -- are
14 discontinued on discharge, wasn't there.
11:15:59 15 So on June 3rd an aide went into the
16 room to provide a.m. care and did it by
17 herself. Clearly, Leona Maxim needed two
18 people to assist that morning. That order
19 should have been in place. There should have
11:16:13 20 been two aides. Unfortunately, she was
21 lowered to the floor, struck her knee and
22 fractured her femur.
23 Now, the picture Mr. Eadie showed you
24 of the bed, that was taken just a couple
11:16:27 25 months ago. With the time that has passed,

1 the beds and how they look are not the same.
2 Further, the bed would not be that high during
3 a.m. care. It would be lower than that. So
4 it wasn't that great distance that you saw.
11:16:41 5 It would be a much lower distance.
6 Also, when she went to Hillcrest, the
7 decision not to operate wasn't because the
8 fracture was so bad that it was inoperable.
9 The decision not to operate was based on the
11:16:56 10 fact that Leona Maxim already did not
11 ambulate; that she was wheelchair and
12 bedbound; that operating on this fracture so
13 she could regain the ability to ambulate
14 wasn't necessary because she would never have
11:17:10 15 that. So the decision was she did not need to
16 go through the extra stress from anesthesia
17 and from the operation, and that it could be
18 properly addressed with this knee immobilizer
19 with her leg being raised when she was in the
11:17:25 20 wheelchair, her leg being straight out from
21 her body. That was why she was not operated
22 on, not because the fracture was so bad that
23 they couldn't operate on it. You could see it
24 in the Hillcrest records a discussion that
11:17:38 25 lays out that that was the reason why the

1 doctors did not recommend an operation.
2 So there are a few things I want to
3 point out that Mr. Eadie said that didn't
4 happen. What didn't happen was repeatedly
11:17:52 5 violating the requirement of two-person
6 assist. He showed you a document that the
7 facility stopped using in 2012, which is why
8 they don't have it. Not because we didn't
9 produce it. And that document talked about
11:18:08 10 bed mobility in general, not bed mobility a.m.
11 care requiring two-person assist when there
12 was a change of position in bed.
13 Because of her PEG tube and oxygen,
14 Leona's head of the bed was going to be
11:18:18 15 elevated. There would be problems with her
16 scooting down or problems with her needing to
17 be repositioned. And when they're not
18 providing care and not changing position, just
19 helping her scoot up, that only required a one
11:18:29 20 person. But I already showed you the May TAR
21 that showed that the two-person assist was
22 being done.
23 Here's the one from March of 2013
24 showing that the aides were using two people
11:18:44 25 to -- staff was using two people when they

1 were providing a.m. care in bed. It wasn't
2 repeatedly being violated as Mr. Eadie
3 claimed.
4 What's also not true? She was not
11:18:56 5 rolled out of bed. I showed you that note
6 already. She was not rolled out of bed.
7 The evidence about the August
8 pneumonia. There's three things you should
9 know that Mr. Eadie didn't disclose. It was a
11:19:08 10 different kind of bacteria that infected her
11 lungs, the sputum, versus what was found in
12 her right calf wound in July. They're
13 different kinds of Klebsiella bacteria.
14 What you will hear from the expert
11:19:24 15 that is going to testify that I retained to
16 testify, Jeffrey Schlaudecker, is that they
17 were different bacteria. It wasn't the same.
18 It's also not clear whether the wound
19 was actually infected or what they got when
11:19:38 20 they swabbed the room in July was just what's
21 called a contaminant. Everyone's skin has
22 bacteria on it. If we swab any of your skin,
23 there would be bacteria on it. And this was a
24 surface swabbing of the wound, not tissue from
11:19:54 25 the debridement. We don't know if the wound

1 was actually infected or if it was just a
2 colonization in there.
3 He also mentioned within a few days
4 she spiked a fever. The medical term if you
11:20:09 5 have a fever is you are febrile. If you don't
6 have a fever, you are afebrile. Leona Maxim
7 was afebrile, without a fever, until
8 August 14th of 2014.
9 And he made the comment that Latricia
11:20:25 10 Boyer did not regularly treat her. Latricia
11 Boyer treated her regularly during the period
12 of July and August and was familiar with her.
13 I said this about the temperature.
14 Here's a sheet in the Kindred records, in the
11:20:39 15 Stratford records, that show the temperature
16 being taken over the course of time starting
17 in April through August 14th. And you have
18 here July 26th, 2013, temperature 98.4 oral,
19 normal. July 27th, 98.3 oral. August 8th,
11:21:01 20 that's the day that he points to the note that
21 she said she wasn't feeling well, 99.6. While
22 that is technically elevated over what we all
23 think is 98.6, in the medical field a
24 temperature of 99.6 would not cause anyone
11:21:16 25 great alarm or concern. That would be

1 considered a normal temperature.
2 It was finally six days later when
3 she spiked a temperature. And during those
4 days from August 8th to August 14th she wasn't
11:21:28 5 making any complaints or problems. And what's
6 interesting, the expert that Mr. Eadie
7 retained to testify doesn't criticize how the
8 staff at Stratford treated Mrs. Maxim from
9 August 8th to August 14th, expresses no
11:21:46 10 criticism saying they should have done
11 something they didn't do.
12 What he also neglects to tell you is
13 they got a chest -- they called the doctor on
14 August 8th. The doctor said get a chest
11:21:58 15 x-ray. They get the x-ray. The conclusion is
16 bilateral minimal infiltrates. There was
17 slight pleural effusion. The findings are
18 improved from May 12th of 2013. What that
19 means from the radiologist is she didn't have
11:22:13 20 pneumonia. There was nothing going on. There
21 was no evidence that these -- over these days
22 until August 14th of a urinary tract
23 infection.
24 The signs and symptoms of urinary
11:22:25 25 tract infection are things like burning on

1 urination, maybe even some back pain. There
2 was no indication she had any of those things
3 during the course of these six days.
4 You see here Mercedes Chisholm,
11:22:35 5 according to the note, in talking about what
6 they did; they called the doctor, they gave
7 her some Tylenol.
8 Inadequate care for the UTI.
9 Mr. Eadie implies in his statements that if a
11:22:56 10 resident develops a urinary tract infection a
11 facility is negligent. Again, the expert
12 Mr. Eadie retained on behalf of the Plaintiff
13 will not testify to that. The fact of the
14 matter is Leona Maxim was incontinent and she
11:23:14 15 was elderly. Urinary tract infections in
16 residents like that are very common.
17 She had several urinary tract
18 infections during 2012. She had a urinary
19 tract infection in April. No expert's
11:23:30 20 critical of that. There were no signs or
21 symptoms to tip the staff off. You don't know
22 someone has a urinary tract infection. You
23 can't just say, oh, I think tomorrow she's
24 going to wake up with a urinary tract
11:23:41 25 infection. You have to wait until symptoms

1 present themselves in order to make the
2 diagnosis.
3 The statement bonus for each
4 percentage below budget, a couple times he
11:23:54 5 made that statement. That's not true. That
6 is flatly not true. Grossly mischaracterizes
7 the testimony of Prentice Lipsey. Prentice
8 Lipsey was the executive
9 director/administrator from 2011 up until
11:24:10 10 2014. This is one of five different
11 facilities that he's been the
12 administrator/executive director at. He's
13 been in the nursing home industry for 15,
14 16 years. He will tell you how things are
11:24:23 15 done at Stratford were similar to all the
16 other four places he worked.
17 What he said about the bonus wasn't
18 that he got a bonus for each percentage point
19 below the budgeted number for the year. What
11:24:37 20 he said was the bonus was based in part on
21 staying within a certain percentage of your
22 budgeted amount both up and down. That they
23 don't want people to run too much under budget
24 and they don't want people to run too much
11:24:57 25 over budget. They want people to run at about

1 the budget that is set. There are reasons you
2 aren't going to make it exactly. You don't
3 know what your census are going to be for the
4 year, you don't know what the care needs from
11:25:10 5 the residents would necessarily be. So it's
6 impossible to run it right at budget. But the
7 bonus was based on staying at about where the
8 budget was. That is a flat out misstatement
9 of Prentice Lipsey's testimony.
11:25:23 10 Also, the inadequate staffing. Not
11 true. The statement of Mr. Eadie, bare
12 minimum staffing. Not true. He showed you
13 that one sheet that had at the beginning bare
14 minimum staffing. That was a page generated
11:25:36 15 by Prentice Lipsey during the budget process
16 in September of 2012. When he testified about
17 that, when he testifies to you, what he will
18 tell you is what he meant by that when they
19 ran the numbers and this was the staffing
11:25:49 20 level he believed that if he got the budget at
21 this staffing level the facility would be
22 appropriately staffed. That's what he's going
23 to say.
24 What he didn't tell you was that
11:26:03 25 Brian Newman, Brian Newman, who was the

1 district director of operations, who was quote
2 unquote Prentice Lipsey's boss, he didn't tell
3 you that two weeks later Brian Newman has an
4 exchange of e-mails with Prentice Lipsey,
11:26:18 5 with director of nursing Jose Giner, and the
6 district director of clinical operations, sort
7 of a resource person for the nursing staff to
8 go to if they had questions. And during this
9 conversation you have Brian Newman saying,
11:26:30 10 listen, I want to advocate for more staffing
11 than you're proposing, I think you need more
12 staffing than you're proposing. And they came
13 up with a staffing proposal that was in excess
14 over what Prentice Lipsey had given two weeks
11:26:43 15 earlier.
16 So you have not trying to force the
17 facility to work with less staff, but work
18 with the right amount of staff. That's what
19 you were getting from the district and the
11:26:55 20 people upstream from the facility.
21 And talking about staffing,
22 Plaintiff's expert is a gentleman named
23 Ernest Tosh. Ernest Tosh has never worked in
24 a nursing home. Ernest Tosh has no clinical
11:27:10 25 background. He's not a nurse. He's never

1 worked as a nursing assistant. He's not a
2 physical therapist, an occupational therapist,
3 a speech therapist. He's not a physician,
4 none of those things. Not a licensed nursing
11:27:23 5 home administrator. Never worked for a
6 company that operates a nursing home.
7 What Ernest Tosh is is an attorney in
8 Fort Worth, Texas. What Ernest Tosh is is a
9 lawyer in Fort Worth, Texas who five years ago
11:27:39 10 decided he was going to start suing nursing
11 homes. He had previously done largely
12 criminal defense work. He sues nursing homes.
13 What Ernest Tosh has come up with is a number
14 that he says is what is the reasonably
11:27:51 15 expected -- the expected number of staff that
16 you will have based on per patient day for a
17 facility based on a score submitted to the
18 federal government for Medicare reimbursement.
19 That's the number he comes up with. Per
11:28:08 20 patient day is determined simply by taking the
21 total number of staff hours, nurse's aides and
22 nurses who work, not just the nurses on the
23 floor but it could be the restorative nurse,
24 and dividing it by the number of residents.
11:28:24 25 What is required of a nursing home in

1 Ohio is to run a PPD that's like 2.2. At
2 Stratford during this period of time the PPD
3 for the aides and the nurses was running
4 between 3.7 and 3.9, far in excess of what
11:28:40 5 would be required of this facility.
6 What you're going to learn from I
7 call these the internal experts on staffing;
8 Jose Ginner, Prentice Lipsey and Brian Newman,
9 is the way that Stratford went about
11:28:53 10 determining a budget and assigning staff is
11 whatever -- is what is expected of a
12 reasonable nursing home in this country. They
13 start out by looking at the budget from the
14 year before and saying here's our budget from
11:29:06 15 the year before. Do we need -- Is this budget
16 adequate? Do we need more or do we need less?
17 They played with that and they spent several
18 months in advance of the next calendar year
19 determining the budget.
11:29:19 20 Once they determine the budget, it's
21 then left up to the director of nursing, in
22 this case Jose Giner, to decide where the
23 staff would be allocated within the building,
24 on which units.
11:29:28 25 There were four units at this

1 facility. There were about 153 beds. You
2 will see the census, the number of residents,
3 typically in this building in 2013. And May
4 and June of 2013 was 115, 116, maybe 114,
11:29:44 5 maybe 118. And you will see that the staff
6 was allocated throughout the different units.
7 No one unit was short staffed.
8 What Jose Ginner will tell you is he
9 might have been only a nurse for five years
11:30:00 10 when he was promoted after Kindred acquired
11 the building, not before, promoted to the
12 director of nursing. He has gone on from
13 working at Stratford and joined another
14 company called Saber Healthcare where he was
11:30:10 15 the director of nursing at a facility for
16 Saber Healthcare. Subsequent to that, Saber
17 has promoted him to a regional position where
18 he oversees several nursing homes in terms of
19 the clinical care. This is not some slouch as
11:30:24 20 Mr. Eadie implied.
21 And Jose Ginner will tell you he
22 never had to worry about the budget when he
23 was doing the staff. If he wanted -- If he
24 thought he needed more staff on shift, he
11:30:36 25 would add more staff on a shift. He never got

1 any blowback from anyone saying you're running
2 too much staff, it's costing us too much
3 money. If they needed to do overtime, they
4 would do overtime. If somebody called off,
11:30:49 5 they would find someone to come in and fill
6 in. The staffing was never an issue at this
7 facility, never an issue at this facility.
8 Mr. Eadie made the comment that each
9 nursing aide had to take care of 11 residents.
11:31:04 10 Well, that's a little bit -- That doesn't
11 really explain the whole process. That is not
12 an usual number of residents for a nursing
13 aide to take care of. They normally work in
14 teams. They have other people that help them
11:31:17 15 if they need help. They can call for
16 additional help and they work as a team.
17 You're also going to hear from Mark
18 Levine. Mark Levine has 30 plus years in the
19 nursing home industry. He's a licensed
11:31:29 20 nursing home administrator. He will tell you
21 that the way that the staff levels were
22 determined and the staffing that actually was
23 at Stratford in June of 2013 was more than
24 adequate, more than appropriate, and more than
11:31:42 25 reasonable. The only one that is going to

1 disagree with that is this lawyer from Fort
2 Worth, Texas who sues nursing homes, and hopes
3 to have some kind of standard adopted to make
4 it easier to sue nursing homes.
11:31:56 5 So what is the role of Kindred
6 Healthcare Operating? Kindred Healthcare
7 Operating in not the big Kindred company as
8 Mr. Eadie implied. It's a subsidiary of
9 Kindred Healthcare, Inc. Under it there's
11:32:12 10 another subsidiary, then a second subsidiary
11 underneath it called KND Development 51. You
12 might have heard Judge Coyne reference KND
13 Development 51. That's the actual corporate
14 name for Kindred Transitional Care &
11:32:28 15 Rehabilitation - Stratford. That whole long
16 name is just a business name.
17 There is a contract that exists
18 between KND Development 51 and Kindred
19 Healthcare Operating that sets forth the
11:32:41 20 responsibilities and duties and the
21 relationship between those two corporate
22 entities. It's per that contract that Kindred
23 Healthcare Operating provides services which
24 are typically called back office services,
11:32:54 25 doing things such as helping with benefits,

1 worker's compensation insurance and handling
2 worker compensation claims, providing health
3 insurance, getting insurance for the
4 employees, and those kinds of things. In
11:33:07 5 addition, they supply these district level
6 people, like Brian Newman, like the district
7 director of clinical operations, to provide
8 assistance to the facility and those within
9 the facility. And they also help with the
11:33:21 10 budget process. But it's not just a top down
11 budget process you will hear. It's a process
12 where the facility itself has say in it. And
13 more importantly, when it comes down to the
14 day-to-day operations of the facility and the
11:33:36 15 care that's being provided, that is all being
16 handled at facility level.
17 The employees are facility employees.
18 The nurses, the nurse aides are facility
19 employees. The discipline of those employees
11:33:48 20 is done at the facility level. It's not done
21 upstream. So in terms of actually determining
22 where the staff should be, Kindred Healthcare
23 Operating had no role in the case. The role
24 only was left to Stratford, not that big
11:34:04 25 company.

1 So at the end of this case, this is a
2 little different because you're going to have
3 to make a determination as to how much money
4 to award. That's a given because there is no
11:34:15 5 doubt Stratford made a mistake and caused an
6 injury to Leona Maxim. So you're going to
7 have to decide on the pain and suffering that
8 she sustained. You're also going to decide
9 what are the medical bills that are related.
11:34:28 10 The rule for compensation is it has
11 to be fair and reasonable. In this phase at
12 this point in time it's not to punish
13 Stratford for anything. It's simply to
14 compensate the family a fair and reasonable
11:34:41 15 amount caused by the mistake. That's it. If
16 you go beyond that -- Back up. In analyzing
17 that, there's several things you need to
18 consider.
19 First, let's talk about the wound --
11:34:57 20 knee immobilizer. There definitely was a
21 wound that developed because of the knee
22 immobilizer, developed on the front of the
23 shin. Definitely developed because of that.
24 It doesn't matter whether the care
11:35:08 25 was appropriate with the knee immobilizer and

1 the wound still developed, it doesn't matter
2 if it was negligence, because the knee
3 immobilizer wasn't necessary other than due to
4 the femur fracture, and Stratford's
11:35:23 5 responsible. It doesn't matter.
6 The thing to also know about the knee
7 immobilizer, you're going to hear from both an
8 occupational therapist and physical therapist
9 and they're both going to tell you those knee
11:35:37 10 immobilizers are notorious for not staying in
11 place. They're notorious for not staying in
12 place. They move about. And it's not unusual
13 to have to train the staff or remind the staff
14 about where the knee immobilizer should be.
11:35:51 15 And this wound, yes, wounds sometimes
16 go from Stage I -- go non-existence to Stage
17 II where someone doesn't see it. It's sort of
18 like if you're out in the yard doing yard work
19 and you have gloves on and doing raking, as
11:36:06 20 we're coming up on leaf season, and all of a
21 sudden you take your glove off and you have a
22 blister. You didn't see it before and all of
23 a sudden it's there. That's not unusual for
24 that to happen.
11:36:16 25 You'll realize when that blister went

1 away then there was this wound, the depth of
2 that wound, how far down it went, the deepest
3 it ever got was .5 millimeters. But it was
4 generally around .2 to .3. That's almost like
11:36:29 5 shaving and nicking your skin how deep the
6 wound was.
7 And the thing about this wound, on
8 July 24th it was cultured and it was this
9 Klebsiella bacteria. Whether it was actually
11:36:43 10 an actual infection or not, it was treated.
11 It wasn't ignored. She had a seven-day course
12 of antibiotics. If you follow the chart notes
13 about it from July 24th on up until
14 August 14th, the wound never appeared infected
11:37:00 15 after that. They described the tissue that
16 was around it. If you nick your skin and
17 sometimes the skin around it gets puffy and
18 red. The way it was documented in the weekly
19 skin checks, what it looked like, was the
11:37:14 20 tissue around it looked normal like normal
21 healthy tissue, and the drainage that was
22 coming out of it was clear, thin, serous
23 drainage; just the kind of drainage you get
24 when you have a blister, nothing that was
11:37:28 25 unusual; you have a strawberry, that's oozing

1 that comes out. It didn't have the appearance
2 of being infected. Not only was it not
3 infected after the antibiotics, it decreased
4 by about 75% in size. It was getting better.
11:37:44 5 It was healing before she went out. No one
6 criticized the care and treatment. Their
7 expert doesn't criticize the care and
8 treatment for the wound.
9 If you look at the Ahuja Medical
11:37:58 10 Center record from the August 14th admission,
11 the doctors that consult and treat Mrs. Maxim,
12 none of them relate the wound, the infection
13 to the wound, to her developing sepsis, the
14 systemic infection of the body. None of them
11:38:13 15 relate the wound to the infection. They
16 concentrate on aspiration pneumonia. And they
17 concentrate on aspiration pneumonia because
18 she had all this fluid in her lungs, she
19 aspirated. And the infectious disease expert
11:38:28 20 they consulted and the doctor who did the
21 discharge summary listed the cause of death as
22 aspiration pneumonia.
23 It's important when you hear talk
24 about Dr. Gilson, and Dr. Gilson did this
11:38:41 25 investigation, Plaintiffs are going to submit

1 this little binder here. This is Dr. Gilson's
2 file of the materials he reviewed. It's
3 124 pages. A lot of it -- Some of it is
4 administrative-type documents, some fax
11:38:57 5 covered pages. 50 some pages of it are rhythm
6 strips, rhythm strips in the back, which he
7 will tell you really didn't play a role. He's
8 got maybe 20 pages of record from Stratford.
9 That's it.
11:39:10 10 He never talked to one member of the
11 staff at Stratford. He didn't talk to the
12 physicians at Ahuja. He didn't look at the OT
13 or PT notes to see whether she returned to
14 baseline. What he relied on in making the
11:39:22 15 determination that the cause of death was
16 related to the femur fracture was the phone
17 call they got from the nurse saying, hey, we
18 have a case we want to send you that we're
19 going to report. She had a femur fracture in
11:39:34 20 June and she never got back to baseline -- she
21 never recovered, not just back to baseline but
22 she never recovered. That's it.
23 If you look over here (indicating),
24 this isn't even all of them, these two binders
11:39:47 25 here are medical records you're going to have

1 from Kindred, from Stratford, from Ahuja and
2 from Hillcrest. He didn't look at anything
3 like that in making his determination. He
4 didn't talk to the infectious disease expert
11:40:03 5 doctor at Ahuja when he reached his
6 conclusion.
7 The fact that she recovered to
8 baseline. You heard Mr. Eadie say after her
9 pneumonia in April she recovered to baseline
11:40:13 10 before the fracture. Well, she basically was
11 back there also by the third week in July.
12 I told you earlier that in March
13 through May of 2012 she went through a round
14 of occupational therapy. They didn't meet the
11:40:29 15 goals in occupational therapy in 2012. They
16 didn't meet them. They discharged her because
17 she had plateaued and wasn't getting any
18 better. Her ability at that time to propel
19 herself in her wheelchair was somewhere
11:40:41 20 between 25 to 100 feet depending on the day.
21 Well, before the femur fracture on
22 June 3rd she could consistently wheel herself
23 about 75 feet in the wheelchair even though on
24 one day at least she reached 100 feet.
11:40:56 25 What Mr. Eadie didn't tell you was

1 before the fracture on June 3rd she was going
2 to be discharged from therapy because she had
3 plateaued. The decision was we're going to
4 discharge her from therapy. She wasn't going
11:41:09 5 to get this goal of 200 feet self-propelling
6 around the facility. That wasn't going to
7 happen.
8 When she came back to Stratford after
9 the femur fracture they worked with her in
11:41:19 10 occupational therapy and physical therapy. By
11 the time she was discharged from occupational
12 therapy on July 22nd she could wheel herself
13 consistently 80 feet in her wheelchair and at
14 times up to 100 feet.
11:41:32 15 It's not just me telling you this and
16 the records telling you this that she
17 basically returned to baseline. Christine
18 Guest, the daughter, one of the daughters who
19 lived in town, testified that she -- basically
11:41:46 20 within a couple weeks she was back, she got
21 back to where she was before.
22 Her mental cognition continued to wax
23 and wane. It didn't stay the same, but it was
24 also affected by medications. And Leona Maxim
11:41:59 25 was getting some Percocet. She was getting

1 some narcotic medications, Percocet. The
2 doctor, recognizing that that would sometimes
3 cause mental status changes, wrote the order.
4 When she changed the order in July, she
11:42:14 5 changed the order to say the Percocet every
6 six hours but hold if there are any mental
7 status changes. We're responsible for the
8 mental status changes because of the femur
9 fracture, but she was having these periodic
11:42:31 10 fluctuations in June and July and August of
11 her mental status because of her pain
12 medication, not because she had a return to
13 baseline.
14 When she develops the aspiration
11:42:43 15 pneumonia in August, this is the one time she
16 could no longer recover and it had nothing to
17 do with the femur fracture. It had nothing to
18 do with the femur fracture. That is what the
19 evidence will show. Thank you.
11:43:04 20 THE COURT: Let me see
21 counsel at sidebar for a moment, please.
22 - - - oOo - - -
23 (Thereupon, a discussion was had
24 between Court and counsel at
11:43:07 25 sidebar.)

1 - - - o0o - - -
2 THE COURT: Ladies and
3 gentlemen, the opening statements of counsel
4 have concluded. We're going to start the
11:44:10 5 evidence, but we're going to break just a
6 little bit early for lunch and we're going to
7 start the testimony at 1 o'clock. So
8 everybody will be in luncheon recess. Come
9 back at 1 o'clock. The first witness will be
11:44:26 10 called.
11 Do not discuss the case with anyone.
12 Do not permit anyone to discuss the case with
13 you. Have a nice lunch. See you back here at
14 1 o'clock.
11:44:40 15 - - - o0o - - -
16 (Thereupon, a luncheon recess was
17 had.)
18 - - - o0o - - -
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25

1 C E R T I F I C A T E

2 I, Angela R. Cudo, Official Court
3 Reporter for the Court of Common Pleas,
4 Cuyahoga County, Ohio, do hereby certify that
5 as such reporter I took down in stenotype all
6 of the proceedings had in said Court of Common
7 Pleas in the above-entitled cause; that I have
8 transcribed my said stenotype notes into
9 typewritten form, as appears in the foregoing
10 Transcript of Proceedings; that said
11 transcript is a complete record of the
12 proceedings had in the trial of said cause and
13 constitutes a true and correct Transcript of
14 Proceedings had therein.
15
16
17
18
19 ---------------------------
Angela R. Cudo, RPR/CRR
20 Official Court Reporter
Cuyahoga County, Ohio
21
22
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