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

IN THE COURT OF COMMON PLEAS

CIVIL BRANCH

ESTATE OF LEONA MAXIM BY CHRISTINE GUEST, EXECUTOR,

Plaintiff,

-v-) Case No. **CV 15 845038**

KINDRED NURSING & REHAB - STRATFORD, et al.,

Defendants.

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TRANSCRIPT OF PROCEEDINGS

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Whereupon the following proceedings were had in Courtroom No. 3-A, Lakeside Courthouse, Cleveland, Ohio, before the Honorable William J. Coyne, commencing on Tuesday, October 11th, 2016, upon the pleadings filed heretofore.

APPEARANCES:

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

on behalf of the Plaintiff;

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

on behalf of the Defendants.

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

piecemeal fashion.

With that, I'll call on Mr. Eadie on behalf of the Plaintiff.

MR. EADIE: Thank you, Your Honor.

09:37:38

Good morning.

THE JURY PANEL: Morning.

PLAINTIFF'S OPENING STATEMENT

MR. EADIE: A nursing home caregiver who turns a resident on her side in bed must not let the resident fall out of the other side of the bed. If they do, and as a result the resident is injured, the nursing home is responsible for the harms and losses that result.

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A nursing home corporation must prevent avoidable skin wounds and prevent skin wounds from becoming infected. If they don't, and as a result the resident is injured, the nursing home is responsible for the harms and losses that result.

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Now, let me tell you the story of what happened in this case. Let me take you back to 2007. Kindred - Stratford -- I'm sorry. Stratford Commons Nursing Home in

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Solon, Ohio. Stratford Commons receives a resident for long-term care. Stratford Commons learns the resident had recently suffered a stroke and as a result could not use her legs fully. She needed to use a wheelchair and she needed help, assistance, getting in and out of bed, getting dressed and cleaned.

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Now let me take us forward to April of 2010, a few years later. One of the largest nursing home corporations in America, Kindred Healthcare, buys the nursing home. They take it over and add it to their chain of hundreds of nursing homes throughout the country. They rename it Kindred Transitional Care and Rehabilitation - Stratford. Kindred - Stratford.

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They send a team of people from corporate to transition the nursing home to the Kindred systems. They implement hundreds of Kindred policies on how to provide care to residents, they implement electronic systems for records, medical records and notes. They implement financial controls and budgeting systems. And they provide the facility, like

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all their facilities, with a budget. They replace the head clinical person in the nursing home, called a director of nursing, with a nurse who's never been an assistant director of nursing, or a director of nursing, and only had been nursing at all for five years. They replace the head of the facility, the local facility head person. In Ohio that's called an administrator. Kindred - Stratford calls them executive directors. And they replace that person with somebody and tell them you will be paid more bonus for every percent, 5, 10, 15, you spend under the budget. They tell the administrator the number one expense you have is staff and the number one revenue item you have are residents at the facility.

Every week the Kindred corporate regional director has a phone call with all of the administrators for all the nursing homes Kindred has in Ohio specifically to keep them on target on their financial goals; spending less, making more. They ask for staffing levels that are bare minimum staffing levels.

Now let's step forward to March 29th

of 2011. It's about just over a year past the transition period. An aide, a nursing aide, sometimes called a nursing assistant, walks into a resident's room. They walk up to the
09:42:16 bed, she turns the resident on her side. The resident falls out the other side of the bed, complains of pain in her legs.

The nursing assistant or nursing aide goes out and gets a nurse, who comes back and
09:42:34 documents that she finds the resident on her knees next to the bed on the floor holding onto the side rail of the bed. The resident's complaining of pain. They help the resident to the bed.

09:42:51 They call the resident's doctor, who is not a Kindred employee, who says x-ray her legs. They x-ray her legs. There's no break. Just abrasions.

Family's notified. Family said, what
09:43:08 happened? And they ask, as documented in the nursing note, for the facility to put a second person in the room on the other side of the bed when they're giving her care in bed. That very same day her doctor sends a doctor's
09:43:29 order to Kindred, March 29th, 2011, two-person

assist for all care given in bed that requires position change of the resident. Two-person assist for all care that requires a position change of the resident.

09:43:59 Over the ensuing months after this 2011 fall out of bed there are records that Kindred has the nursing assistants keep as to the level of assist the resident needs, how much they can do on their own scored from 0 to 8, and how much support was provided, the second number, how much they get. And the code indicates 0 means for the second numbers no setup or help. 1 indicates setup help only, they got things ready for the person. 2 indicates one-person physical assist. 2 means one-person physical assist. 3 means two-person assist. And the records in the months after that order is put in place you'll see show 2s, one-person assistance, sometimes there's a 3 for two-people. Sometimes there's a 2 for just one-person.

Now, let's step forward to June of 2013. A nursing aide or assistant walks into the resident's room in the morning for what's called a.m. care. She stands next to the

resident and turns her on her side in bed. She's alone. The resident's legs fall out the other side of the bed and hit the floor. The resident is clinging with her upper body to the side rail. The aide walks around the bed, lowers her the rest of the way to the floor and gets a nurse.

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The nurse comes in. They help the resident to bed who is complaining of leg pain. They call the doctor. The doctor says x-ray the legs. By the evening Kindred has an x-ray technician come in. They have portable folks who can come into facilities like this to take an x-ray and send the results to a doctor or hospital. And the x-ray reveals that the resident's right thigh bone, called the femur, the largest and strongest bone in our body, has broken. And you'll see images that you will see during the course of trial that show the break of her bone (indicating).

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When the physician sees or hears the report of the x-ray he says send her to the hospital. And they do. They send her to Hillcrest Hospital.

At Hillcrest they determine that,

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because of the nature of the break, how bad the break is, and the fact that the resident uses a wheelchair instead of walking, that the safest and best course for her is to avoid
09:47:30 surgery, but to use an immobilizing brace secured on her leg that will hold the bone that's been repositioned in place and allow her body to try to heal the break.

The doctor sends orders to Kindred -
09:47:48 Stratford, and the orders include how to manage the brace. The brace has to remain on the right leg at all times, it must be positioned appropriately, it should be as high on the thigh as possible to protect her bone,
09:48:12 it can be opened for skin care but should not be removed, and there should be precautions taken to prevent wounds - decubitus is a word for wound, a pressure ulcer - on her heels and her legs.

09:48:34 In the week she's hospitalized she's stabilized. She goes back to her home, Kindred - Stratford, with that order to maintain the brace.

Within the first week she's back at
09:48:52 Kindred the family sees the brace isn't on

correctly, and they complain. The second week the brace is still not on correctly, not being put on correctly, not being managed correctly. The family complains. The physical therapy
09:49:11 department is asked to retrain nursing staff on how to manage the brace. A blister is discovered on her upper leg and eventually a wound is discovered, 33, 33 (indicating), three weeks after she returns to the nursing
09:49:37 home. They discover a Stage II wound. And you'll see the illustration Kindred provides to its nursing staff about a Stage II wound. It's a wound that's open and going down but it hasn't gotten to the fat layers underneath our
09:49:57 skin.

Within a few days of discovering this already Stage II wound, it's progressed to a Stage III. And you'll see Stage III. And you'll see Kindred's representation of a Stage
09:50:25 III pressure wound. It's an open wound, and that's III out of IV, that has penetrated the subcutaneous fat layer underneath our skin layers.

A wound doctor from outside the
09:50:42 facility comes in and has to surgically remove

the dead, necrotic tissue around the wound. It's called debridement. Shortly after that the therapy department that had been helping -- trying to help Leona get back to wheeling herself in the wheelchair decides she can't attain the goals they set. She's about halfway there and she's not going to get any better, and they discharge her.

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On July 17th -- She returns to the facility on June 10th. By July 17th the wound has progressed to a Stage IV out of IV. It's one of three wounds that have developed, if you include the blister. And you'll see Kindred's representation of a Stage IV wound. It's a wound that has gotten past the layer of fat under our skin and is exposing bone or tendon.

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The wound doctor again has to come in and surgically remove dead and dying tissue around the wound. He's asked for consultation from the facility's dietitian. That's somebody's responsible for setting the standard meals in the facility to keep everyone in good diet and health, and also in special cases to consult. And she indicates

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that she's addressing wounds associated with the brace. She'll try to set higher levels because the resident's body is trying to heal a broken bone and now trying to heal open
09:52:49 wounds and requires extra protein.

The wound doctor orders a test to determine if the wound is infected. It's called a wound culture. And the wound culture results come in four days later, and it is
09:53:05 infected Klebsiella pneumoniae ESBL. Klebsiella. The ESBL means it has already developed the type of bacteria that has resistance to many types of antibiotics. Sometimes referred to as a super bug.
09:53:27 Klebsiella is identified in the wound.

A few dates later the resident spikes a fever, indicates she's not feeling well. And then on August 8th, after the wound doctor has been back again, a nurse goes into the
09:53:54 resident's room and documents that the resident complains of not feeling well, takes her vital signs and discovers 100.1 degree fever, and puts on a stethoscope and listens to the resident's lungs and hears sounds in
09:54:17 her upper lungs, sounds that you will hear

concern that nurse. This is August 8th of 2013. It's a Thursday.

The next day, no one takes the resident's temperature. The next day, Saturday, no one takes the resident's temperature. In fact, you'll see there's no notes from any nursing care at all. On Sunday no one takes the resident's temperature. Again, you'll see there are no notes that day for any nursing care whatsoever. On Monday, no one takes the resident's temperature. On Tuesday, no one takes the resident's temperature.

On Wednesday, a nurse who had not been caring for her regularly, walks in, takes one look at her and describes her. Elevated temperature, heart rate and pulse. Her heart's raising. Her pulse ox, the clip on your finger that checks how well oxygenated your blood is, out of 100% is at 85% despite the nasal cannula, the tube she uses. She looks lethargic, she's sweaty. When she puts on the stethoscope and listens to her lungs, those sounds have gotten worse in those six days and they're now in the top and bottom

parts of her lungs.

She makes her supervisor aware. They call the doctor, and the doctor says send her to the hospital. They call an ambulance service that's going to take an hour. Supervisor says call 9-1-1 emergency. They call 9-1-1, she's taken out on a stretcher. They say we won't take her to Hillcrest. She has to go to a different hospital, Ahuja, because of how her condition is.

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She's taken to Ahuja where she's diagnosed with sepsis. You'll learn that sepsis is a system-wide reaction to infection. It's when your whole body is reacting to infection, not just a local infection.

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They suspect she might have pneumonia. She's not able to sustain her life by breathing so they surgically put a tube into her lungs and attach that to a machine to push air in and out of her lungs, called a ventilator. They perform a procedure to try to get what they think might be fluid in her lungs out, and they discover there is not enough fluid to get out. There is enough in her throat to test it for bacteria, for

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infection. And it comes back Klebsiella. Klebsiella.

From August 8th for the next couple of weeks she doesn't improve, she doesn't get better. She's stabilized, she's kept alive on a ventilator, and eventually the family has to confront and make one of the hardest decisions of their life. They have to, in consultation with her healthcare providers, make the decision that, because she's not going to improve and they believe would not want to be kept alive indefinitely on the machine, disconnect the ventilator and she passes away on August 23rd, 2013, 11 weeks after an aide walked into her room, turned her on her side and her legs fell out of bed.

The coroner, we call it the Cuyahoga County Medical Examiner, or ME, Dr. Thomas Gilson, opens an investigation. His investigation consists of obtaining medical records, talking to healthcare providers, examining her body, and, if necessary, performing a surgical procedure called an autopsy to open her body.

He determines there's no need for an

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autopsy, and he determines in a legal Death Certificate that the cause of her death was right femur fracture with complications. He lists the time and date and location of the
09:59:20 injury as occurring at Stratford Commons on June 3rd, 2013. That day is the second time she was turned on her side and fell out the other side of the bed. That resident had prior conditions that the medical examiner was
09:59:50 aware of and determined did not cause her death.

That resident was Leona Maxim. And I represent the estate of Leona Maxim through the executor of the estate, one of her
10:00:05 daughters, Christine Guest, in an action to recover for two groups.

One is for Leona Maxim herself, what she went through in being rolled out of bed the second time, breaking her leg, the
10:00:22 complications that arose, the wounds, infection, the decline, what she suffered. And a second group, her immediate family, called next of kin, for what they endured and continue to endure from the untimely and
10:00:42 premature loss of their mother.

Now let me tell you a little bit about who we're suing and why. We're suing two companies. The first is an entity, a legal entity, one of hundreds that Kindred forms to hold a nursing home -- to actually have the license for a particular location. It's called KND Development 51, LLC. There's a 50, there's a 52. That's the nursing home itself, Kindred - Stratford.

10:01:19 We're also suing the Kindred parent company that operates and is responsible for all of those nursing homes. That's called Kindred Healthcare Operating, Inc. Kindred - Stratford and Kindred corporate. And we're

10:01:36 suing them for violating four safety rules.

The first rule they violated is that when a caregiver turns a resident on their side in bed they must not let the resident fall out the other side of the bed. We know

10:01:53 Kindred violated the rule because an aide walked in and turned Leona on her side in bed alone and she fell out the other side of the bed.

And we know this is a rule because,

10:02:07 as you will hear during the trial from

Kindred's own employees, they're required to provide adequate and timely care, they're required to follow doctor's orders, and, based on what they knew about Leona from caring for her, from evaluations that were conducted in the nursing home that she had been in and lived in as her home since 2007, they knew she needed a second person on the other side of the bed, and on June 3rd they only had one.

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We know they had been violating this rule repeatedly because, as you'll see in the records the nursing aides keep, all of those 2s showing only one person was providing assistance with bed mobility. You'll see that that is a pattern that continues all the way until July of 2012, which is the last of these records Kindred gave us.

You'll hear from Kindred staff that it was the nurses who are responsible for making sure that those physician's orders and the care needs are followed and met with the aides. They supervise the aides.

You'll hear from Kindred's director of nursing at the time who will explain that it was his job to make sure the nurses were

supervising the nursing assistants. And we know what happened as a result. We know she broke her leg from the force of the impact, and because she needed the brace and her body
10:03:52 was struggling to heal the broken bone that her skin declined, open wounds all the way down to bone and tendon, and we know it became infected, the infection spreads, she can't breathe, goes to the hospital and dies.

10:04:12 You'll hear from Kindred's nursing staff who will tell you the reason that order was in place, the reason somebody should have been on the other side of the bed, was to prevent this type of injury. It was for the
10:04:24 resident's safety, and that someone on the other side of the bed would have been standing there making sure she was positioned safely and if she started to fall to prevent that from happening. So if Kindred had followed
10:04:39 the rule and the physician's order all those other times, falls like this would be prevented.

The second reason we're suing Kindred is because they violated the rule that a
10:05:01 nursing home corporation must make sure

residents don't develop wounds, and, if they do - avoidable wounds - and if they do, they must prevent those wounds from becoming infected.

10:05:19 We know they violated those rules because despite the doctor with Hillcrest saying take precautions with her skin, keep the brace in place, they didn't. In fact, they didn't even notice one of the wounds

10:05:36 until it was already a Stage II out of IV.

You'll learn what Kindred teaches its staff is that there's a stage before it's a wound when you can identify red areas, bruising, things like that that might indicate

10:05:51 some type of skin breakdown. Then there's Stage I, a blister or open wound. Then Stage II. Then they let it progress to Stage III and Stage IV, and critically they let it become infected. They didn't take adequate

10:06:08 precautions cleaning and changing dressings to prevent that infection with Klebsiella. We know the result of that; it was one more stress on her body when she was already trying to repair the broken bone, and it seeded an

10:06:25 infection of the same family of bacteria

that's later found in her lungs when she can't breathe -- or in her throat.

You will hear from Kindred's own nursing staff who will agree with this rule. They'll agree that if they were taking -- that it was their job to check the skin for possible skin wounds, Stage I, and not let it get to a Stage II before they even notice it.

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And you'll hear from an occupational therapist from Kindred who testified and he'll explain to us that after three weeks of her coming back from the hospital they were still having to train the staff again on how to keep the brace in the right position. You'll learn they took a picture of it and stuck it on the wall because of the complaints about it not being positioned correctly.

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The third reason we're suing Kindred is because they violated a safety rule that a nursing home must put residents' safety ahead of its own profit. Safety of residents comes before corporate profit. We know they violated this rule. We have months and months of records showing there's not a second person on the other side of the bed consistently.

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We know, and you'll hear about, how much care residents require for that morning care, afternoon care, taking to and from meals, and every time they push a button that they need help, and you'll learn that every nursing aide in the facility was caring for 10 or more people at a time.

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You'll learn that there was a budget sent to the facility administrator who had been asked to provide the bare minimum staffing projections, and that the number one way to spend less in the facility was to have fewer staff and the number one way to make more money was to have more people who need help, more residents in the facility. And you'll learn that they paid the administrator more money the less money he spent.

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Every week they made him get on a call and report how they were doing financially. Not because Kindred needed to know. You'll hear from that corporate representative. Not because Kindred needed to know. They had all the numbers. They had every number for every nursing home they owned and operated. They did it to remind the

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administrators what was important. They did it to keep the administrators focused on the bottom line because the more you talk about it, they had found, the more likely they were
10:09:35 to keep it in top of their mind and focus on it.

And you'll hear from an expert who's looked at the numbers Kindred provided about how much care their residents needed, and
10:09:51 he'll explain to us that if you take the amount of care they said their residents needed and you compare that with studies that show how many minutes on average a staff member would need to spend with someone like
10:10:05 that, that the care needs were up here and the minutes were down here (indicating).

We know what would have happened if Kindred had followed the rule and put safety of Leona above its own profits. We would have
10:10:24 had more people in the room. Every time they turned Leona they would have a second person on the other side of the bed who would have prevented this fall, and they would have had more people available to do those skin checks
10:10:35 to take that precaution that the doctor at

Hillcrest said they needed to take with her skin and identify that a wound was developing earlier and help prevent it from becoming infected. And they would have made sure that
10:10:49 their staff knew and had time to make sure that brace was on correctly. That would have prevented the injury, and even after the fall it would have prevented some of the complications that arose.

10:11:03 The fourth reason we're suing Kindred is because they violated the rule that nursing homes must ensure that incontinent residents, like Leona, were given appropriate treatment and services to prevent urinary tract
10:11:21 infections.

Now, we know they violated this rule because after those six days with no one checking her temperature, when that nurse finally comes in and sees her and says, oh, my
10:11:39 God, and they send her to the hospital, she has a urinary tract infection that they had not only not provided adequate services to prevent, they had not even noticed.

More than that, you will learn that
10:11:54 while making her home at Kindred - Stratford

and relying on them for care, she had multiple urinary tract infections. This was a pattern of failure on the part of Kindred. Broken bone, skin wounds, infection in her skin
10:12:13 wound, infection in her urinary tract, that's what Leona had to fight through, but it was too much. And we know what would have happened if they had followed that rule. It would have been at least one less thing that
10:12:28 her body would have had to fight to fix.

The final reason we're suing Kindred - Stratford and the company that operates it is because they refuse to take full responsibility for harming Leona and her
10:12:47 death. And so we were forced to come to trial to hold them accountable.

Now, before we could come to trial and do all this and ask you to be here, we had to answer some questions, and one of those
10:13:06 questions we had to answer was was Leona so sickly already when the second time they pushed her out of bed that she was going to be dead in 11 weeks anyways. Because you'll learn Leona had a list of health conditions.
10:13:25 In fact, many of them she had when she arrived

in the 2000's. They included things like Parkinson's, COPD. She needed that oxygen tube on all the time. She had seizure disorder from when she was a child and had some seizures. She had a vitamin D deficiency. The list goes on.

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So we investigate it. We called the Cuyahoga County Medical Examiner who had investigated and issued a cause of death. He told us he had reviewed just the way he normally would medical records. He talked to staff at Ahuja who told him this is someone who had a fall and never returned to her baseline.

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You'll learn that through his investigation, which includes notes on all of those pre-existing conditions, that it was his decision, his determination, more likely than not, and frankly he's sure, that the cause of death was the broken leg and the complications from that, not her prior health conditions.

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We also reached out to a doctor out of Chicago who has been practicing 30 plus years. This is the Death Certificate you'll see. We sent the Death Certificate, but we

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also sent years of records, medical records for Leona, from Kindred, from Hillcrest after the broken leg, from Ahuja Hospital, images of the x-rays, and we asked that doctor, someone who teaches other doctors, who has a special certification called board certification in family medicine, and you'll learn underneath that his subset is gerontology, specializing in the care of older people. That's what he is.

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That doctor, Dr. Seskind, will testify and explain his investigation as well. And he'll say he agrees with the medical examiner. He'll explain that all of these other conditions can be serious, no question about it. That COPD, she needed an oxygen tube. Not everyone needs that. But he'll explain that Leona was stable with those conditions.

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Parkinson's is a cause of abnormal movement. You'll see records from Kindred that document no abnormal movements. Month after month, 0, 0, 0, 0, down the page. In fact, they eventually stopped checking because it's not an issue. You'll see that 0, 0, 0,

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all the way until they stop bothering to check.

You'll learn that he looked at the hospitalization that occurred about a month prior to the fall, and found that there was a bout of pneumonia. She was in the hospital for three days, returned, and returned to her baseline. In fact, after that she's evaluated by that occupational therapist at Kindred, and you'll hear from him. You'll see his records where he evaluates Leona.

Prior to the leg break he evaluates her for therapy, says she's a good candidate for therapy, assigns goals to her that she is meeting and progressing towards, that she's recovering. You'll see there's no signs or symptoms of infection, that that had resolved. And you'll see what happens after the broken leg when the same occupational therapist goes to evaluate her, describes her as lethargic and she's not even able to get out of bed for two weeks until the physical therapy folks and the occupational therapy folks and the nurses all get together to help her overcome her terror to get out of bed. She's afraid

they're going to drop her again.

We talked to Leona's caregivers at Kindred, other caregivers, the nurses. We looked at the records, we looked at evaluations, and you'll see evaluations like a mental status evaluation from May after the short bout with pneumonia prior to the June 3rd getting pushed out of bed. It shows she's cognitively intact, 15 out of 15 on that test.

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And you'll see a mental status evaluation on June 17th, two weeks after she's pushed out of bed, that describes her as having severe impairment, cognitive impairment. At this point she has sores, eventually therapy discontinues altogether.

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And you'll hear from staff that describe Leona before the broken leg as someone who loved life, who was out of bed every day in her wheelchair at activities. And not passively at activities, not rolled to some room where she sits there. She was participating. She loved bingo. She won bingo a lot. You'll learn that she won all these stuffed animals that she gave to one of

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her daughters so their dog could play with it. She loved that. She played cards. She played rummy all day. She went to the music. She went to the sing-alongs. Kindred staff who
10:19:18 worked with her every day will say she loved life. This was her home. She was enjoying her life before that broken leg.

Finally, we asked Leona's family, tell us about Leona before, and they said the
10:19:34 same thing. In fact, you'll learn they were there. Her two daughters that lived in town were there every weekend playing endless gin rummy far longer than anyone should like to play gin rummy because their mom loved it and
10:19:54 it was an excuse to have conversation. They brought flowers every week. It was her home. It was just where she needed to be to get assistance getting out of bed, she could get assistance getting changed. It wasn't where
10:20:12 she went to die. It's where she went to live.

They'll describe Leona after the broken leg; a decline. She stops being as active. For two weeks she's not out of bed. When she's finally able to get out of bed,
10:20:24 she's not able to participate as much in

therapy, she's not as interested in activities, she's hunched over, she declined. And they try to keep her engaged. Leona is someone they would take out of the facility on a regular basis, take her from her home to their home to see the extended family. And they tried to do that even into August. And you'll see the photos of her from that and you'll see the difference.

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That's how we determined Leona wasn't somebody that because she has a long list of health concerns, for years had had those, she wasn't somebody who was just coincidentally going to die 11 weeks later after they broke her leg.

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The next question we had to answer was whether it mattered that on June 3rd that doctor's order that had been put in place in 2011 didn't show up anymore, because what we learned when we read the medical records is that it shows up in the physician's orders month after month after month after month and then on June 1st it's gone. On June 3rd they rolled her out of bed.

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What we learned from Kindred was that

when Leona in April, the end of April, beginning of May, had gone out to the hospital briefly, when she got back they had discontinued all her orders and then they put them back on except for the two-person assist in bed. And so if that means that Leona didn't need two people to help her, if that means the nursing home wasn't required to have a second person there, then we couldn't come in here and ask them to be responsible for not having that other person there.

So we investigated. We asked those caregivers did you know Leona needed help, a second person on the other side of the bed, regardless of whether there was an order in place? Oh yeah, we knew that. We looked at evaluations of her safety in bed that determined she needed a second person on the other side of the bed, or showed these caregivers she needed that.

She didn't have trunk control. She didn't have control of her legs. She could wheel herself around the facility all day long. She could go to activities. She could enjoy life, but she needed help when it came

to her legs and her balance. Her caregivers knew that, and it was their job to make sure the aides knew it. Even when that order was in place you'll see those records showing it
10:23:21 wasn't being followed by the nursing aides, and the nurses weren't doing anything about it, and the director of nursing wasn't doing anything about it.

You'll also learn that taking that
10:23:34 order off should only be done by a physician, and you will see no evidence that after returning from a bout of pneumonia her doctor was ever contacted or ever contacted them to say take that order off. This is a glitch,
10:23:51 this is a system mistake, and that's how it was determined that regardless of whether that order was in place or not on June 3rd, the nursing home had to have a second person on the other side of that bed.

10:24:12 We also determined that Leona's family was never called about that order going away. Why is that important? Well, you'll hear from the head of the nursing home when this happened, the administrator that Kindred
10:24:32 calls an executive director. No longer works

there. But he'll testify by video for you and he will tell you, well, if we change that order, that should only be changed by a doctor, that would be a change in what's called the treatment plan. And when you change the treatment plan for a resident, you have to tell their responsible party, which in this case was Leona's daughters. And they never did. And if they had, and you'll hear what would have happened, why are you changing that? Someone needs to be on the other side of the bed. Instead of doing that, on June 10th, or somewhere between June 3rd and June 10th when she comes back from the hospital, they write in the records we're putting on an NO, new order, for two-person assist. They knew that wasn't in the order. You just have to look to last month and see, and you'll learn nobody can tell you if there was an investigation into what happened. No one was punished. There is no accountability for how that happened.

We also had to the determine if Leona was somebody that because of her nature, her health, no one could blame anyone for her

broken leg. Maybe her bones were so weak that it just happened when she turned on her side. She has a vitamin K deficiency. She's been taking medicine for Parkinson's for years, and
10:26:13 we learned that can cause bones to be more brittle. We investigated that and looked at it. We looked at those x-ray films and we sent that to a doctor, and he told us this type of break, where the bone isn't just
10:26:30 broken but actually at an angle, that's the result of force. And you'll see in the note the description of her legs hitting the floor. And you'll learn that when she had the same conditions in 2011 versus her bones, when they
10:26:57 rolled her out of bed that time it didn't break her bones.

She's not somebody when they took her in and out of bed every single day prior to this that her bones were just snapping. She
10:27:10 was somebody for whom force was required. And we also learned that in Ohio if somebody is susceptible to an injury and you're careless and you hurt them, and because of who they are it hurts them more than it might hurt somebody
10:27:32 else, you don't get a pass on that. And

you'll learn that everything you will hear about Leona's medical conditions are things Kindred knew, her caregivers knew. And you'll hear them explain that the more at risk
10:27:51 somebody is that they're caring for for things like a fall or an injury the more careful they're supposed to be. That's the point of being there is to have help with things that you need.

10:28:03 And that's how we determined that Leona wasn't some special case where you couldn't blame Kindred for what happened.

We also had to look at and answer the question regarding Leona's wounds, this
10:28:24 blister or the smaller ones, the Stage II that became a Stage III that became a Stage IV that got infected. Was Leona some person for whom those were just unavoidable because of her conditions.

10:28:36 And, in fact, we looked and we saw an order put in place back in February of 2012, and the order says to left ischial. Ischial is the part of the body where your butt meets your leg. There could be a fold there. If
10:28:57 you're sitting in a wheelchair or lying in bed

and you're older and you're at risk of skin breakdowns, that's one area that can happen.

And we were concerned is this somebody who has a history since 2012 of having these wounds here, so we looked. We looked at the nursing notes for February of 2015 -- 2012. And what that revealed was that the nurse documented that she had an abrasion to her ischial from an incontinence pad. The doctor ordered that when she had an incontinent moment she could be cleaned, dried and there should be cream put on it to prevent the wound because there was a risk.

You'll learn there was never a wound, and that order stayed in place and there was never a wound.

We also pulled every single weekly skin check for the year prior to her fall, and we looked at them. And other than a fungal infection of her cuticle, there was no significant wound at all. It was only after the June 3rd fall, after the need for the brace, after having her body direct her energy to her leg did she need -- have these significant wounds. That's how we were able

to determine these weren't unavoidable. This isn't somebody who just chronically had skin wounds. This was caused by the broken leg, this was caused by the brace.

10:30:40 We also had to determine if that bout of pneumonia about a month before she was rolled out of bed, if that might be what caused her death almost two months after she broke her leg. So in that three-month spread

10:30:58 that brief bout of pneumonia, was that actually responsible. If it was, in fairness we could ask for redress for what she went through but not her death. So we investigated.

10:31:09 We looked at the records from the hospital for that hospital stay, and it showed that she may have aspirated. It's where you're eating and you choke but some of the food gets in your lungs and causes an

10:31:23 inflammatory reaction. And that she was stabilized and sent home to Kindred - Stratford after just a couple days.

You'll learn that she didn't have signs or symptoms related to any pneumonia in

10:31:40 that month before her leg was broken. In

fact, after those six days in August when they knew she had a fever and no one was checking it, when that nurse finally came in and they took films of her chest, actually during that
10:31:55 period it showed that it was actually better than the films taken back in May. Meaning now that she's on this decline, she still must have improved past that point and come back down.

10:32:12 We asked the geriatrician, Dr. Seskind, and he'll explain to us that that had nothing to do with what happened to her and the fall, the broken leg, it had nothing to do with the complications of that.

10:32:27 We'll hear from the medical examiner. He'll say this was caused by the broken leg and complications from the broken leg. And that's how we were able to determine that that bout had nothing to do with her death.

10:32:48 Finally, we had to ask the hard question; was Leona or Leona's family somehow to blame. So we investigated and started by asking Kindred. We asked the nurses, did Leona have anything to do with the fall or her
10:33:06 decline? Was it something she did? They all

said no, you can't blame Leona. What about her family? You'll hear their testimony about Leona's family being attentive, concerned, visiting frequently, even her out of town
10:33:24 daughter and her out of town son, that they were right there complaining about the brace, they were right there being reassured that things were going to go well.

Kindred will explain, and the
10:33:41 physician they hired to talk to you about this, everyone will explain, Kindred and everyone, that Leona's family bears no responsibility, and that's how we were able to determine that we didn't need to worry about
10:33:56 blame for them.

So we were able to bring this case and we were able to bring this case to trial with you.

Let me talk about damages because
10:34:13 you're going to be asked if you find that Kindred was careless you're going to be asked to return a money verdict for the harm they caused. And I want to talk to you about that because I have the burden, we have the burden,
10:34:30 of proving that to you. So let me start by

saying we're not going to show this for sympathy. The judge will tell you, I'll tell you, opposing counsel will tell you, sympathy doesn't enter into your verdict; not sympathy for Leona, not sympathy for her family, not sympathy for Kindred. You can feel sympathy, you're human beings, but, when it comes to evaluating a verdict, that's outside the box.

What you have to look at is the evidence of what Leona went through and experienced and what her family, her immediate family's relationship, was, and the loss of this person in their lives, and that's unique to them. So I have to present that to you not for sympathy but because that's how we prove that part of our case.

So let me tell you a little bit about what you're going to learn about the harms and losses in this case. You're going to hear about being rolled out of bed. You'll hear about the break and type of break it is. You're going to see the complaints of pain and what she experienced. You're going to learn how that break led to the hospitalization which led to energy her body didn't have much

of being directed to her leg, the skin wound healing, the urinary tract infection, the infection in her leg. You'll hear from the medical examiner, Dr. Gilson. He'll explain
10:36:08 to you that we all have a limited amount of energy for things like that. When our body has to heal us and there is an emergency to our body, it has to redirect our energy. You'll hear that from Dr. Seskind as well.
10:36:23 You'll also hear about the second type of damages. You'll hear about Leona's place in the family. You'll hear about Leona's two local daughters. You'll learn that the whole reason she was at Stratford
10:36:37 Commons to begin with is because they wanted her close. You'll hear about them going to the facility every single weekend. You'll hear from the staff about knowing them by name, knowing the family. The daughter who
10:36:51 lived out of state, they knew her by name because she called so much to talk, called so much to talk with her mom. You'll hear that those three daughters talked with their mom every day.
10:37:04 Mark, the young one, the son, has a

family in Florida. You'll hear that they visited for holidays. When he says holidays, he'll explain for him in his family how that worked, that included Mother's Day, that included her birthday. And if his family wasn't all able to come, he came alone.

10:37:20

You'll hear about how Leona was the center matriarch of this family; that she was the strength emotionally for them when they lost their father; that when Chris lost her husband due to a medication problem unexpectedly it was Leona she turned to to help her grieve, to help console her, to help give her strength.

10:37:37

10:37:58

You'll hear about stories of them coming to the facility playing games all day for hours and really looking to her in their life for support. And those are the types of things you'll have to consider and the law asks you to consider in assigning value, as hard as that can be, to loss of life.

10:38:15

This is a case, you'll hear me say again, it's a very important case. It's a case that raises questions about what a nursing home ought to do, how a nursing home

10:38:37

ought to care for somebody. Those are questions you're going to decide. It's the type of case that I think you'll understand once you've seen the evidence and heard the
10:38:57 testimony is the type of case where I have to ask for a lot of money, and at the conclusion of this trial I'm going to ask you to return a verdict of $9 million. Thank you.

THE COURT: Ladies and
10:39:18 gentlemen, I'm going to give you about a ten-minute recess at this time. Once the defense lawyers start I don't want to interrupt his argument, either, so we'll go for the morning recess. Approximately
10:39:32 10 minutes.

Everybody rise while the jury leaves the courtroom. Don't discuss the case with anyone. Don't let anybody discuss the case with you.

10:39:40 - - - o0o - - -

(Thereupon, a recess was had.)

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THE COURT: Counsel may proceed with your opening statement.

10:55:10 **DEFENDANTS' OPENING STATEMENT**

C E R T I F I C A T E

I, Angela R. Cudo, Official Court Reporter for the Court of Common Pleas, Cuyahoga County, Ohio, do hereby certify that as such reporter I took down in stenotype all of the proceedings had in said Court of Common Pleas in the above-entitled cause; that I have transcribed my said stenotype notes into typewritten form, as appears in the foregoing Transcript of Proceedings; that said transcript is a complete record of the proceedings had in the trial of said cause and constitutes a true and correct Transcript of Proceedings had therein.

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