Arkansas
State Claims Commission
AUG 15 2013
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Please Read Instructions on Reverse Side of Yellow copy

Please print in ink or type

BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

Do Not Write in These Spaces
Claim No. 14-0154-CC
Date Filed August 15, 2013 (Month) (Day) (Year)
Amount of Claim $?
Fund DHS/BHS

Failure to Follow Procedure, Wrongful Death, Negligence, Pain and Suffering, Mental Anguish

☐ Mr.
☒ Mrs.
☐ Ms.
☐ Miss Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, deceased, Claimant

vs.

State of Arkansas, Respondent
DHS/Behavioral Health

COMPLAINT

Lanelle Kendrick, as Special Administrator (Name), the above named Claimant, of 2109 East 12th St. (Street or R.F.D. & No.), Russellville (City), AR (State), 72802 (Zip Code), 479-967-4802 (Daytime Phone No.), County of Pope, represented by The Edwards Firm, P.L.L.C. (Legal Counsel, if any, for Claim) [handwritten margin note, partly illegible] of 711 W. 3rd St. (Street and No.), Little Rock (City), AR (State), 72201 (Zip Code), 501-372-1329 (Phone No.), 501-372-1336 (Fax No.)

State agency involved: DHS-Division of Behavioral Health-AR Health Cntr. Amount sought: to be determined

Month, day, year and place of incident or service: July 15, 2013

Explanation: PLEASE SEE ATTACHED COMPLAINT

CLAIMANT WILL SUPPLEMENT COMPLAINT WITH A CERTIFIED COPY OF DEATH CERTIFICATE AS WELL AS ANY OTHER REPORT THAT ARE PERTINENT TO THIS CLAIM AS THEY BECOME AVAILABLE.

PURSUANT TO THE RULES & REGULATIONS OF THE ARKANSAS STATE CLAIMS COMMISSION THE CLAIMANT, LANELLE KENDRICK, STATES:

MR. KENNY KENDRICK DIED IN THE FACILITY WHILE A RESIDENT OF ARKANSAS HEALTH CENTER. UPON INVESTIGATION TO DATE, MR. KENDRICK'S FAMILY HAS CONCLUDED THAT THERE IS NO LIABILITY ON THE PART OF ANYONE, OTHER THAN AR. DEPT. OF HUMAN SERVICES, THE DIV. OF BEHAVIORIOL HEALTH SERVICES, AR HEALTH CENTER. THERE FORE, THERE ARE NO REMEDIES TO BE PURSUED AGAINST ANY INSURER

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? NO (Yes or No); when? (Month) (Day) (Year); to whom? (Department); and that the following action was taken thereon:

and that $ ______ was paid thereon: (2) Has any third person or corporation an interest in this claim? ______; if so, state name and address

(Name) (Street or R.F.D. & No.) (City) (State) (Zip Code)

and that the nature thereof is as follows: ______; and was acquired on ______, in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

Lanelle Kendrick, SPECIAL ADMINISTRATOR (Print Claimant/Representative Name) [signature] (Signature of Claimant/Representative)

(SEAL) ROBERT EDWARDS COM. EXP. NOTARY PUBLIC 5-16-2015 PULASKI COUNTY, ARKANSAS

SWORN TO and subscribed before me at Russellville (City), Arkansas (State)

on this 15th (Date) day of August (Month) 2013 (Year)

Robert H. Edwards (Notary Public)

My Commission Expires: May (Month) 16 (Day), 2015 (Year)

SF1-R7/99

Arkansas
State Claims Commission
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IN THE ARKANSAS CLAIMS COMMISSION

Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, deceased, and on behalf of the wrongful death beneficiaries of Kenny Kendrick — CLAIMANT

vs. CLAIM # - _____

State of Arkansas, Department of Human Services, Division of Behavioral Health Services, Arkansas Health Center — RESPONDENT

COMPLAINT

Comes now Claimant, Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, deceased, and on behalf of the wrongful death beneficiaries of Kenny Kendrick, and for her cause of action against Respondent, the State of Arkansas, Department of Human Services, Division of Behavioral Health Services, Arkansas Health Center, states:

JURISDICTIONAL STATEMENT

1. Lanelle Kendrick is Special Administrator of the Estate of Kenny Kendrick, deceased, pursuant to Order of Saline County Circuit Court, Probate Division, Case No. PR-63-13-402-2, attached hereto as **Exhibit A**, and brings this claim on behalf of the Estate of Kenny Kendrick, deceased, and on behalf of the wrongful death beneficiaries of Kenny Kendrick, pursuant to the Arkansas Survival of Actions Statute (Ark. Code Ann. § 16-62-101) and the Arkansas Wrongful Death Act (Ark. Code Ann. § 16-62-102). Lanelle Kendrick brings this action against Respondent claiming damages on behalf of Kenny Kendrick arising out of his care and treatment by Respondent that occurred at Arkansas Health Center.

2. Lanelle Kendrick is the mother of Kenny Kendrick and is a resident of Russellville, Pope County, Arkansas.

3. Upon information and belief, Kenny Kendrick was admitted in June, 2013 as a resident of the Arkansas Health Center located at 6701 Highway 67, Benton, Arkansas 72015. Kenny Kendrick remained a resident of the Arkansas Health Center until his death, July, 15, 2013.

4. Defendant Arkansas Health Center is part of and run by the Division of Behavioral Health Services of the Arkansas Department of Human Services for the State of Arkansas and is engaged in the business of custodial care of elderly individuals who are chronically infirm, mentally impaired and/or in need of nursing care and treatment. Upon information and belief, at all times material to this action, Respondent Arkansas Health Center held the license for the facility located at 6701 Highway 67, Benton, Arkansas 72015. The causes of action made the basis of this suit arise out of such business conducted by Respondent Arkansas Health Center in the ownership, operation, management, licensing and/or control of the facility during the residency of Kenny Kendrick. The registered agent for service of process of Defendant Arkansas Health Center is John Selig, the Director of the Arkansas Department of Human Services.

5. Jurisdiction and venue are proper in the Arkansas Claims Commission.

FACTUAL ALLEGATIONS

6. Upon information and belief, Kenny Kendrick was admitted in June, 2013 as a resident of Arkansas Health Center (sometimes referred to herein as "the facility"). Kenny Kendrick remained a resident of the facility until his death on July 15, 2013.

7. Respondent was aware of the medical condition of Kenny Kendrick and the care he required when they represented that they could adequately care for his needs.

8. In an effort to ensure that Kenny Kendrick and other residents whose care was partially funded by the government were placed at Arkansas Health Center, Respondent held themselves out as being:

a) Skilled in the performance of nursing, rehabilitative and other medical support services;

b) Properly staffed, supervised and equipped to meet the total needs of their nursing home residents;

c) Able to specifically meet the total nursing home, medical and physical therapy needs of Kenny Kendrick and other residents like him; and

d) Licensed by DHS and complying on a continual basis with all rules, regulations and standards established for nursing homes.

9. Respondent failed to discharge its obligations of care to Kenny Kendrick with a conscious disregard for his rights and safety. At all times mentioned herein, Respondent had knowledge of, ratified and/or otherwise authorized all of the acts and omissions that caused the injuries suffered by Kenny Kendrick, as more fully set forth below. Respondent knew that this facility could not provide the minimum standard of care to the weak and vulnerable residents of the facility.

10. The severity of the recurrent negligence inflicted upon Kenny Kendrick while under the care of the facility accelerated the deterioration of his health and physical condition and resulted in the physical and emotional injuries described below:

a) Pain;

b) Suffering;

c) Mental Anguish;

d) Neglect;

e) Suffocation; and

f) Untimely death.

The above-identified injuries, as well as the conduct specified below, caused Kenny Kendrick to suffer loss of personal dignity, pain and suffering, degradation, mental anguish, disability, emotional distress, and caused his untimely death.

11. Respondent controlled the operation, planning, management and quality control of Arkansas Health Center. The authority exercised over the nursing facility included, but was not limited to, marketing, human resources management, training, staffing, creation and implementation of all policy and procedure manuals used by Arkansas Health Center, federal and state reimbursement, quality care assessment and compliance, licensure and certification, legal services, and financial, tax and accounting control through fiscal policies established by Respondent.

12. Respondent owed a duty to Kenny Kendrick to maintain and adequately staff their facility with sufficient numbers of qualified, trained staff to meet the needs of the residents, including Kenny Kendrick, and are directly liable for the failure to exercise reasonable care in hiring, supervising, training and retaining sufficient numbers of qualified nurses and other staff employees and caregivers during the residency of Kenny Kendrick. Said failures placed the residents of the facility, including Kenny Kendrick, at risk of harm. Respondent are directly liable for injuries suffered by Kenny Kendrick as a result of these failures to exercise reasonable care. Likewise, Respondent owed a duty to Kenny Kendrick to have adequate and available food, fluids, supplies and functioning equipment to meet the needs of the residents, including Kenny Kendrick, and are directly liable for the failure to exercise reasonable care in providing and maintaining adequate and available food, fluids, supplies and functioning

equipment to meet the needs of the residents. Said failures placed the residents of the facility, including Kenny Kendrick, at risk of harm. Respondent are directly liable for injuries suffered by Kenny Kendrick as a result of these failures to exercise reasonable care.

13. Claimant alleges that during his residency at the facility, Kenny Kendrick was under the care, supervision and treatment of Respondent and that the injuries complained of were proximately caused by the acts and omissions of Respondent.

14. Respondent are vicariously liable for the acts and omissions of all persons or entities under their control, either directly or indirectly, including employees, agents, consultants and independent contractors, whether in-house or outside entities, individuals, or agencies causing or contributing to the injuries of Kenny Kendrick.

CAUSES OF ACTION AGAINST RESPONDENT

COUNT ONE - NEGLIGENCE

15. Claimant re-alleges and incorporates all of the allegations contained in Paragraphs 1 – 14 as if fully set forth herein.

16. Respondent owed a non-delegable duty to residents, including Kenny Kendrick, to provide adequate and appropriate custodial care and supervision, which a reasonably careful person would provide under similar circumstances.

17. Respondent owed a non-delegable duty to their residents, including Kenny Kendrick, to exercise reasonable care in providing care and services in a safe and beneficial manner.

18. Respondent owed a non-delegable duty to their residents, including Kenny Kendrick, to hire, train and supervise employees to deliver care and services to residents in a safe and beneficial manner.

19. Respondent breached these duties by failing to exercise reasonable care and by failing to prevent the mistreatment, abuse and neglect of Kenny Kendrick. The negligence of Nursing Home Respondent includes, but is not limited to, the following acts and omissions:

a) Failure to provide sufficient nursing and other staff that was properly qualified and trained;

b) Failure to adequately, timely and appropriately educate and inform the caregivers at the facility of the needs, level of assistance, and prescribed care and treatment for Kenny Kendrick;

c) Failure to take reasonable steps to prevent, eliminate and correct deficiencies and problems in resident care at the facility;

d) Failure to ensure that Kenny Kendrick attained and maintained his highest level of physical, mental, and psychosocial well-being;

e) Failure to establish, publish and/or adhere to policies for nursing personnel concerning the care and treatment of residents with nursing, medical and psychosocial needs similar to those of Kenny Kendrick;

f) Failure to ensure that Kenny Kendrick received adequate and proper nutrition, fluids, supervision, and skin care;

g) Failure to take necessary and reasonable custodial and hygiene measures, including turning and repositioning, to prevent the onset and progression of skin breakdown and pressure sores during the residency;

h) Failure to provide proper supervision and intervention in order to prevent falls;

i) Failure to ensure that Kenny Kendrick received adequate nutrition to prevent malnutrition;

j) Failure to provide and maintain an adequate and appropriate fluid maintenance program for Kenny Kendrick to prevent dehydration and urinary tract infections;

k) Failure to provide care and treatment in accordance with physician's orders;

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l) Failure to provide Kenny Kendrick with adequate sanitary care;

m) Failure to provide adequate hygiene and sanitary care to prevent infections;

n) Failure to adequately and appropriately monitor Kenny Kendrick and recognize significant changes in his health status, and to timely notify him and his family of significant changes in his health status;

o) Failure to monitor or increase the number of nursing personnel at the facility to ensure that Kenny Kendrick received necessary supervision, timely and accurate care assessments, received proper treatment and diet, received timely custodial intervention due to a significant change in condition, and was protected from accidental injuries by the correct use of ordered and reasonable safety measures;

p) Failure to provide adequate supervision to the nursing staff to ensure that Kenny Kendrick received adequate and proper nutrition, fluids, therapeutic diet, sanitary care treatments to prevent infection, and sufficient nursing observation and examination of the responses, symptoms, and progress in the physical condition of Kenny Kendrick;

q) Failure to adequately screen, evaluate, and check references, test for competence and use ordinary care in selecting nursing personnel to work at the facility;

r) Failure to terminate employees at the facility assigned to Kenny Kendrick who were known to be careless, incompetent and unwilling to comply with standards governing care, treatment and services provided to residents like Kenny Kendrick;

s) Failure to assign nursing personnel at the facility duties consistent with their education and experience based on:

1. Kenny Kendrick's medical history and condition, nursing and rehabilitative needs;

2. The characteristics of the resident population residing in the area of the facility where Kenny Kendrick was a resident; and

3. The nursing skills needed to provide care to such resident population;

t) Failure by Nursing Home Respondent to discharge their legal and lawful duties to protect the health and safety of residents, such as Kenny Kendrick, that such duties were consistently complied with on an ongoing basis; and to ensure appropriate corrective measures were implemented to correct problems concerning inadequate resident care;

u) Failure by Nursing Home Respondent to discharge their legal and lawful obligation to ensure compliance with the facility's resident care policies;

v) Failure to adopt adequate guidelines, policies, and procedures of the facility for documenting, maintaining files, investigating and responding to any complaint regarding the quality of resident care or misconduct by employees at the facility, regardless of whether such complaint derived from a resident of the facility, an employee of the facility or any interested person;

w) Failure to document and maintain medical records on Kenny Kendrick in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized with respect to diagnosis, treatment and assessment and establishment of appropriate care plans of care and treatment;

x) Failure to properly in-service and orient e mployees to pertinent patient care needs to maintain the safety of residents; and

y) Failure to ensure that services provided or arranged by the facility were provided by qualified persons in accordance with Kenny Kendrick's written plan of care and failure to ensure that the physician's plan of care was implemented.

20. A reasonably careful nursing home operating under similar circumstances would foresee that the failure to provide the ordinary care listed above would result in devastating injuries to Kenny Kendrick.

21. Respondent further breached their duty of care to Kenny Kendrick by violating certain laws in force in the State of Arkansas at the time of the occurrences discussed herein including, but not limited to, the following:

a) By failing to provide the necessary care and services to attain or maintain the highest practicable, physical, mental and psychosocial well-being of Kenny Kendrick, in accordance with the comprehensive assessment and plan of care;

b) By failing to ensure a nursing care plan based on Kenny Kendrick's problems and needs was established that contained measurable objectives and timetables to meet his medical, nursing, and mental and psychosocial needs as identified in his comprehensive assessment;

c) By failing to review and revise Kenny Kendrick's nursing care plan when his needs changed;

d) By failing to treat Kenny Kendrick courteously, fairly and with the fullest measure of dignity;

e) By failing to provide sufficient nursing staff and nursing personnel to ensure that Kenny Kendrick attained and maintained his highest practicable physical, mental and psychosocial well-being;

f) By failing to notify the family and physician of Kenny Kendrick of a need to alter his treatment significantly;

g) By failing to provide a safe environment; and

h) By failing to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

22. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed above. Each of the foregoing acts of negligence on the part of Nursing Home Respondent was a proximate cause of Kenny Kendrick's injuries as more specifically described herein, which were all foreseeable and caused his untimely death. Kenny Kendrick suffered personal injuries including pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, and loss of personal dignity, which caused his family to suffer grief upon his death. Claimant prays for compensatory damages against Nursing Home

Respondent for the wrongful death of Kenny Kendrick, including the grief suffered as well as the expenses of funeral and other related expenses.

23. Respondent knew, or ought to have known, in light of the surrounding circumstances, that their conduct would naturally and probably result in injury to Kenny Kendrick. Yet, Respondent continued such conduct in reckless disregard of the consequences, from which malice may be inferred. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious and/or intentional conduct, Claimant asserts a claim for judgment for all compensatory and punitive damages against Respondent including, but not limited to, Kenny Kendrick's medical expenses, pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, loss of personal dignity, loss of life and related expenses, in an amount to be determined by the jury, but in excess of the minimum jurisdictional limits of this Court and exceeding that required for federal court jurisdiction in diversity of citizenship cases, plus all other relief to which Claimant is entitled by law.

COUNT TWO

NEGLIGENCE AS DEFINED BY THE ARKANSAS MEDICAL MALPRACTICE ACT, ARK. CODE §§ 16-114-20 *et seq.*

24. Claimant re-alleges and incorporates all of the allegations contained in Paragraphs 1 – 23 as if fully set forth herein.

25. Respondent are either medical care providers as defined by Ark. Code § 16-114-201(2) and/or are liable for medical care providers as defined by Ark. Code § 16-114-201(2).

26. Respondent owed a non-delegable duty to residents, including Kenny Kendrick, to use reasonable care in treating their residents with the degree of skill and

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learning ordinarily possessed and used by nursing home facilities in and affiliated health care providers in the same or similar locality.

27. Respondent owed a non-delegable duty to assist all residents, including Kenny Kendrick, in attaining and maintaining the highest level of physical, mental and psychosocial well-being.

28. Respondent failed to meet the applicable standards of care and violated their duty of care to Kenny Kendrick through mistreatment, abuse and neglect. Respondent failed to adequately supervise nurses and other professional medical staff, and failed to hire sufficient nurses and other professional medical staff. As such, the nurses and other professional medical staff were unable to provide Kenny Kendrick the requisite care, and as a result, acts of professional negligence occurred as set forth in this paragraph. The medical negligence of Respondent includes, but is not limited to, the following acts and omissions:

a) Failure to ensure that Kenny Kendrick received the following:

   1. timely and accurate care assessments;

   2. proper treatment, medication and diet;

   3. necessary supervision; and

   4. timely nursing and medical intervention due to a significant change in condition.

b) Failure to provide sufficient numbers of qualified personnel, including registered nurses, licensed practical nurses and other professional medical staff to meet the total needs of Kenny Kendrick throughout his residency;

c) Failure to provide, implement, and ensure adequate nursing care plan revisions and modifications as the needs of Kenny Kendrick changed;

d) Failure to provide, implement and ensure that an adequate nursing care plan for Kenny Kendrick was followed by nursing personnel;

e) Failure to provide care, treatment, and medication in accordance with physician's orders;

f) Failure to assess the risk and prevent Kenny Kendrick from falls;

g) Failure to provide adequate care and treatment to Kenny Kendrick in order to prevent infections;

h) Failure to properly treat infections or to obtain necessary medical care and treatment of infections to prevent their worsening;

i) Failure to ensure that Kenny Kendrick was assessed in order to receive adequate and proper nutrition, fluids, supervision, therapeutic diet, and skin care;

j) Failure to assess the risk and to seek timely medical assistance to prevent, treat or heal the development and worsening of skin breakdown and pressure sores;

k) Failure to provide Kenny Kendrick with adequate and appropriate nursing care, treatments and medication after the development of skin breakdown and pressure sores;

l) Failure to ensure that Kenny Kendrick received adequate assessment and monitoring of his nutritional needs and intake to maintain proper nutrition and prevent malnutrition;

m) Failure to assess Kenny Kendrick's fluid intake to ensure he received sufficient amounts of fluids to maintain hydration and to prevent dehydration and infections;

n) Failure to provide proper treatment, assessment and monitoring of Kenny Kendrick in order to identify signs and symptoms of pain, and to appropriately treat and prevent his pain;

o) Failure to adequately and appropriately monitor Kenny Kendrick and recognize significant changes in his health status, and to timely notify his physician of significant changes in his health status; and

p) Failure to ensure that Kenny Kendrick was not deprived of the services necessary to maintain his health and welfare.

29. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed in the above complaint. Each of the foregoing acts of negligence on the part of the Respondent was a proximate cause of Kenny Kendrick's injuries as more specifically described herein, which were all foreseeable, and caused his untimely death. Kenny Kendrick suffered personal injuries, including pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, and loss of personal dignity, which caused his family to suffer grief upon his death. Claimant prays for compensatory damages against the Respondent for the wrongful death of Kenny Kendrick, including the grief suffered as well as the expenses of funeral and other related costs.

30. Respondent was negligent and reckless in breaching the duties owed to Kenny Kendrick under the Medical Malpractice Act for the reasons specifically enumerated in this Complaint.

31. Respondent knew, or ought to have known, in light of the surrounding circumstances, that their conduct would naturally and probably result in injury or death to Kenny Kendrick. Yet, Respondent continued such conduct in reckless disregard of the consequences, from which malice may be inferred. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Kenny Kendrick suffered injuries as described herein. Claimant asserts a claim for judgment for all compensatory and punitive damages against Respondent, including, but not limited to, Kenny Kendrick's medical expenses, pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, loss of personal dignity, and loss of life and related expenses, in an amount to be determined by the jury, but in excess of the minimum jurisdictional limits of this Court and exceeding

that required for federal Court jurisdiction in diversity of citizenship cases, plus all other relief to which Claimant is entitled by law.

COUNT THREE

LIABILITY OF THE LICENSEE OF ARKANSAS HEALTH CENTER FOR VIOLATIONS OF THE LONG-TERM CARE FACILITY RESIDENTS ACT, PURSUANT TO ARK. CODE §§ 20-10-1201, *et seq.*

32. Claimant re-alleges and incorporates all of the allegations contained in Paragraphs 1 – 31 as if fully set forth herein.

33. The Respondent, as the licensee, had statutorily mandated duties to provide Kenny Kendrick his basic, nursing home resident's rights as set forth in the Protection of Long-Term Care Facility Residents Act, Ark. Code §§ 20-10-1201, *et seq.*

34. The Protection of Long-Term Care Facility Residents Act mandates the development, establishment, and enforcement of basic standards for the health, care and treatment of persons in long-term care facilities; and mandates that the maintenance and operation of long-term care facilities will ensure safe, adequate, and appropriate care, treatment, and health of residents, like Kenny Kendrick.

35. The statutory duties imposed upon the facility licensee to prevent deprivation or infringement of the resident's rights of Kenny Kendrick were non-delegable. Thus, the Respondent, the licensee is directly liable to Claimant for any deprivation and infringement of Kenny Kendrick's rights occurring as a result of their own action or inaction, and as a result of the action or inaction of any other person or entity, including employees, agents, consultants, independent contractors and affiliated entities, whether in-house or outside entities, individuals, agencies or pools, as well as any deprivation and infringement of Kenny Kendrick's resident's rights caused by the Respondent' policies, procedures, whether written or unwritten, and common practice.

36. Any person or entity acting as an employee or agent of the Arkansas Health Center assumed and undertook to perform the non-delegable and statutorily-mandated duties of the licensee to provide Kenny Kendrick his nursing home resident's rights as set forth in Ark. Code §§ 20-10-1201 *et seq.* in the operation and management of Arkansas Health Center assumed.

37. Notwithstanding the responsibility of the licensee to protect and provide for these statutorily mandated, nursing home resident's rights, Respondent infringed upon, and Kenny Kendrick was deprived of, rights mandated by Ark. Code §§ 20-10-1201 *et seq.*, including, but not limited to, the following:

a) The right to receive adequate and appropriate health care and protective and support services, including social services, mental health services, if available, planned recreational activities, and therapeutic and rehabilitative services consistent with the resident care plan for Kenny Kendrick, with established and recognized practice standards within the community, and with rules as adopted by federal and state agencies, such rights including:

1. the right to receive adequate and appropriate custodial service, defined as care for Kenny Kendrick, which entailed observation of diet and sleeping habits and maintenance of a watchfulness over his general health, safety, and well-being; and

2. the right to receive adequate and appropriate residential care plans, defined as a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and Kenny Kendrick or his designee or legal representative, which included a comprehensive assessment of the needs of Kenny Kendrick, a listing of services provided within or outside the facility to meet those needs, and an explanation of service goals;

b) The right to regular, consultative, and emergency services of physicians;

c) The right to appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff;

d) The right to access to dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to the needs and conditions of Kenny Kendrick, and not directly furnished by the licensee;

e) The right to a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition, guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics, and such therapeutic diets as may be prescribed by attending physicians;

f) The right to a facility with its premises and equipment, and conduct of its operations maintained in a safe and sanitary manner;

g) The right to be free from mental and physical abuse, and from chemical restraints;

h) The right of Kenny Kendrick to have privacy of his body in treatment and in caring for his personal needs;

i) The right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to resident care and the behavior of other residents;

j) The right to the obligation of the facility to keep full records of the admissions and discharges of Kenny Kendrick, and his medical and general health status, including:

1. medical records

2. personal and social history;

3. individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals; and

4. making it a criminal offense to fraudulently alter, deface, or falsify any medical or other long-term care facility record, or cause or procure any of these offenses to be committed;

k) The right to participate in social, religious, and community activities;

l) The right to properly supervised staff and residents to prevent the misappropriation of personal property; and

m) The right to be treated courteously, fairly, and with the fullest measure of dignity.

38. The aforementioned infringement and deprivation of the rights of Kenny Kendrick were the result of Respondent failing to do that which a reasonably careful person would do under similar circumstances.

39. As a result of the aforementioned violations, Kenny Kendrick suffered injuries as described herein. Claimant, pursuant to Ark. Code § 20-10-1209(a)(4), is entitled to recover actual damages against the licensee of the facility, including, but not limited to, Kenny Kendrick's medical expenses, pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, loss of personal dignity, and loss of life and related expenses, in an amount to be determined by the jury, but in excess of the minimum jurisdictional limits of this Court and exceeding that required for federal court jurisdiction in diversity of citizenship cases, plus all other relief to which Claimant is entitled by law.

40. The infringement or deprivation of the resident's rights of Kenny Kendrick Robinson by Respondent was willful, wanton, gross, flagrant, reckless, or consciously indifferent. Pursuant to Ark. Code § 20-10-1209(c), Claimant is entitled to recover punitive damages against the licensee of the facility.

DAMAGES

41. Claimant re-alleges and incorporates all of the allegations contained in Paragraphs 1 – 40 as if fully set forth herein.

42. As a direct and proximate result of the negligence of Respondent as set out above, Kenny Kendrick suffered injuries including, but not limited to, those listed herein. As a result, Kenny Kendrick incurred significant medical expenses, suffered

unnecessary loss of personal dignity, pain and suffering, mental anguish, degradation, disability, disfigurement, emotional distress, loss of life and related expenses, for which Claimant is entitled to recover compensatory and punitive damages.

43. Claimant seeks punitive and compensatory damages against Respondent in an amount to be determined by the jury, but in excess of the minimum jurisdictional limits of a State Court and exceeding that required for federal court jurisdiction in diversity of citizenship cases, plus all other relief to which Claimant is entitled.

DEMAND FOR HEARING

44. Claimant demands a hearing on this matter before the Commission.

PRAYER FOR RELIEF

WHEREFORE, Claimant, Lanelle Kendrick, as Personal Representative of the Estate of Kenny Kendrick, deceased, and on behalf of the wrongful death beneficiaries of Kenny Kendrick, prays for judgment against Respondent as follows:

1. For damages in an amount adequate to compensate Claimant for the injuries and damages Kenny Kendrick sustained.

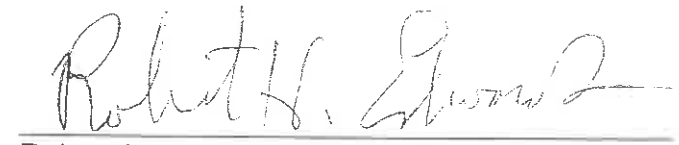
2. For all general and special damages caused by the alleged conduct of Respondent.

3. For punitive damages sufficient to punish Respondent for their egregious and malicious misconduct in reckless disregard and conscious indifference to the consequences to Kenny Kendrick and his statutory beneficiaries, and to deter Respondent and others from repeating such atrocities.

4. For all other relief to which Claimant is entitled.

Respectfully submitted,

Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, deceased, and on behalf of the wrongful death beneficiaries of Kenny Kendrick

By: 

Robert H. "Bob" Edwards (AR 99010)
The Edwards Firm, P.L.L.C
711 West Third Street
Little Rock, AR 72201
501-372-1329
501-372-1336

Attorney for Claimant

Exhibit A

FILED
SALINE COUNTY
PROBATE & COUNTY CLERK
08/08/13 09:31:15
BY _____

IN THE CIRCUIT COURT SALINE COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE
OF KENNY KENDRICK, DECEASED

PR-63PR-13-402-2

ORDER APPOINTING SPECIAL ADMINISTRATOR
OF DECEDENT'S ESTATE

On this 5th day of August, 2013, there is presented to the Court the petition of Lanelle Kendrick, for appointment as special administrator of the Estate of Kenny Kendrick, deceased, and upon consideration of such petition, and the facts and evidence in support thereof, the Court Finds that this Court has jurisdiction, and venue properly lies in this county; that Lanelle Kendrick, mother of the decedent, is the proper person and is fully qualified by law to serve as Special Administrator of said Estate and to administer the Estate of the deceased.

IT IS THEREFORE CONSIDERED AND ORDERED by the Court that administration of the Estate be, and hereby is opened, and that Lanelle Kendrick is hereby appointed as Special Administrator of the Estate of the decedent; that letters of administration shall be issued to said person; and that the requirement for a bond shall be waived since the only asset of the Estate is a potential wrongful death claim being handled by the Estate's attorney.

SALINE COUNTY CIRCUIT JUDGE

Date: 8-8-13

Doug Curtis
Attorney
8/8/13

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Saint Mary's Regional Medical
1808 West Main Street
Russellville AR 72801

DISCHARGE SUMMARY

PATIENT:	KENDRICK,KENNETH	**LOC:** EA.ICU
ACCOUNT:	EA0303076434	**RM#:** EA.106
PHYSICIAN:	James R Crouch	**MR#:** E000005678
ATTENDING:	Lavon J Wood	**DOB:** 05/21/1972
DISCHARGE DT:		**ADM:** 06/07/13

DISCHARGE PHYSICIAN: JAMES R. CROUCH, M.D.

ADMITTING PHYSICIAN: Dr. Wood

ADMISSION DIAGNOSES:
1. 41-year-old white male with muscular dystrophy and chronic respiratory failure on home vent.
2. Diabetes.
3. Morbid obesity.
4. Gastroparesis.

HISTORY: This patient is a 41-year-old white male who is a patient of Dr. Berner's. Patient apparently was transferred from Johnson County Regional Hospital. Apparently he had a new ventilator and he needs to be stable on his ventilator for five days before transfer to a nursing care facility. There is no 24 hour care available for him.

HOSPITAL COURSE: The patient was admitted to the ICU, he is morbidly obese, he was alert and oriented X three. He had some anterior rhonchi. He had obesity, he had a small skin tear on his right rib area.

The patient's admitting white count was 12, hemoglobin 14.2, hematocrit 42.9. The patient was admitted and continued on his home vent. He had no complications during his hospital stay. DuoNeb updrafts along with Mucomyst and Budesonide were ordered as he developed some wheezing and increased rhonchi. However, he seemed to tolerate his new ventilator without any difficulty. He had no trouble with vomiting or with his gatroparesis. Insulin was gradually increased to 100 units of Levimire twice daily. Blood sugars were running in the low to mid 200s. It is my understanding he has been accepted to a nursing care facility in Benton for long term care. Subsequently he will be transferred today.

On 06/17/2013 his sodium was 137, potassium 3.9, chloride 99,

PATIENT:	KENDRICK,KENNETH	**LOC:** EA.ICU
ACCOUNT:	EA0303076434	**RM#:** EA.106
PHYSICIAN:	James R Crouch	**MR#:** E000005678
ATTENDING:	Lavon J Wood	**DOB:** 05/21/1972
DISCHARGE DT:		**ADM:** 06/07/13

carbon dioxide 29, BUN 8, creatinine 0.1, glucose 204, calcium 8.9. On 06/09/2013 his sodium was 140, potassium 3.6, chloride 103, carbon dioxide 26, BUN 8, creatinine less than 1. His admitting white count on 06/09/2013 according to the computer was 7.1, hemoglobin 13.1, hematocrit 41.5, platelets 284.

DISCHARGE INSTRUCTIONS: The patient will be discharged to a nursing care facility in Benton for long term care. His discharge meds will be Fleets enema daily, Glipizide 10mg twice daily, Hydroxyzine 25mg at bedtime, Ibuprofen 400mg q.6 hours PRN pain or fever, Levimire 100 units twice daily, calcium carbonate 500mg q.6 hours, Lotrisone twice daily to areas of yeast. Benadryl 25mg q.6 hours PRN itching, Dulcolax two tabs every other day, subq Lovenox 40mg daily, iron 325mg daily, DuoNeb updrafts q.4 hours with Muocmyst q.4 hours and Budesonide twice daily, Aldactone 50mg daily, Bumex 2mg daily, NovoLog sliding scale, Protonix 40mg daily, Paxil 20mg daily, Phazyme 180mg daily, Phenergan 25mg q.6 hours nausea and vomiting, Reglan 15mg q.i.d., Melatonin 10mg at bedtime, MiraLAX twice daily, Lactulose 20g daily, Ativan 1mg q.4 hours PRN anxiety, Magoxide 400mg daily at bedtime.

DISCHARGE DIAGNOSIS:

1. **41-year-old white male with muscular dystrophy and chronic respiratory failure.**
2. **Morbid obesity.**
3. **Diabetes.**
4. **Gastroparesis.**

Discharge time 31 minutes.

1255386.42542
Cc: **Dr. Berner**

James Crouch, MD

*** END OF REPORT ***
Dictated by - **Crouch, James MD**

Saint Mary's Regional Medical

DISCHARGE SUMMARY

PATIENT:	KENDRICK,KENNETH	**LOC:** EA.ICU
ACCOUNT:	EA0303076434	**RM#:** EA.106
PHYSICIAN:	James R Crouch	**MR#:** E000005678
ATTENDING:	Lavon J Wood	**DOB:** 05/21/1972
DISCHARGE DT:		**ADM:**06/07/13

Dictated Dt/Tm - **06/17/13 0736**
Transcribed by - **MEX9461**
Transcribed Dt/Tm - **06/17/13 2105**

CC:
ADMIT - Wood, Lavon, Jeneen, MD
ATTEND - Wood, Lavon, Jeneen, MD
PCP -
OTHER -

END OF REPORT

Capella LIVE | Discharge Order Medication Profile | Page: 15 | Date: 06/17/13 07:21

Patient: KENDRICK, KENNETH
Location: EA.ICU | Room: EA.106-1 | Acct: EA0303076434 | Age/Sex: 41/M
Attending: Lavon J Wood | Admit Date: 06/07/13 | MRN: E000005678 | Ht: 5 ft 3 in
Reason For Visit: RESPRATORY FAILURE | DOB: 05/21/1972 | Wt: 18.68 kg
Allergy/AdvReac: Ceftazidime Pentahydrate(Unknown), clindamycin(Unknown), metformin HCl(Unknown)

Physician Signature: [signature] 6/17/13 Date/Time: 7:20pm

Chart Copy Only - Not For Patient Use

25

DISCHARGE ORDERS

D'scharge Diet: 1800 adB

Diet Texture- Solids: Regular

Diet Texture- Liquids: REG

Additional Diet Instructions:
INFLATE CUFF WITH 7-10CC OF AIR WHILE EATING OR GIVING MEDICATIONS.

Fluid Restrictions(ml/day):

Discharge Activity:

Oxygen Orders: continue vent
TRACH 8 EXTRA LONG CUFFED SHILEY - UNFILLED UNLESS EATING OR MEDS GIVEN
SIMV RATE 16. TV 850. P/S 5. PEEP 5. 3L BLEED IN

Weight Monitoring:

Other orders:

Contact physician for worsening symptoms of:chest pain, fever, chills, difficulty breathing, nausea, vomiting, or other concerning symptoms.

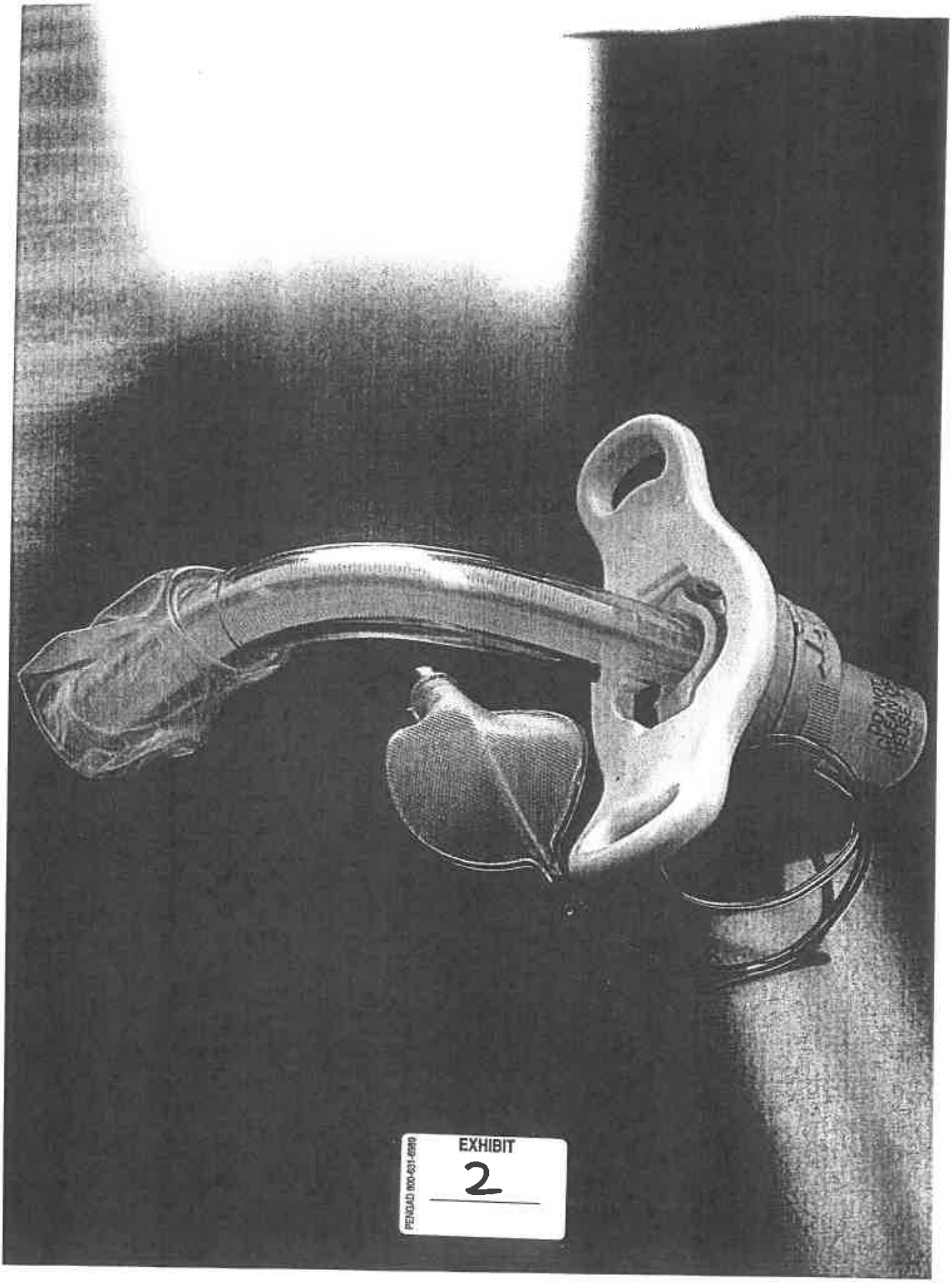

EXHIBIT
2

PENDAD (800-631-6989)

PENGAD 800-631-6989
EXHIBIT
3

EXHIBIT
4

PENGAD 800-631-6989

Saline Memorial Hospital Ambulance Service

Patient Care Record

Name: KENDRICK, KENNETH **Incident #:** 13-5234 **Date:** 07/15/2013 Patient 1 of 1

Patient Information

KENDRICK	2109 East 12th ST
KENNETH	
	Russellville
Male	AR
05/21/1972	72801
41 Yrs, 1 Months, 25 Days	UNITED STATES
350lbs - 159kg	
	Hill, Edward
	Not Hispanic or Latino
White	

Clinical Impression

Cardiac Arrest

cardiac arrest

Level of Consciousness - Unconscious
Cardiac - Cardiac Arrest

Medical
Unconscious
None

Medication/Allergies/History

Medications	
Allergies	Other - clindamycin, fortaz, metformin, glucophage
History	CHF,Diabetes,Morbid Obesity,Other - Duchene's MD; gastroesophageal reflux; quadriplegia; tracheostomy; resp failure; vent dependent

Vital Signs

12:24	U		Lay	/	64	0							3		
12:27				/	14										
12:30				/	48										
12:33				/	63										

Flow Chart

12:31	CPR	Patient Response: Unchanged;	
12:33	Stretcher	Patient Response: Unchanged;	YORK, MICHAEL
12:36	IV Therapy	20 ga; Antecubital-Right; Saline Lock; Total Fluid 1; Patient Response: Unchanged; Unsuccessful;	YORK, MICHAEL
			YORK, MICHAEL

Treatments Prior To Arrival

Defib/Cardio/Pace CPR	Other Healthcare Provider	Unchanged	

EXHIBIT 15

30

Initial Assessment			
Mental Status		Mental Status	⊕Unresponsive
Skin		Skin	⊕Pale
HEENT	tracheostomy in place	Head/Face	Not Assessed
		Eyes	Not Assessed
		Neck	⊕Other
Chest		Chest	Not Assessed
		Heart Sounds	Not Assessed
		Lung Sounds	Not Assessed
Abdomen		General	Not Assessed
		Left Upper	Not Assessed
		Right Upper	Not Assessed
		Left Lower	Not Assessed
		Right Lower	Not Assessed
Back		Cervical	Not Assessed
		Thoracic	Not Assessed
		Lumbar/Sacral	Not Assessed
Pelvis/GU/GI		Pelvis/GU/GI	Not Assessed
Extremities		Left Arm	Not Assessed
		Right Arm	Not Assessed
		Left Leg	Not Assessed
		Right Leg	Not Assessed
		Pulse	Not Assessed
		Capillary Refill	Not Assessed
Neurological		Neurological	Not Assessed

Assessment Time:

Ongoing Assessment

Mental Status		Mental Status	⊕Unresponsive
Skin		Skin	⊕Pale
HEENT	tracheostomy in place	Head/Face	Not Assessed
		Eyes	Not Assessed
		Neck	⊕Other
Chest	PEA	Chest	Not Assessed
		Heart Sounds	Not Assessed
		Lung Sounds	Not Assessed
Abdomen		General	Not Assessed
		Left Upper	Not Assessed
		Right Upper	Not Assessed
		Left Lower	Not Assessed
		Right Lower	Not Assessed
Back		Cervical	Not Assessed
		Thoracic	Not Assessed
		Lumbar/Sacral	Not Assessed
Pelvis/GU/GI		Pelvis/GU/GI	Not Assessed
Extremities		Left Arm	Not Assessed
		Right Arm	Not Assessed
		Left Leg	Not Assessed
		Right Leg	Not Assessed
		Pulse	Not Assessed
		Capillary Refill	Not Assessed
Neurological		Neurological	Not Assessed

Assessment Time:

Narrative

Disp 41 YO male pt at AR Health Center for respiratory emergency. Notified en-route by communications that pt is now code blue w/CPR in progress. AOS to find pt unresponsive, skin pale, morbidly obese, CPR in progress, BVM ventilations through pre-existing tracheostomy, AED in place w/no shocks advised. Pt moved to stretcher w/draw sheet, secured w/safety restraints. CPR continued as pt moved to and loaded into ambulance, placed on cardiac monitor, IV attempted, transported Code Blue to SMH ER w/health center employee on board to assist with CPR efforts, transferred to SMH ER staff in trauma 1 w/continuation of CPR efforts until terminated by attending physician following ultrasound of pt's heart.

Specialty Patient - CPR

Yes, Prior to EMS Arrival		Unknown			
Respiratory		Not Applicable			
15-20 Minutes					
5 Minutes		PEA			
8 Minutes		Asystole			
Witnessed by Healthcare Provider		No			
Medical/Health Care provider		Pronounced in the ED			
12:23 07/15/2013		No			
Yes					
No					
Yes					
Medical/Health Care provider					
No					

Saline Memorial Hospital Ambulance Service

Patient Care Record

Name: KENDRICK, KENNETH Incident #: 13-5234 Date: 07/15/2013 Patient 1 of 1

Incident Details

Arkansas Health Center
6701 Hwy 67
Willow CT
Haskel
AR
720158909
MEDIC 3
911 Response (Emergency)
Lights/Sirens
Green 8am
District 1
Advanced Life Support

Destination Details

Transported No Lights/Siren
Patient
Saline Memorial Hospital ER
NH Staff
Hospital ER
1 Medical Park Drive
Benton
AR
720153353
District 1

Incident Times

12:19:45
12:19:46
12:19:47
12:30:09
12:31:30
12:37:45
12:44:40
12:53:00

Crew Members

YORK, MICHAEL	Lead	EMT-Paramedic-25007;
NALLEY, BRETT	Driver	EMT-Basic-20368;

Insurance Details

KENNETH KENDRICK
Self
431-35-8942
05/21/1972
2109 East 12th ST
Russellville
AR
72801
UNITED STATES

431828662C1
0634246001

Respiratory Emergency
Immediate

Mileage

0.0
5.8
5.8
0.0

Delays

Additional Agencies

None

Next of Kin

UNITED STATES

Consumables

Airway - Oxygen & Supplies A0422 (2900389)	1	EKG - Cardiac Monitor (2900157)	1	EKG - CPR Stat Pads (4008462)	1
IV - IV & Supplies A0394 (2900264)	1				

Personal Items

None

Transfer Details

ALS, Level 1 Emergency

Charles Smith
Cardiac Arrest-Resuscitation in Progress (ALS-427.5)

Emergency-Cardiac Arrest-CPR

Billing Authorization

es

Section I - Authorization for Billing

Name: KENDRICK, KENNETH Incident #: 13-5234 Date: 07/15/2013 Patient 1 of 1

I, the undersigned, hereby authorize payment directly to Saline Memorial Hospital of the AMBULANCE benefits payable to me not to exceed the regular charges for this type of service. I understand, I am financially responsible to Saline Memorial Hospital for charges not covered by this authorization and do hereby guarantee payment of this bill within 15 days. I further agree that if collection is made by suit or otherwise, I agree to pay all collection costs including reasonable attorney fees. I hereby release said ambulance service, its owner and employees from any claim whatsoever. I also understand that Medicare will only pay for services that it determines to be reasonable and necessary. If Medicare determines that a particular service though it would be otherwise covered, is not reasonable and necessary under Medicare standards that Medicare will deny payment for the service rendered and I hereby guarantee payment of this bill in its entirety. I, hereby authorize the release of medical information and/or demographics to Saline Memorial Hospital from any medical provider, where the undersigned has been a recipient of medical services. I hereby acknowledge that I have been provided with a copy of Saline Memorial Hospital's Notice of Privacy Practices on this date.

Signature

[redacted]

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

- [redacted] Patient's Legal Guardian
- [redacted] Patient's Medical Power of Attorney
- [redacted] Relative or other person who receives benefits on behalf of the patient
- [redacted] Relative or other person who arranges treatment or handles the patient's affairs
- [redacted] Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for services rendered.

Signature

[redacted]

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

[redacted] Michael York
cardiac arrest

Facility Representative Signature

Facility Signatures

Provider Signatures

MICHAEL YORK

Saline Memorial Hospital

#1 Medical Park Drive
Benton AR 72015

Patient Information

Name: **KENDRICK, KENNETH**
Status: **EMERGENCY** Service: **EMR**
Admit Priority: 1
Race: **W** Sex: **F**
Marital Status: **S** Religion: **UNK**
Authorization: **PT UNABLE TO SIGN**
Adv. Directive: **UNABLE TO INFORM**
Address: **2109 EAST 12TH STREET RUSSELLVILLE, AR, 72837**
Phone: **(479) 886-1726**
Employer: **Unknown**

Account: **2006399303** MR#: **18-47-40**
Svc Type: **E** Admit Type: **1**
Admit Date/Time: **7/15/2013 12:49**
Age: **41Y 5M** Birth Date: **5/21/1972**
SSN:

Power of Attorney: **UNABLE TO DETERMINE**
Occupation:

Attending Physician: **CHARLES SMITH , MD**
Admitting Physician: **CHARLES SMITH , MD**
Primary Care Physician:
Admitting Diagnosis: **CODE**

Discharge Information

Discharge Date: **7/15/2013**
Discharge Diagnosis : **4275, CARDIAC ARREST**

Guarantor Information

Name: **KENDRICK , KENNETH**
Address: **2109 EAST 12TH STREET , RUSSELLVILLE, AR, 72837**
Phone: **(479) 886-1726**

Birth Date: **5/21/1972**

Emergency Contact

Name: **GOODIN , SHIRL**
Emergency Contact Phone: **(479) 886-1726**

Insurance Companies

Policy Holder: **KENDRICK , KENNETH** PH Employer: **Unknown**
Provider: **MEDICARE OUT PATIENT PO BOX 890103, CAMP HILL, PA, 17089**
Policy#: **431829622C1**
Insurance Group: Pre Cert#:

Policy Holder: **KENDRICK , KENNETH** PH Employer: **Unknown**
Provider: **MEDICAID OUT PATIENT PO BOX 8033, LITTLE ROCK, AR, 72203**
Policy#: **0634246001**
Insurance Group: Pre Cert#:

Patient Information

Acct #: 2006399303
Patient Name: KENDRICK, KENNETH
Address: 2109 EAST 12TH STREET
City: RUSSELLVILLE State: AR Zip Code: 72837
Phone #: 479 886-1726
Patient's Employer:

ADM. Date: 07/15/13
ADM. Time: 12:49
Registrar's Initials: THW
Sex: F
DOB: 5/21/1972

Room:
Unit:
Race: W
Age: 41Y
Marital Status: S

M.R. #: 18-47-40
DC Date/Time: 0:00

Medical Information

Admitting Diagnosis:
CODE
MED SVC: EMR
P. Type: E
Remarks: AUTH SIGNED

Secondary Diagnosis:
Advance Directive Date:
7/15/2013
Privacy Practice:

Attending Phy:
WHITE, JUSTIN
Referring Phy:
Primary Care Phy:
PREV ADM:
Staff Alerts:

Relative 1

Relationship.:
0000000000
EMP

Relative 2

Relationship.:
00 000-0000
EMP

Guarantor

KENDRICK, KENNETH
A 2109 EAST 12TH STREET RUSSELLVILL, AR
4798861726
SSN:

Insurance

INSURANCE NAME	Policy #:	Insurance Group#:	Subscriber's Name:
MEDICARE OUT PATIENT	431829662C1		KENDRICK, KENNETH
MEDICAID OUT PATIENT	0834246001		KENDRICK, KENNETH

[redacted]

ed0610

k

ED Admission Time 1217 Exam Room 1

ED Discharge Time 1705 ATS Band #

Physician/Patient Contact Time 1247

Triage Class: ☒ I ☐ II ☐ III ☐ IV ☐ V

Date 7-15-13 Triage Time 1247 RN JR

Name Kenneth Kendrick Age 41 Sex M

ERP Charles Smith PCP

Mode of Arrival: ☒ EMS ☐ Ambulatory ☐ W/C ☐ Carried

EMS Treatment PTA: ☒ Report Received ☐ IV ☒ O2 ☐ Other: Trach pt.

ALLERGIES: ☐ NKDA

☐ dyes/contrast

☐ latex/adhesives

☐ food:

BP:	SaO2: ☐ room air ☐ O2:	HR:	TEMP: ☐ Oral ☐ Rectal	RR:	Level of Pain: at present ____ at worst ____

Chief Complaint/Triage Assessment: Cardiopulmonary arrest, CPR in progress per EMS. Pt has trach, unable to obtain IV access. (ATC Resident)

Onset approx 15-25 mins

VITAL SIGNS

Time RN	BP	SaO2	HR	T	R	LOP
	No vitals					

Past Medical/Surgical History

☐ None ☐ Asthma ☐ CAD ☐ Cancer ☐ CHF ☐ COPD ☐ CVA ☐ Diabetes ☐ GI Disorder ☐ Migraines ☐ Seizures ☐ Tonsillectomy/Adenoidectomy

☐ Appendectomy ☐ CABG ☐ Cardiac stents ☐ Cholecystectomy ☐ Hysterectomy ☐ Hypertension ☐ Pacemaker/AICD ☐ Psychiatric Disorder ☐ Renal Disease ☐ Thyroid Disease

Muscular dys.

Home Medications: ☐ None ☐ See Home Medication List Sheet

Advance Directive: ☐ Yes ☒ No Full Code

LMP:

Height:

Weight:

Social History: ☐ Tobacco use ☐ ETOH ☐ Illicit drug use

Learning Barriers: ☒ No ☐ Yes Type

Nutritional Risk: ☒ No ☐ Yes

Immunizations: ☐ UTD ☐ Yes ☐ No Tetanus: ☐ <5 years ☐ >5 years

Pneumovax w/in 5 yrs: ☐ Yes ☐ No Year: Flu Vaccine: ☐ Yes ☐ No Year:

Discharge Vitals: BP: SaO2: HR: RR: LOP:

Outcome:
☐ Unchanged
☐ Improved
☐ Death Coroner released (Y) N

Discharge Mode:
☐ Ambulatory ☐ Carried
☐ Ambulance ☐ Crutches
☐ W/C ☐ Walker
☒ Stretcher

Disposition:
☐ Home/Discharged
☒ Nursing Home: AR Mort.
☐ Transferred to:
☐ Funeral Home:
☐ Crime Lab:
☐ Admit/Room:
☐ Report to:
☐ Transported by

Instructions:
☐ Given written instructions
☐ Verbalized understanding
☐ Patient ☐ Family ☐ Caregiver
☐ RX given x
☐ School/work excuse slip
☐ Left AMA (☐ signed AMA form)
☐ Discharged with driver

Patient Property:

given to: ☐ patient ☐ family ☐ security ☐ Other ☐ placed in safe

ED Nursing Record
Page 1 of 2

Progress Notes

5/10/11

KENDRICK, KENNETH
Room/Bed.ED/OPAdmission:7/15/2013
Sex:F Age 41 yr 2 m DOB:
MR: 18-47-40 Acct#: 2008398303

Here

[redacted]

Neuro: ☐ alert oriented to person, place, time ☐ disoriented to person ☐ weakness
☐ No apparent neurologic deficit ☐ disoriented to place ☐ confusion
☒ see primary assessment ☐ disoriented to time ☐ decreased LOC

CV: ☐ regular rate ☐ pulses strong ☐ tachycardia ☐ cap refill > 3 sec
☐ regular rhythm ☐ cap refill < 3 sec ☐ bradycardia ☐ pulse deficit
☒ see primary assessment ☐ irregular rhythm

Resp: ☐ no respiratory distress ☐ mild distress ☐ wheezing
☐ breathe sounds clear and equal ☐ mod. distress ☐ crackles
☒ see primary assessment ☐ severe distress

Psych: ☐ calm ☐ anxious ☐ uncooperative
☐ cooperative ☐ agitated ☒ see primary assessment

Skin: ☐ warm, dry ☐ no cyanosis ☐ skin intact ☐ diaphoresis ☐ rash

Ext: ☐ move all extremities ☐ non tender ☐ tenderness ☒ see primary assessment
☐ no pedal edema ☐ limited ROM ☐ pedal edema

GI/GU: ☒ no GI/GU complaint ☐ nontender ☐ tenderness ☐ distention
☐ see primary assessment ☐ nondistended ☐ guarding ☐ rigidity
☐ soft ☐ bowel sounds present ☐ rebound ☐ abnormal bowel sounds

Time	Initials	Actions/Procedures
		Cardiac monitor applied
		Pulse ox Placed
		Supplemental O2
		EKG completed
		Repeat EKG done
		Lab/Blood drawn
		Blood Cultures-1st set drawn
		Blood Cultures-2nd set drawn
		UA specimen collection
		Foley ___ Fr placed
		In & Out Cath for UA
		Surgery consent complete
		CT consent complete
		Oral contrast start
		Oral contrast done
		Pt meds obtained
		Strep swab obtained

Fall Risk: ☐ Yes ☐ No
Safety Measures:
☐ ID Bracelet ☐ Bed locked and down
☐ Side rails up ☐ Allergy band

Primary Assessment/Additional Findings: (1247) Pt brought in by ems. Apneic and purple. Still had pulse became pulseless. Compressions in progress, Pt trach, Pt being bagged. Asystole on monitor. Pt hooked to Zoll pads

IV Starts

Time	Initials	Location	Gauge	# Attempts	DC Time	Initials
1247	LL	R wrist	20g	x1		

IV Fluids

Start Time	Stop Time	Location	Solution	Rate	Amount In	Initials
1247	1249					

EMERGENCY DEPARTMENT MEDICATION RECORD (See ED MAR for further meds given)

Start Time:	Stop Time:	Medication:	Dose:	Route:	Location	Initials	Response/LOP	Time	RN:
1248	1248	Epinephrine	1mg	IVP	—	[illegible]			

Additional Nursing Notes: (1349) Code called by Dr. Smith. —LL (1400) Family in family room. —LL (1415) Dr Smith in family room speaking c family. —LL (1500) Arkansas Mortuary called to get pt. —LL

Laura Clift RN (signature)
RN Signature and Initials:

(signature) (TBL)
RN Signature and Initials:

RN Signature and Initials:

ED Nursing Record
Page 2 of 2
Progress Notes

05/05/10

KENDRICK, KENNETH
Room/Bed.ED/OPAdmission:7/15/2013
Sex:F Age 41 yr 2 m DOB:5/21/1972
MR 16-47-40 Acct#: 2006399303

cp0810

CODE BLUE ORDER FORM

Crash Cart # ________
Airway Box # ________

Date: 07-15-13 Time event recog.: ________ Time Code Team Called: ________ Time Code Team Arrived: ________ Location: ________

Weight: ________ Witnessed: ☐ Yes ☒ No Family notified: ☐ No ☐ Yes Whom: ________ Recorder's Name: ________

Airway / Ventilation

At onset: ☐ Spontaneous ☐ Apnea ☐ Agonal ☒ Assisted

Time of first assisted ventilation: ________

Type of: ☐ Mouth / Mask ☒ BVM

Intubation: Time: ________ ☐ ETT ☐ Tracheotomy

Size: ________ By whom: ________

Secondary confirmation: ☐ Ausculation ☐ Ex. CO2 ☐ X-ray

Circulation

First documented rhythm: PEA

☐ Pulse ☐ Pulse (poor perfusion) ☒ Pulseless

Time chest compressions were started: PTA @ AHC

Patient defibrillated: ☐ Yes ☒ No Time: [illegible] en route

AED applied: ☒ Yes ☐ No

Pacemaker on: ☐ Yes ☒ No

Outcome

Resuscitation event ended at: 1249

Status: ☐ Alive ☒ Dead

Reason resuscitation ended:

☐ Advance directive

☐ Restrictions by family

☒ Code terminated by Physician

Time	Rhythm	Pulse: Palp Spontaneous/ compressions	BP	Resp: Spontaneous/ assisted	Defibrillation Joules	Bolus Dose/Route: Amiodarone	Atropine	Epinephrine	Lidocaine	Other	Infusion Dose: Dopamine	Dobutamine	Epinephrine	Norepinephrine	Other infusion and any other comments
1247	Asystole	Ø compressions cont.		BVM to trach						20g [illegible] X1 stick (L) wrist					
1248	Asystole	X [illegible]		BVM to trach				1mg							

Code Team Members: [signature] [signature]

Physician Signature: [signature] Date/ Time: ________

Code Blue Order Form

Physician Order

9/9/10

KENDRICK, KENNETH
Room/Bed:ED/OPAdmission:7/15/2013
Sex:F Age 41 yr 2 m DOB:5/21/1972
MR: 18-47-40 Acct#: 2008399303

Original: Medical Records
Fax Copy to Quality & Risk Management @ 6278
Copy: Unit Manager

40

#6 Cardiopulmonary Resuscitation

check box or circle word(s) if affirmative, strike word(s) if negative, note additional findings

Date: 7-15-13 Time: 1247 Room:

Patient's PMD or Cardiologist:

☑ Vital Signs Reviewed

P: BP: RR: T: ☐ oral ☐ tymp ☐ rectal Wght: ☐ lb ☐ kg

Allergies: ☐ NKDA ☑ see RN notes

Arrived by: ☑ EMS ☐ walk-in ☐ wheelchair

Historian: ☐ patient ☐ family / friend ☑ EMS

Chief Complaint: ☐ collapsed ☐ stopped breathing ☐ lost pulse ☑ found unresponsive

History of Present Illness

Levels 1, 2, 3: 1-3 elements Levels 4, 5: 4 or more elements

Onset: ☐ unknown

☑ today _____ ☐ am ☐ pm

12-25 ☐ minutes ☐ hours P.T.A.

Witnessed: ☐ yes ☑ no

Symptoms Prior to Arrest:

☑ unknown ☐ abdominal pain

☐ chest pain ☐ headache

☐ dyspnea ☐ lightheaded

☐ back pain ☐ weakness

Quality (Findings and Treatment Prior to E.D. Arrival):

Initial Findings: ☐ medic ☑ bystander ☐ _____

Mentation:	Pulse:	Respirations:
☑ unresponsive	☑ not palpable	☑ none
☐ ↓'d responsiveness	☐ present, weak	☐ present, agonal
☐ awake and alert	☐ present, strong	☐ present, normal
☐ _____	☐ _____	☐ _____

☐ blood pressure: _____/_____

☐ blood glucose: _____ mg/dl

☐ rhythm on monitor: _____

Initial Treatment: ☐ medic ☑ bystander ☐ _____

☐ oxygen ☑ CPR ☐ epinephrine

☐ bag-valve-mask ☐ defibrillation ☐ atropine

☐ intubation ☐ IV fluids ☐ sodium bicarb

Timing / Course:

Down-time before ACLS:

☑ 12-25 min.

☐ unknown

Response to Treatment:

☐ return of pulse

☐ continued pulseless

On Arrival to ED:

☐ pulse present

☑ in arrest / pulseless

☐ total time pulseless P.T.A. was 60 min.

Context: ATTENDANT LIFT PT X ~15', CPR UNDERWAY ON HIS ARRIVAL PER EMS INITIALLY

Review of Systems

Levels 1, 2, 3: 1 system Level 4: 2-9 systems Level 5: 10 or more systems

☑ All Systems Reviewed and were Negative (except as marked below) ☑ History Limited due to Altered Mental Status or Patient Acuity

Constit: ☐ fever / chills ☐ weight loss

Eyes: ☐ visual change

ENT: ☐ sore throat

CV: ☐ chest discomfort ☐ palpitations ☐ ankle swelling

Resp: ☐ difficulty breathing ☐ cough ☐ hemoptysis

GI: ☐ abdominal pain ☐ vomiting ☐ diarrhea ☐ black / bloody stool

GU: ☐ kidney problems

Musc: ☐ painful extremity

Neuro: ☐ headache ☐ numbness / tingling ☐ weakness

Skin: ☐ rash

Psych: ☐ anxiety ☐ depression

Immun: ☐ HIV / AIDS

Past, Family, and Social History

Levels 1, 2, 3: no history areas Level 4: 1 history area Level 5: 2-3 history areas

PMH: ☐ none ☐ unknown ☐ see RN notes

☐ HTN ☐ CAD ☐ MI ☑ high cholest.

☐ IDDM ☐ NIDDM ☐ CHF ☐ A-Fib / SVT

☐ CVA ☐ PE / DVT ☐ COPD ☐ V-Fib / V-tach

Meds: ☐ none ☐ see RN notes

Surgical Hx: ☐ none

☐ CABG

TRACH

Family Hx: ☐ none

Social Hx: ☐ unknown

Tobacco ☐ yes ☐ no

ETOH ☐ yes ☐ no

Drugs

Occupation

Home circumstances ☐ lives alone ☐ with family or friend ☐ nursing home

ARK. VISITA CTR

Physical Exam

Level 1: 1 organ system Levels 2, 3: 2-5 organ systems Level 4: 6-7 organ systems Level 5: 8 or more organ systems

Gen: ☑ CPR in progress ☑ intubated ☑ unresponsive

MIRRICLY OBESE

Eyes: ☐ PERRL ☐ EOMI ☑ lids, sclera nl

ENT: ☑ oropharynx clear ☐ mucosa nl

Head / Neck: ☐ no evidence of trauma ☐ neck without swelling or mass

CV: ☐ regular rate, regular rhythm ☐ heart sounds nl, no murmur ☐ carotid and femoral pulses equal ☐ no JVD

NO PULSE

Resp: ☐ no resp. distress ☐ breath sounds clear and equal ☐ no rhonchi ☐ no wheezes

NO RESP. 3 BAGGING

Abd: ☑ soft, nontender ☐ no mass ☐ rectal nl, heme negative

DISTENDED, TYMPANIC

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SALINE MEMORIAL HOSPITAL
#1 MEDICAL PARK DRIVE
BENTON, AR 72015

KENDRICK, KENNETH
Room/Bed: ED/OP Admission: 7/15/2013
Sex: F Age: 41 yr 2 m DOB: 2

MR: 18-47-40 Acct#: 2006399303

#6 CPR

Physical Exam (continued) ☐ *Exam limited by patient condition or acuity*

Musculoskeletal: ☑ no evidence of trauma

Skin: ☐ warm, dry ☐ no rash ☐ no pedal edema

MULT TEARS, APPEAR FRESH, CONSIST c̄ MOVING PT

Lymph: ☐ no adenopathy

Neuro: ~~☐ alert and oriented~~ x 3 ~~☐ motor grossly nl~~ ☐ cranial nerves 2-12 intact ☐ sensation intact to light touch ☐ speech nl ☐ gait nl

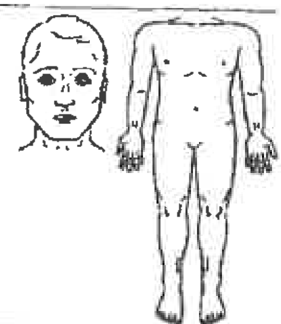
UNRESPONSIVE

~~**Psych:** ☐ affect, mood nl ☐ judgment nl~~

Repeat Exam at: _______

REMAINED UNCHANGED

Additional Findings:



Medical Decision Making *Level 1: straightforward Levels 2-3: low complexity Level 4: moderate complexity Level 5: high complexity* ☐ = PQRI

Differential Diagnosis ☐ myocardial infarction ☐ V-fib / V-tach ☐ cardiac tamponade ☐ electrolyte abnormality ☐ cancer
☐ cardiac arrest ☐ pulmonary edema ☐ asystole / PEA ☐ tension pneumothorax ☐ sepsis / infection ☐ ______
☐ respiratory arrest ☐ pulmonary embolism ☐ A-fib / SVT ☐ exsanguination / GI bleed

Labs ☐ CBC: ☐ nl ☐ nl except values noted below:
WBC_____ Hb_____ Hct_____ Plt_____
neut_____ lymphs_____ other_________
☐ Chem: ☐ nl ☐ nl except values noted below:
Na_____ K_____ Cl_____ CO_2_____
BUN_____ Cr_____ Glucose_______
☐ cardiac enzymes: troponin _____ CK / CK-MB _______
☐ INR __________ ☐ PT / PTT __________
☐ D-dimer __________ ☐ B-NP __________
☐ ABG on ________: pH _____ pCO_2_____ pO_2_____

☐ **Pulse Ox:** _____ % on ☐ RA or ☐ O_2: ________
Saturation is: ☐ normal ☐ hypoxic

☐ **EKG:** rate:_______ rhythm:________________
axis:_____ intervals:________ ST/T-waves__________
comments:________________________
compared to: ___________ ☐ no significant change ☐ changed

Repeat EKG: rate:______ rhythm:________________
comments:________________________

Cardiac Monitor: rate:______ rhythm:________________

X-rays / Imaging (NAD = no acute disease) interpreted by: ☐ me ☐ radiologist ☐ discussed w/ radiologist
1.____________________ ☐ NAD 2.____________________ ☐ NAD

Treatment / Management / Course

treatment / response:
☑ CPR
☐ O_2 at
☑ intubation PTA
☐ defibrillation
☐ pacemaker
☑ ACLS meds PTA PER E+

INITIAL ASYSTOLE, CONFIRMED c̄ 2 LEADS, LIM. CARD US c̄ ASYSTOLE. Hx PER CORONER - PT FOUND c̄ DISPLACED TUBE

Reviewed: ☐ nurses notes ☐ EMS notes ☐ old records
☐ Procedure:____________ ☐ see addendum
☐ Critical Care:_______ min. ☐ see addendum
☐ Consult: Dr.______________ (time)_____
☐ signed out to Dr.
☐ PQRI / Quality Measures Addressed
☐ see addendum

☐ **Intubation**
Meds: ☐ midazolam ☐ etomidate ☐ succ. choline ☐ ketamine ☐ rocuronium ☐ ________
☐ oral or ☐ nasal ☐ curved blade or ☐ straight blade
☐ ET tube # _____ ☐ direct visualization of ET tube passage through cords
Confirmation of Placement:
☐ auscultation ☐ post-intubation O_2 sat _____ ☐ CXR
☐ $ETCO_2$ ☐ direct visualization
☐ no complications

☐ **Central Line**
☐ subclavian ☐ internal jugular ☐ femoral
☐ sterile prep and drape ☐ standard technique
Confirmation of Placement:
☐ good blood return, easily flushed ☐ CXR
☐ no complications

Course: ☐ same ☐ better ☐ worse ☐ expired

Diagnosis 1. ACUTE ON CHRONIC RESPIRATORY FAILURE / CARDIAC ARREST ASYSTOLE

Disposition ☐ Admit (☐ medical ☐ surgical ☐ monitor ☐ ICU) Admit Physician: ☐ Transfer to:

Condition: ☐ unchanged ☐ improved ☐ critical ☑ expired

signature [signature] 12 title date 7-15-13 time

☐ Case discussed with: ☐ patient ☐ family ☐ caretaker FAMILY [illegible]

title date time

☑ Case discussed with Medical Examiner

SALINE MEMORIAL HOSPITAL
#1 MEDICAL PARK DRIVE
BENTON, AR 72015

KENDRICK, KENNETH
Room/Bed ED/OPAdmission 7/15/2013
Sex F Age 41 yr 2 m DOB
MR: 18-47-40 Acct#: 200639303

er0008

Emergency Department Physician's Orders

LIGHT BLUE 45

Date: _____ Allergies: _____

COMMON LABS:

- ❑ CBC
- ❑ BMP
- ❑ CMP (BMP + Liver Enzyme)
- ❑ BNP
- ❑ D Dimer
- ❑ ETOH
- ❑ Finger Stick Glucose
- ❑ I Stat 6
- ❑ UA
- ❑ UPT
- ❑ UDS
- ❑ Amylase
- ❑ Blood Culture x _____
- ❑ CRP
- ❑ LFT
- ❑ Lipase
- ❑ PT/PTT
- ❑ PT with INR
- ❑ Type and Cross _____ units
- ❑ Type and Screen
- ❑ UR Culture
- ❑ Wound Culture _____
- ❑ Flu Swab ❑ Lipid Profile
- ❑ Rapid Strep
- ❑ RSV Swab

Stool

- ❑ C Diff
- ❑ E Coli
- ❑ Rotovirus

❑ Other: _____

❑ Abdominal = CBC, BMP, LFT, Amylase, Lipase, UA: ❑ CRP, ❑ UPT
❑ Cardiac = CBC, BMP, CK, MB, Troponin, Myoglobin, Mg, EKG, P-CXR, ❑ BNP, ❑ D Dimer, ❑ PT, ❑ PTT
❑ CVA w/u = CBC, BMP, PT/PTT, Finger Stick Glucose, STAT Head CT, ❑ EKG, ❑ Lipid Profile
❑ Geri Psych w/u = CBC, BMP, UA
❑ Psych w/u = CBC, BMP, ETOH, UA, UDS, UPT
❑ Septic w/u = CBC, CMP, PT/PTT, Finger Stick Glucose, BCX2, UA, UR CX, P CXR, Lactic Acid
❑ Trauma Lab = CBC, BMP, LFT, PT/PTT, UA-dip for blood, Type and Screen
Altered Mental Status/OD = ❑ CBC, ❑ CMP, ❑ ETOH, ❑ UDS, ❑ UA, ❑ UPT, ❑ Acetaminophen, ❑ Salicylate, ❑ Ammonia Level
Pelvic Problem = ❑ CBC, ❑ Type and Screen, ❑ UA: ❑ UPT, ❑ BHCG, ❑ Serum Pregnancy, ❑ Wet Prep, ❑ GC/Chlamdia
Seizure w/u = ❑ CBC, ❑ BMP, ❑ ETOH, ❑ UDS, ❑ UPT (female), ❑ Head CT, ❑ Dilantin, ❑ Tegretol, ❑ Phenobarbital, ❑ Depakote

Trauma Activation:	X-RAY:	CT:	US:	CARDIO:
❑ Full ❑ Limited	❑ AAS ❑ C-Spine ❑ CXR ❑ PA/Lat ❑ Portable ❑ L Spine ❑ AP Pelvis ❑ Other_____	❑ Abd. and pelvis with contrast ❑ C-Spine ❑ Head ❑ PE Protocol ❑ Stone Protocol	❑ Abd. ❑ Gallbladder ❑ Pelvic ❑ Venous Doppler	❑ EKG ❑ ABG ❑ Updraft ❑ Albuterol ❑ Albuterol/Atrovent (Duoneb) ❑ Heliox ❑ Pulmocort ❑ Xopenex

NURSING ORDERS:

❑ Blood sent _____ ❑ Urine sent _____ ❑ Other sent _____ ❑ EKG Done _____
❑ O2: _____
❑ Place on Cardiac Monitor
❑ Saline lock: _____
❑ IV: _____ @ _____ ml/hr _____
❑ IV bolus: _____ ml @ _____ ml/hr ❑ TdaP ❑ Td (Pertussis allergy)
❑ Foley Cath: _____

Physician's Signature **Date/Time**

4/24/13

ED Department Physician Orders

Progress Notes

KENDRICK, KENNETH

Room/Bed:
Age/Sex: -
DOB: *
Admission:07/15/13
MR: 18-47-40
Att. Phy: WHITE, JUSTIN

2006399303

[redacted]
as0264

RECORD OF DEATH

Red 9

RECORD OF DEATH

Date of Death 07/15/2013 Hour 1249 Time Pronounced 1249
Was patient in restraints @ time of death? ☐ Yes ☒ No
Was patient in restraints within past 24 hours? ☐ Yes ☒ No If yes House Manager notified @ _____ (time)
Autopsy: ☐ Yes ☒ No Autopsy Permit Signed: ☐ Yes ☐ No Coroner to be notified: ☒ Yes ☐ No
Coroner Notified by L Clark PN Coroner's Response: ☐ Accept ☒ Release body
Communicable Disease: ☐ Yes ☐ No If yes, get appropriate toe tag from House Manager (CJD has a specific tag)
Physician Pronouncing Death: Dr. Smith Primary Physician: _____

PERMIT FOR RELEASE OF BODY

Funeral Home to be notified: _____ Time Notified: _____

DISPOSITION OF CLOTHING AND VALUABLES

Clothing: none Valuables: none

Received by: _____ (Signature - Relationship) Received by: _____ (Signature - Relationship)

Release Authorization Received From: Danielle Kendrick (Name and address of Nearest Relative or Person Authorized to Release Body)

Witness: Laura Clark PN Date: 7-15-13

ROUTINE NOTIFICATION

Time ARORA (1-800-727-6726) was notified: _____

☐ Potential Organ/Tissue Donation (Brain Death Present/Imminent & Heart beat present).
☐ Potential Tissue Donation Only (Heart beat not present).
☒ Does not meet criteria. Reason given by ARORA Coordinator: per Will Bearden.

DONATION OPTION

(Complete after speaking with ARORA Coordinator)

☐ Presented to Next of kin. Name: _____ Relationship to Decedent: _____
☐ Not Present to Next of kin. why not? _____ By Whom

☐ Donation Declined: Reason, if indicated. _____
☐ Donation Allowed. Completed Donor Consent Form. _____ Nursing Completing Form

FUNERAL DIRECTOR'S RECEIPT

Received from Saline Memorial Hospital the body of _____
The body of the above named person has been received by the undersigned person who also certifies that he is duly authorized by the responsible party to receive the body.

Funeral Director Signature: Bob Joe Adam

Sic Dr Ed Hill

[redacted]
07/10/09

Record of Death

R A D KENDRICK, KENNETH
Room/Bed:ED/OPAdmission:7/15/2013
Sex:F Age:41 yr 2 m DOB:5/21/1972
MR: 18-47-40 Acct#: 2008399303

EXHIBIT "F"
44

STATE OF ARKANSAS

TYPE / PRINT IN PERMANENT BLACK INK. SEE INSTRUCTIONS

AUG 9 2013

ARKANSAS DEPARTMENT OF HEALTH
Vital Records Section
CERTIFICATE OF DEATH

13 017739

To Be Completed / Verified by FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix): Kenneth Merion Kendrick
2. SEX: Male
3a. DATE OF DEATH (Mo/Day/Yr): July 15,2013
3b. TIME OF DEATH: 12:49 ☐ AM ☒ PM
4. SOCIAL SECURITY NO.:
5a. AGE – Last Birthday (Years): 41
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo/Day/Yr): May 21,1972
7. BIRTHPLACE (City and State or Foreign Country): Danville,AR.
8a. RESIDENCE STATE or FOREIGN COUNTRY: Arkansas
8b. COUNTY: Pope
8c. CITY OR TOWN: Russellville
8d. NUMBER AND STREET: 2109 E. 12th St.
8e. APT. NO.:
8f. ZIP CODE: 72802
8g. INSIDE CITY LIMITS? ☒ Yes ☐ No
9. EVER IN US ARMED FORCES? ☐ Yes ☒ No
10. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but Separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown
11. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage.): None
12a. IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☒ Emergency Room / Outpatient ☐ Dead on Arrival
12b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Decedent's Home ☐ Hospice Facility ☐ Nursing Home / Long Term Care Facility ☐ Other (Specify)
12c. COUNTY OF DEATH: Saline
12d. FACILITY NAME (If not institution, give number & street): Saline Memorial Hospital
12e. CITY OR TOWN: Benton
12f. ZIP CODE: 72015
13. FATHER'S NAME (First, Middle, Last): Albert Merion Kendrick
14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Nell Jones
15a. INFORMANT'S NAME: Nell Jones
15b. RELATIONSHIP TO DECEDENT: Mother
15c. MAILING ADDRESS (Number and Street or PO Box, City, State, Zip Code): 2109 E.12th.St.,Russellville,AR. 72802
16a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
16b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Old Hickory Cemetery
16c. LOCATION – CITY, TOWN, AND STATE: Hattieville,AR.
17a. EMBALMER'S NAME: ☒ Not Embalmed
17b. EMBALMER'S LICENSE #: N/A
17c. SIGNATURE (FUNERAL SERVICE LICENSEE OR OTHER AGENT):
17d. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Shinn Funeral Svc., P.O.Box 700, Russellville,AR. 72811
17e. LICENSE #: 83
18a. DATE PRONOUNCED DEAD (Mo/Day/Yr): July 15,2013
18b. TIME PRONOUNCED DEAD: 12:49 ☐ AM ☒ PM
18c. NAME AND TITLE OF PERSON PRONOUNCING DEATH (Print / Type): Charles Smith M.D.
19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☒ Yes ☐ No

NAME OF DECEDENT
For use by Indoor of Death Certificate

To Be Completed / Verified by MEDICAL CERTIFIER

20. CAUSE OF DEATH
PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Unknown
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that caused the events resulting in death) LAST.
b. Due to (or as a consequence of)
c. Due to (or as a consequence of)
d. Due to (or as a consequence of)

APPROXIMATE INTERVAL: Onset to Death: 20 min

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

21a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No
21b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No
22. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☒ Could not be determined
23. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown
24. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within last year.
25a. DATE OF INJURY (Mo/Day/Yr):
25b. TIME OF INJURY: ☐ AM ☐ PM
25c. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area):
25d. INJURY AT WORK? ☐ Yes ☐ No
25e. LOCATION OF INJURY. (Number, Street, Apartment No., City, State, Zip Code):
25f. DESCRIBE HOW INJURY OCCURRED:
25g. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver / Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

26a. CERTIFIER (Check only one)
☒ Certifying Physician – To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying Physician – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Coroner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the causes(s) and manner stated.
☐ Hospice Registered Nurse – To the best of my knowledge, death occurred due to the cause(s) and manner stated.
SIGNATURE: [signature] TITLE: MD DATE: 7/16/13 (Mo/Day/Yr)
26b. NAME AND COMPLETE MAILING ADDRESS OF PERSON SIGNING ITEM 26a. (Type / Print): Ed Hill M.D. 112 N.Main,Benton,AR. 72015
26c. LICENSE #: 56655
27a. SIGNATURE OF REGISTRAR: Theresa Duncan – Deputy Registrar
27b. FOR REGISTRAR ONLY – DATE FILED (Mo/Day/Yr): AUGUST 16, 2013

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THE ARKANSAS DEPARTMENT OF HEALTH.

OCT 9 2013

Paul W. Johnson
State Registrar

ARKANSAS DEPARTMENT OF HEALTH SEAL LITTLE ROCK, ARK.

WARNING: A REPRODUCT... EMBOSSED SE... ALTER OR CO... ...ID AND INVALID. DO NOT ACCEPT UNLESS ...F HEALTH IS PRESENT. IT IS ILLEGAL TO

4117564

EXHIBIT 20

45

- Food shall not be brought in to or stored in the resident's room unless in a covered container.
- Smoking will be allowed only in areas as designated and at no time in the resident rooms.
- Resident will be considerate of other residents by cooperating in the use of heating and air conditioning equipment.
- Any resident who destroys another resident's property may be held responsible for making restitution.
- The resident, family members, or significant others will be responsible for making burial arrangements.

Resident Behavior and AHC Practices

Restraints-

- AHC may not use physical restraints or psychoactive drugs for discipline or convenience or when they are not required to treat medical symptoms.

Abuse-

- You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

Staff Treatment-

- AHC must implement procedures that protect you from abuse, neglect or mistreatment, and misappropriate of your property.
- In the event of an alleged violation involving your treatment, AHC will report it to the appropriate officials.
- All alleged violations must be thoroughly investigated and the results reported.

Quality of Life-

- AHC will care for you in a manner that enhances your quality of life.

Dignity-

Kenny Kendrick was owed these duties

- AHC will treat you with dignity and respect in full recognition of your individuality.

Self Determination-

- You may choose your own activities, schedules and health care and any other aspect affecting your life at AHC.
- You may interact with visitors of your choice.

ARKANSAS HEALTH CENTER

AHC Mission:

To provide exceptional nursing home care to Arkansans with special medical or behavioral needs that are not generally available through traditional nursing facilities.

EXHIBIT 5

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Charting/Nurse's Notes	NS 1301

1. PURPOSE: It is the purpose of this policy to establish a mechanism for communication among members of the health care team; to provide pertinent, accurate, and current information about the resident; to assure a mechanism for the evaluation of individual resident care; to provide a permanent legal record of the care provided to the resident; to improve the quality of nursing documentation; to maximize the nurse's time for high quality care; to improve quality of professional practice; and to prevent duplication of information. Professional responsibility and accountability are among the most important reasons for accurate documentation. Documentation is a part of the nurse's total responsibility of care. The purpose of documentation is to describe the nursing care of the resident outcome. The medical record facilitates care, enhances continuity of care, and helps to coordinate the treatment and evaluation of the resident.

2. SCOPE: All licensed staff.

3. POLICY:

A. Every caregiver places the date and time of each entry in the Nurses' Notes and signs their name and title at the end of each note.
B. All documentation is to be neat and legible.
C. Only black ballpoint pen is to be used for writing in the medical record.
D. Ink eradicators are not to be used.
E. Narrative nursing notes on the resident's current status and progress toward achievement of goals include:

1. Applicable comments made by the resident that address his or her goal achievement (subjective data).
2. Data observed by the licensed nurse regarding the resident's problem/behavior/goal achievement: examples: physical assessment data, lab data, etc. (objective data).
3. A description of the nurse's approaches used to attain the goal and/or manage the identified problem(s)/behavior(s).
4. An assessment of the effectiveness of the approaches used to manage the identified problem(s)/behavior(s).
5. A modification of the identified goal and/or approaches based upon nursing assessment is documented when applicable.

F. There is at least a 2 week narrative nursing note describing the resident's mental status during the previous two weeks.
G. There is at least a 2 week narrative-nursing note describing the resident's response to changes in medications and/or treatments that were implemented during the previous two weeks.
H. There is at least a 2 week narrative nursing note summarizing the usage of physical and/or chemical restraints during the previous two weeks.
I. Each resident's medical record has a narrative nursing note completed by a night shift licensed staff member at least every 2 weeks that focuses on the resident's night time behavior, sleep patterns, activity, pain, continence, etc.
J. During the 2 week narrative, a complete picture of all aspects of daily living, nursing care provided etc. will be documented on each resident.
K. Daily or PRN charting will be done when the following occurs on any resident:

1. Episodes of acute illness occur – these will be documented every shift until the illness is resolved.
2. Doctor visits or out-to-doctor office visits (time left and returned with notation of new orders) will be documented.
3. Completed lab work will be documented.
4. When a resident is out on pass, the time they left, returned and the destination will be documented. List medications by the name and number of each medication sent out with the resident. Upon return, medications are to be listed and number returned documented.
5. Refusal of medication, treatments, meals, baths, etc. should be documented.
6. Change in condition including notification of physician and family or responsible party should be documented.
7. When a PRN IM medication is given, the site of injection and effectiveness after 30-60 minutes of injection should be documented in the medical record.
8. Unusual occurrences, incidents and accidents will be followed up on and documented on for at least 48 hours or as long as necessary.
9. H.S. snacks for residents receiving therapeutic diets will be documented in the chart.
10. Variances from regular appetites will be recorded.
11. Indwelling catheters, catheter irrigation and urine output may be documented on appropriate flow sheets unless there are abnormal findings and then it will be documented in the nurse's notes
12. Treatments may be documented on the appropriate flow sheet unless there are abnormal findings and then it will be documented in the nurse's notes
13. Any variances in mental status will be documented.
14. Weight gains or losses in excess of 5% in 1 month, 7.5% in 3 months and/or 10% in 6 months.

L. Legal Aspects of Charting:

1. Write neatly and legibly.
2. Use proper spelling and grammar.
3. Document in black ink and use military time.
4. Use a minimal of authorized abbreviations.
5. Make sure the resident's name is on every sheet in the medical record.
6. Transcribe orders carefully. Although other licensed staff may transcribe orders, the RN has the ultimate responsibility for the accuracy of the transcription.

Guidelines for the transcription of orders include:

a. Think through the orders and question inappropriate ones.
b. If a physician's order is unclear, ask the physician who wrote the order to clarify it.

7. Document complete information about medications. For each medication administered, document the date, time and your initials. Document sites for all intramuscular and subcutaneous injections. Document the reason why medications were omitted. Document the reason that led up to a decision to withhold a medication. If you are unable to reach the physician and decide to withhold a medication, write in the nurse's notes that you attempted to reach the physician and your reason for withholding the medication (e.g. withholding Digoxin due to a pulse rate of 48).

8. Document promptly. Chart as close as to the time you make an observation or provide care as possible.
9. Chart after the delivery of nursing care.
10. Identify late entries correctly. The procedure for adding late entries is:
    a. Add the entry to the first available line.
    b. Label the entry "Late Entry" to indicate it is out of sequence.
    c. Record the time and date of the entry.
    d. In the entry, record the time and date it should have been made.
11. Correct mistaken entries properly. Procedure for correcting mistaken entries:
    a. Draw a single line through the entry so that it is still readable.
    b. Write the words "mistaken entry or M.E." above the original entry.
    c. Place the date and your initials next to the words mistaken entry/M.E.
12. Do not tamper with medical records. Tampering with the medical record involves:
    a. Adding to the existing record at a later date without indicating the addition is a late entry.
    b. Placing inaccurate information into the record.
    c. Omitting significant facts.
    d. Dating a record to make it appear as if it were written at an earlier time.
    e. Rewriting or altering the record.
    f. Destroying records.
    g. Adding to someone else's notes.
13. Chart only care you provide or supervise (A.M. care provided by J. Doe, C.N.A.).
14. Avoid using the medical record to criticize nurses, physicians or other professionals.
15. Fill in appropriate blanks on flow sheets.
16. Avoid using words that reveal negative attitudes toward the resident such as lazy, demanding, nasty, and disagreeable, etc.
17. Be precise in documenting the information you report to the physician. It is a legal "must" to chart every substantive conversation you have with a physician about a resident. Always document on the record the time of a phone call informing a physician of a change in the resident's condition or a critical abnormal laboratory value, etc. After notifying the physician, write, "Dr. Smith notified of resident's symptoms: BP 90/40, pulse 120, pale, clammy skin. No new orders received."

M. INFORMATION THAT SHOULD BE INCLUDED IN NURSES' NOTES:

1. Record information on the nurses notes that IS NOT already recorded on flow sheets. Flow sheet information needs to be included in the nurses notes only when there is a change in the resident's condition such as a change in BP, nausea and/or vomiting, change in appearance of urine from a catheter, change in IV site, foul smelling drainage from decubitus, etc.
2. Document resident's response to nursing interventions that are addressed on the care plan (e.g. decubitus shows no signs of infection, resident has shown no aggressive behavior this shift, etc.).
3. Identify a specific time for each entry NO BLOCK CHARTING.
4. Physician's visits are to be recorded in the nurse's notes.
5. Use specific, definitive words when describing a resident's condition or status. Document objective and subjective observations.

Revised Date: June, 2012
Effective Date: March, 1999

6. Avoid the use of phrases such as "had a good day." Use professional, objective language.
7. When documenting a problem always describe the nursing intervention. (E.g. Shortness of breath, oxygen started at 4 liters).
8. Describe the follow through on a request for medical or nursing orders.
9. Describe follow through on abnormal diagnostic findings (lab, x-ray, TB skin test, accu checks, etc.). Document the physician was notified and the response to the interventions if applicable.
10. Fully describe symptoms that indicate the need to change medications or other interventions (0730 – Resident does not respond to verbal stimuli. Vital signs are: BP 90/40, Respirations 12, and Pulse 58. Dr. Smith notified. Order received to withhold Haldol until further notice).
11. **When any of the following occurs, it must be documented <u>on all residents</u> at the time of occurrence and follow up will be required on <u>each shift</u> according to the resident's condition:**
    a. Episodes of acute illness. Charting will be done at a minimum of <u>every shift</u> until the resident's condition improves.
    b. Doctor visits or appointments outside the facility, to include the time left and returned and notation of new orders.
    c. Lab work completed and by whom.
    d. Out on pass_____ Time left, time returned and the destination. Medication taken with the resident will be listed by name, number of tablets, capsules, etc. Upon return, the medication will be listed by name and the number of each that were returned.
    e. Refused medication. The RN on duty will be notified and the physician will be notified at their discretion.
    f. Refused treatments, baths, meals, etc.
    g. Change in the resident's condition. Include notification of physician and family.
    h. PRN medications, medication strength, time, reason for administration, route of administration, and the effectiveness, will be documented on the PRN medication sheet. (The injection site will be documented in the Nurses Notes).
    i. **Unusual occurrences, accidents, and incidents will be followed up each shift for at least 24 hours, or longer as deemed necessary, to include treatment provided, if the resident is transferred to the hospital or taken to a physician's office, etc.**

6. Documentation
    a. Document daily in the nurse's notes as necessary and according to skill level per Regulatory Requirement.
    b. A nursing summary flow sheet & sleep note is to be completed every 2 weeks on each resident

Director of Nursing	Teena Cimbree RN	**Date** 7/3/12
Director	Jay Hill	**Date** 6/14/12
Medical Director	M. Gallego	**Date** 6/14/12

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Ventilator/Respiratory Care Schedule	NS 602

1. PURPOSE: The purpose of this policy is to ensure continuity of care for residents in the respiratory care unit/Willow.

2. SCOPE: Performed by specifically trained licensed staff or Respiratory Therapist

3. POLICY: These standards of care are to be followed and maintained unless otherwise ordered by the physician.

4. PROCEDURE:
   A. Tracheostomy care will be done each shift or as ordered by the physician. The use of sterile water for trach care instead of sterile normal saline is permitted.

   B. Trach changes are done as deemed necessary or every 3 months. Check for placement, air leakage, and proper functioning every shift and be constantly alert to signs of malfunctioning or reduced ventilation to resident.

   C. Circuit changes are to be made monthly and PRN. Vent/Circuit checks will be done every 12 hours and PRN. This will be documented on the vent check sheet

   D. Chamber changes are to be made monthly and PRN. Temperature should be set so that inspired gas delivered is 28-37 degrees C.

   E. If indicated, suctioning is to be done using five to ten cc's of normal saline lavage with intermittent breathing either by vent or ambu bag. If plugging or excessive thick secretions are present, deep breaths by ambu bag will be more effective. Suction PRN. Yankauers may be used for oral suctioning. Discard weekly or as needed. Do NOT ever suction oral cavity and move to trach suctioning without changing the catheter.

   F. Suction canisters are to be changed weekly and PRN.

   G. Suction tubing is to be changed weekly and PRN.

   H. In-line suction catheters are to be changed once weekly.

   I. Sighing is deep manual breaths by ambu bag. This is done PRN for signs of distress or at the request of the resident. Sighing during suctioning will help to remove secretions and aid in lung expansion. Sighing is done as ordered to prevent pneumonia and maintain resident comfort.

   J. Residents will be on room air unless oxygen is ordered by the physician. If oxygen concentrator machine is used, the filters on it must be removed, washed with soap and water, dried, and replaced every week.

   K. Ventilator settings are done by respiratory therapist or licensed nurse. These settings are changed only when directed to do so by a physician.

L. Sp02 check is to be done with Pulse Oximeter as ordered by the physician. The level may be checked on a resident anytime they show signs of distress or for reassurance of resident or staff. Guidelines are present on the machine.

M. Do NOT change or adjust ventilator settings without a physician order.

N. Keep ventilator carts free of excess materials and dust.

5. DOCUMENTATION:

A. Document in the Respiratory Therapy Notes if the resident has required ambu-bag use.

B. Document in the Respiratory Therapy Notes results of Sp02.

Director of Nursing	Lisa Campbell RN	**Date** 4/26/12
Director	Jay Hill	**Date** 6/01/12
	M Ally	5/12/12

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Behavioral Health Services
Arkansas Health Center
PROGRESS NOTE

KENDRICK, KENNETH WM
NH 000 214 113 ADM 6-18-13
DOB 5-21-72 S
MCD 0634246001
MCR 431829662C1

Department ______

Subsequet notes (date and sign each entry)

7/10/13- 1130 - Trach Δ done ē Shiley XLT proximal #8 DIC ē only
Cuff [illegible] no complications - Casey Fitzgerald [illegible]
7/10/13 - 1820 - SXN mod thin lgt yellow
7/10/13 2150 SPO2 99% HR 75 SXN large amt
pale yellow; trach care done and tape Δ. Orange
Noted on drsg - No s/s distress noted
7/10/13 0200 SPO2 98% HR 78 MDI provided
No distress noted SXN mod amt pale yellow
7/11/13 - 0815 - Vent circuit Δ due to gross contamination of dried
secretion in circuit. IV line, SXN Δ done also
7/11/13 - 1500 - SXN mod thin lgt yellow
7/11/13 - 1750 - SXN small thin lgt yellow
7/11/13 - 1940 Sxn mod amt thin pale yellow secretions,
SpO2 95%, P-81/min. Trach care done.
7/12/13 - 0100 Sxn mod amt thin pale yellow secretions.
7/12/13 - 0530 Sxn mod amt thin pale yellow secretions.
7/12/13 @ 1450 Sxn moderate amount of pale yellow secretions
7/13/13 @ 0830 Sxn moderate amount of pale yellow secretions
7/13/13 @ 1400 Sxn moderate amount of pale yellow secretions
7/14/13 @ 1740 Sxn moderate amount of pale yellow secretions
7/15/13 - 1213 - Called to room by Tasha Marshall and stating he was unresponsive.
Upon entering room he was noted to be very cyanotic. When pulling
the sheet he [illegible] down his head down past jaw line it was observed
the inner cannula of his tracheostomy tube was completely out. It appeared
the end of the inner cannula was against his neck. The ventilator
was not alarming at all. I reinstated (?) the inner cannula and locked
it in. Bag to tube ventilation was started @ the time - [illegible]

DBHS-3837 (7/04)

No documentation on July 15 prior to 12:13pm

Noted to be "very cyanotic"

EXHIBIT
9

7-15-13 1312 I was sitting at Nurse's Station charting. Tasha Lenard, LPN approached me and stated that I needed to come to B's room as ½ of his face was blue. We went to B's room. When I entered B's room, RT, Paul Mills was at bedside manual bagging B per trash; pox was in place on (L) finger. When I entered room pulse ox was not tracking, but then began to track & 02 & HR both in 40's; additional 02 tanks obtained and J. Robertson instructed to call 911. T. Lenard was attempting to obtain carotid pulse. Pulse less than 10 BPM palpable. Rotating bed was put on CPR mode and I started compressions while RT, Paul Mills, continued manual bagging per trash; after approx 1 (one) minute of CPR, B's color became more pink but Ø increase of HR noted; pink color then turned cyanotic again and continued to have no pulse. Switched Compressors approx every 2 min awaiting 911 personnel. AED placed at approx 5 minutes to Code. Ø rhythm detected on AED and continued CPR until Medtran arrived. transferred to Medtran crew & continued CPR & manual bagging to trash. Taken to ambulance for transport to SMH.

55

T. Moseley RN

Arkansas Health Center

Nurse's Notes

ADM 6-18-13

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
7/15/13	0020	24° CC — [illegible] LPN
7-15-13	0820	R in bed [illegible] s/s of distress, [illegible] patient to [illegible], [illegible] discomfort @ [illegible], call light in reach @ [illegible] — Menard LPN
7-15-13	1145	I was sitting at nurses station & R's call light sounded, when I answered the R responded "accident" — [illegible]
7-15-13	@1150	RT in room & checked R's vent monitor, not alarming, @1210 went into R's room to check his BS, spoke out to R several times, R unresponsive. I uncovered R's head R pale & cyanotic, L side of R face noted to be purple, lips & all extrem. noted to be cyanotic, Paul RT & Kay RN immediately notified, RT assessed reported inner cannula popped out, unable to detect O2 sat or HR on pulse oximeter, I palpated HR via carotid artery, less than 10 bpm. @1214 backboard placed Code Blue & CPR initiated @1215 911 called & Dr Hill notified per Jackie LPN CPR continued until 1224 AED applied c̄ no shock advised several times continued CPR @1231 MEMS arrived to transfer to SMC, Kirsh, PSD secretary notified, @1234 mother notified per Kay, 1910 completed & PSD notified @1536 Menard
cont.		R noted he did not use his call light between 1145 & 1210 when R found Kenn[illegible]

No documenta that Kenny was se betwee 8:20am and 12:10p

11:45am Acciden no chec perform

CYNOTI is bluish color of skin because insuffici oxygen

Form No. [illegible] (2/88)

EXHIBIT 8

Nurse's Notes Form No. 1160 (REV 8/85)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Behavioral Health Services
Arkansas Health Center
PROGRESS NOTE

KENDRICK, KENNETH NH
NH 000-214-113 ADM 5-10-12
DOB 5-21-72
MCD 0634246001
MCR 4318296620

Department

Subsequet notes (date and sign each entry)

and Code Blue was initiated @ 1214.
R always requested the nurse "Shut" over his head. Also with the End of the inner cannula against his neck the CTV cont was maintain +5cm of peep and pressuring at least +5cm over peep c each breath therefore no alarms were active. The low MV alarm was off due to R having his leg dysfunctional at times to communicate.

Low minute volume alarm noted to be off at time of death

DBHS-3837 (7/04)

Nursing Care Record

07/01/2013 through 07/31/2013
KENNETH [illegible]ICK   M.R.#000-214-113

Nursing Care	Hour
Bathing (Record as Follows: 1= Shower 2= Tub 3= Bed Bath 4= Whirlpool Bath R= Refused B= Uncooperative Behavior During Care **If Bath is REFUSED notify the Nurse** 06/18/2013	7A-7P / 7P-7A
Bathing: Daily Bedbath--Chart as Follows: Initial When Given R= Refused B= Uncooperative Behavior During Care ** If Refused Notify the Nurse** 06/18/2013	7A-7P / 7P-7A
Bowel Function Description (Record as Follows): S= Small L= Large D= Diarrhea M= Medium H= Hard 06/18/2013	7A-7P / 7P-7A
Bowel Function: Record Number of Bowel Movements Each Shift. **If NO BM For (3) Three Days NOTIFY the Nurse** 06/18/2013	7A-7P / 7P-7A

Days: 1 M, 2 Tu, 3 W, 4 Th, 5 F, 6 S, 7 S, 8 M, 9 Tu, 10 W, 11 Th, 12 Fr, 13 S, 14 S, 15 M, 16 Tu, 17 W, 18 Th, 19 Fr, 20 S, 21 S, 22 M, 23 Tu, 24 W, 25 Th, 26 F, 27 S, 28 S, 29 M, 30 Tu, 31 W

Dates that bathing order is not being followed - only 1 or 2 baths in July

Bowel Functions not being monitored on July 15, 2013

Init.	Signature	Init.	Signature	Init.	Signature
AR	Amanda Rogers	JD	Jessica [illegible]	KC	Kristi Calvert
AC	Amanda Calmore	SL	[illegible]	BM	[illegible]
		LB	[illegible]		

Diagnosis
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;

Allergies
METFORMIN/GLUCOPHAGE;CLINDAMYCIN;FORTAZ

Effective 06/25/2013

Resident	Resident #	Room/Bed	Physician: Hill, Ed	Phone: (501) 778-5400	Page
KENNETH KENDRICK	000-214-113	29 / C	Alt.Phys.:	Phone: ( ) -	1

EXHIBIT 10

07/01/2013 through 07/31/2013

KENNETH KE[redacted]ICK M.R.#000-214-113

Diabetic Meds/Treatments

Diabetic	Hour
FSBS AC and HS with ~~Novolog~~ DC when current bottle depleted	0600
Insulin 100 U / ml to be injected	BS
SQ per Sliding Scale as follows:	2nd NS
	site
101 - 150 = 16 U	1100
151 - 200 = 18 U	BS
201 - 250 = 21 U	2nd NS
251 - 300 = 26 U	site
301 - 400 = 36 U	1600
over 400 = Call MD 06/18/2013	BS
	2nd NS
Pt when Humalog bottle depleted - start Novolog c above SS.	site
	2100
	BS
	2nd NS
	site
Detemir (Levemir) Insulin 100 U / ml - Inject 90 Units SQ twice daily at 0900 and 2100 (IDDM) 06/18/2013	0900
	site
	2nd NS
	2100
	site
	2nd NS
Glipizide Immediate-Release 10 mg (1) Tab PO twice daily at 0900 and 2100 (IDDM) 06/18/2013	0900
	2100

M	Tu	W	Th	F	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	F	S	S	M	Tu	W
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Accucheck order for 11:00am not being followed and was not done

Init.	Signature
SL	[signature]

Init.	Signature
PT	[signature]
TS	[signature]

Init.	Signature
M	[signature]
FA	[signature]
B	[signature]

[redacted]

Diagnosis	Allergies	Effective
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;	METFORMIN/GLUCOPHAGE;CLINDAMYCIN;FORTAZ	06/25/2013

Resident	Resident #	Room/Bed	Physician: Hill, Ed	Phone: (501)778-5400	Page
KENNETH [redacted]RICK	000-214-113	29 / C	Alt.P[redacted]	Phone: ( )	1

EXHIBIT 11

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07/01/2013 through 07/31/2013

KENNETH [redacted]ICK M.R.#000-214-113

Food / [redacted]luid Flow Sheet

Food/Fluid	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		M	Tu	W	Th	[redacted]	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	[redacted]				M	Tu	W
Daily Hydration Pass Record #1	1000																															
06/18/2013	Amount																															
Daily Hydration Pass Record #2	1400																															
06/18/2013	Amount																															
Daily Hydration Pass Record #3	2000																															
06/18/2013	Amount																															
Guidelines for Recording CC's:	7A-7P																															
Styrofoam Cup (Large) Full to	7P-7A																															
Line=360cc,																																
3/4 Full=270cc, 1/2 Full=180cc.																																
Styrofoam Cup (Squat) Full to																																
Line=240cc, 3/4 Full=180cc, 1/2																																
Full=120cc.																																
Styrofoam Cup (Small) Full=120cc.																																
Regular Squat Cup Full To Line (NO																																
Ice)=240cc.																																
Regular Squat Cup (With																																
Ice)=180cc.																																
Coffee Cup Full=240cc.																																
Prepackaged Juice or Juice																																
Glass=120cc.																																
06/18/2013																																
Inflate trach cuff with 10cc water	7A-7P																															
while eating and giving meds	7P-7A																															
06/18/2013																																

No record of water being provided

No record of water being provided

Water provided on 7.15.13 after he died

Document that cuff inflated after he died

Init.	Signature	Init.	Signature	Init.	Signature
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]				

[redacted]

Diagnosis	Allergies	Effective
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;	METFORMIN/GLUCOPHAGE; CLINDAMYCIN; FORTAZ	06/25/2013

Resident	Resident #	Room/Bed	Physician: Hill, Ed	Phone: (501) 778-5400	Page
KENNETH KENDRICK	000-214-113	29 / C	Alt.Phys.:	Phone: ( ) -	1

EXHIBIT 17

tabbies

60

07/01/2013 through 07/31/2013
KENNETH F[illegible]ICK M.R.#000-214-113

Food / Fluid Flow Sheet

Food/Fluid	Hour	Days 1–15 (M Tu W Th F S S M Tu W Th Fr S S M)	Days 16–30 (Tu W Th Fr S S M Tu W Th F S S M Tu)
Regular Chopped with Thin Liquids 06/24/2013	7A-7P	[illegible handwritten initials]	
	7P-7A	[illegible handwritten initials]	
HS Snack Offered (Chart as Follows) A=Accepted R=Refused 06/18/2013	2100	[illegible handwritten initials, R entries]	
IF a Meal is Refused and Resident has NO Supplement ORDERED Offer a Supplement of Choice and Count it as (1) Item of the Over-All Meal Percentage. **DOCUMENT This Percentage on Meal Intake Record** **Initial Here Only When Given** 06/18/2013	Bkfst	/ / / / / / / / / / / / / / /	
	Lunch	/ / / / / / / / / / / / / / /	
	Supper	/ / / / / / / / / / / / / / /	
Notify Unit Nurse if Resident Refuses Food AND Fluids for ANY 24 Hour Period Period. **Only Initial if Nurse is Notified** 06/18/2013	7A-7P	/ / / / / / / / / / / / / / /	
	7P-7A	[illegible handwritten marks]	
Resident May Have a Sandwich For a Snack Between Meals 06/18/2013	1000	[illegible handwritten initials]	
	%	[illegible handwritten entries]	
	1400	[illegible handwritten initials]	
	%	[illegible handwritten entries]	

Food and snacks being offered after he died

Orders not being followed and checks for orders being followed after Kenny died

Snack order on 7.15.13 at 10:00am not done

Init.	Signature	Init.	Signature	Init.	Signature
DS	Donna Strausner			VS	Valorie S[illegible]
CS	Carla Strickland				

Diagnosis
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;

Allergies
METFORMIN/GLUCOPHAGE;CLINDAMYCIN;FORTAZ

Effecti[ve]
06/25/2[illegible]

Physician: Hill, Ed

Phone: (501)778-5400

07/01/2013 through 07/31/2013
KENNETH K[illegible]RICK M.R.#000-214-113

Food / [illegible]uid Flow Sheet

Food/Fluid	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		M	Tu	W	Th	[illegible]	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	[illegible]	[illegible]	[illegible]	M	Tu	W
Meal Consumption: Record %	Bkfast	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
consumed EACH Meal. **If Resident	%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
is Out of the Facility Use the	Lunch	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
Following Key to Identify**	%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																		
PF=Pathfinders	Supper	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
H=Hospital	%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
VO=Visiting Out																																
BF=Food Brought In OR Own Food																																
Eaten 06/25/2013																																

No meal being recorded as given at lunch or dinner on 7.14.13 and no breakfast given on 7.15.13

Init.	Signature	Init.	Signature	Init.	Signature
JS	Jessica [illegible]			VS	[illegible]
CS	[illegible]				

Diagnosis	Allergies	Effective
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;	METFORMIN/GLUCOPHAGE;CLINDAMYCIN;FORTAZ	06/25/2013

Resident	Resident #	Room/Bed	Physician	Phone	Page
KENNETH KENDRICK	000-214-113	29 / C	Physician: Hill, Ed	Phone: (501) 778-5400	3
			Alt. Phys.:	Phone: ( ) -	

07/01/2013 through 07/31/2013

KENNETH [redacted]ICK M.R.#000-214-113

Respiratory Related Orders

Respiratory	Hour	1 M	2 Tu	3 W	4 Th	5	6 S	7 S	8 M	9 Tu	10 W	11 Th	12 Fr	13 S	14 S	15 M	16 Tu	17 W	18 Th	19 Fr	20 S	21 S	22 M	23 Tu	24 W	25 Th	26	27	28 S	29 M	30 Tu	31 W
Routine Trach Care Every Shift and PRN 06/18/2013	7A-7P																														
	7P-7A																														
	PRN																														
RT to Change Vent Circuits on the 1st Monday Night of Each Month and PRN 06/18/2013	PRN																														
	7P-7A																														
RT to check Trach Stoma site and do full description documentation every Wednesday on 7P-7A Shift 06/18/2013	7P-7A																														
RT to check Trach Stoma site QD on 7A-7P Shift (Document any Abnormal Findings) 06/18/2013	7A-7P																														
Wash O2 Concentrator Filters Weekly on Tuesday 7P-7A Shift. 06/18/2013	7P-7A																														
Change and Date Humidifier Chambers Weekly on Tuesday 7P-7A Shift. 06/18/2013	7P-7A																														

Order not followed on 7/1, 7/8, or 7/11

Order not being followed

Init.	Signature	Init.	Signature	Init.	Signature

Diagnosis	Allergies	Effective
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;	METFORMIN/GLUCOPHAGE; CLINDAMYCIN; FORTAZ	06/25/2013

Resident	Resident #	Room/Bed	Physician: Hill, Ed	Phone: (501) 778-5400	Page
KENNETH KENDRICK	000-214-113	29 / C	Alt.Phys.:	Phone: ( ) -	2

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07/01/2013 [illegible]rough 07/31/2013
KENNETH [illegible]RICK
M.R.#000-214-113

Respiratory Related Orders

Respiratory	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		M	Tu	W	Th		S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	Fr	S	S	M	Tu	W	Th	F	S	M	Tu	W	
Change and Date 02 Tubing Weekly on Sunday 7P-7A Shift **Put Sticker on Tubing with Date and Your Initial** 06/18/2013	7P-7A	X	X	X	X	X	X	SL	X	X	X	X	X	X	[initials]	X	X	X	X	X	X		X	X	X	X	X	X		X	X	X
Change and Date Humidifier Chambers Weekly on Tuesday 7P-7A Shift. 06/18/2013	7P-7A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Change and Date Sterile Water Bottles at Bedside Used for Respiratory Care and/or on Aerosols Nightly. 06/18/2013	7P-7A	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]	[initials]																	
Change and Date Yaunkers Weekly on Wednesday 7P-7A Shift. 06/18/2013	7P-7A	X	X	SL	X	X	X	X	X	X	ST	X	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X	X	
Change In-line Suction Catheters Weekly Every Monday on 7A-7P Shift. 06/18/2013	7A-7P	X [initials]	X	X	X	X	X	X	[initials] V	X	X	X [initials]	X	X	X	[initials]	X	X	X	X	X	X	[initials]	X	X	X	X	X	X	[initials]	X	X
Change Trach Ties Twice Weekly (Tues and Sat) on 7P-7A and PRN 06/18/2013	7P-7P	X	[initials]	X	X	X	[initials]	X	X	YU	X [initials]	X [initials]	X	YU	X	X		X	X	X		X	X		X	X	X		X	X		X

Order not being followed

Init.	Signature	Init.	Signature	Init.	Signature
AA	[signature]	PM	[signature]	JM	[signature]
VC	[signature]	ST	[signature]	TS	Tyler Sparks LPN
		SL	[signature]		

Diagnosis
Duchenne's Muscular Dystrophy; Respiratory Failure; Ventilator Dependence; Quadriplegia; Morbid Obesity; Chronic Back Pain; Diabetes Mellitus;

Allergies
METFORMIN/GLUCOPHAGE;CLINDAMYCIN;FORTAZ

Effective 06/25/2013

Resident	Resident #	Room/Bed	Physician: Hill, Ed	Phone: (501)778-5400	Page
KENNETH KENDRICK	000-214-113	29 / C	Alt.Phys.:	Phone: ( ) -	1

EXHIBIT 13

EVENT TRACE:190:VENT 1 E 1 C 1 06/18/2013 11:08:03.000 64 = VER 05.08.06
EVENT TRACE:191:LOW VE 1 E 47 C 1 06/18/2013 11:09:35.895
EVENT TRACE:192:LOW VE 1 E 47 C 16 06/18/2013 11:15:03.771
EVENT TRACE:193:LO PRES1 E 49 C 1 06/18/2013 11:10:07.509
EVENT TRACE:194:LO PRES1 E 49 C 15 06/18/2013 11:15:06.835
EVENT TRACE:195:LO PRES0 E 50 C 1 06/18/2013 11:11:37.563
EVENT TRACE:196:LOW VE 0 E 48 C 1 06/18/2013 11:12:54.015
EVENT TRACE:197:LO PRES0 E 50 C 4 06/18/2013 11:14:38.433
EVENT TRACE:198:LOW VE 0 E 48 C 2 06/18/2013 11:13:52.457
EVENT TRACE:199:HOUR MTR E 3 C 1 06/18/2013 11:15:05.967 12538.4 hours
EVENT TRACE:200:HOUR MTR E 3 C 1 06/18/2013 11:15:08.785 12538.4 hours
EVENT TRACE:201:VENT 0 E 2 C 1 06/18/2013 11:15:11.001 0
EVENT TRACE:202:VENT 1 E 1 C 1 06/18/2013 11:15:19.000 64 = VER 05.08.06
EVENT TRACE:203:LO PRES1 E 49 C 1 06/18/2013 11:15:36.457
EVENT TRACE:204:LO PRES0 E 50 C 1 06/18/2013 11:15:39.103
EVENT TRACE:205:LOW VE 1 E 47 C 1 06/18/2013 11:15:39.153
EVENT TRACE:206:HI PRES1 E 42 C 1 06/18/2013 11:15:39.757
EVENT TRACE:207:HI PRES0 E 43 C 1 06/18/2013 11:15:39.923
EVENT TRACE:208:LOW VE 0 E 48 C 1 06/18/2013 11:15:45.891
EVENT TRACE:209:HI PRES1 E 42 C255 07/15/2013 06:52:17.403
EVENT TRACE:210:HI PRES0 E 43 C256 07/15/2013 06:52:17.567
EVENT TRACE:211:LO PRES1 E 49 C146 07/15/2013 12:44:42.281
EVENT TRACE:212:LOW VE 1 E 47 C 3 06/18/2013 11:16:12.225
EVENT TRACE:213:LO PRES0 E 50 C147 07/15/2013 12:44:40.957
EVENT TRACE:214:TBN ZERO E 45 C 1 06/19/2013 14:48:02.899
EVENT TRACE:215:TBN ZERO E 45 C 27 07/14/2013 22:48:12.289
EVENT TRACE:216:HI PEEP1 E 75 C 1 06/22/2013 09:13:40.273. Mon PEEP = 27.2 cm
EVENT TRACE:217:HI PEEP0 E 76 C 1 06/22/2013 09:13:44.015
EVENT TRACE:218:HI PEEP1 E 75 C 6 07/07/2013 19:42:21.561. Mon PEEP = 32.5 cm
EVENT TRACE:219:HI PEEP0 E 76 C 6 07/07/2013 19:42:22.747
EVENT TRACE:220:HIGH DIS E 8 C 1 06/26/2013 04:12:22.833 1
EVENT TRACE:221:DISC 0 E 10 C 1 06/26/2013 04:12:26.387
EVENT TRACE:222:HIGH DIS E 8 C 33 07/15/2013 06:05:01.635 1
EVENT TRACE:223:DISC 0 E 10 C 37 07/15/2013 06:05:03.577
EVENT TRACE:224:LOW DIS E 9 C 1 06/30/2013 15:48:36.605 1
EVENT TRACE:225:LOW DIS E 9 C 5 07/06/2013 09:19:19.489 1
EVENT TRACE:226:HOUR MTR E 3 C 1 07/15/2013 12:42:16.675 13187.8 hours
EVENT TRACE:227:HOUR MTR E 3 C 1 07/15/2013 12:44:40.879 13187.9 hours
EVENT TRACE:228:VENT 0 E 2 C 1 07/15/2013 12:44:43.001 0
EVENT TRACE:229:VENT 1 E 1 C 1 07/16/2013 12:42:12.000 64 = VER 05.08.06
EVENT TRACE:230:EXT LST1 E 15 C 1 07/16/2013 12:42:13.013
EVENT TRACE:231:HOUR MTR E 3 C 1 07/16/2013 12:42:13.013 13187.9 hours
EVENT TRACE:232:HOUR MTR E 3 C 1 07/16/2013 12:53:23.715 13188.1 hours
EVENT TRACE:233:LO PRES1 E 49 C 1 07/16/2013 12:43:45.095

Respiratory therapist checks machine

Vent machine turned off

No alarms between 6:52am and 12:44pm on July 15, 2013

EXHIBIT 14

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Inflation/Deflation of Cuffed Tracheostomy Tube	NS 604

1. **PURPOSE:** The purpose of this policy is to prevent irritation of the tracheal wall; to prevent aspiration while eating or drinking; and to provide adequate ventilation.

2. **SCOPE:** Specifically trained licensed staff or Respiratory Therapist

3. **POLICY:** Licensed, certified staff inflate/deflate cuffed tracheostomy tubes.

4. **PROCEDURE:**
   A. Wash hands well.
   B. Assemble equipment.
      1. 10 cc syringe
      2. suction equipment
   C. Explain procedure to the resident.
   D. Deflation of cuff:
      1. Suction resident prior to deflating the cuff to removal all excess secretions.
      2. Remove all air from the cuff during an inspiration cycle of breathing. This helps to force secretions on top of the cuff into the pharynx.
      3. Remove all air from the cuff.
         a. Insert the tip of the syringe into the airline set at Pilot.
         b. Pull back on the plunger until the balloon is flat.
         c. Remove the syringe from the balloon port.
   E. **If a resident has an order to have cuff deflated, they will be required to have a trach tube WITHOUT a removable inner cannula.**
   F. Inflation of cuff
      1. Suction resident prior to inflating the cuff to remove all excess secretions.
      2. Fill a 10 cc syringe with room air/sterile H20. (Shiley/Portex trach's use air; Bivona trach's use sterile H20 or saline)
      3. Attach a 10 cc syringe to distal end of inflatable cuff making sure seal is tight.
      4. Inflate prescribed amounts of air or sterile H20 to create a leak-free system. The cuff is inflated correctly when you cannot hear the resident's voice or any air movements from the nose or mouth. Some authorities believe a minimal air leak is best. A minimal leak can be detected by listening for a "hissing" sound with a stethoscope held over the trach.
      5. Remove the syringe.

Part E was added after Kenny's death to prevent this from happening again

G. **DOCUMENTATION:**
   Document on the treatment sheet the procedure and the amount of air inserted into the cuff.

Director of Nursing	Teena Campbell RN	**Date** 8/22/13
Director	Jay Hill	**Date** 8/22/2013
Medical Director	M. Ally MD	8/22/13

Revision Date: August 2013
Effective Date March 1999

EXHIBIT 15

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West's Arkansas Code Annotated
Title 20. Public Health and Welfare
Subtitle 2. Health and Safety (Chapters 6 to 44)
Chapter 10. Long-Term Care Facilities and Services (Refs & Annos)
Subchapter 12. Protection of Long-Term Care Facility Residents

A.C.A. § 20-10-1204

§ 20-10-1204. Residents' rights

Currentness

(a) All long-term care facilities shall adopt and make public a statement of the rights and responsibilities of the residents of the facilities and shall treat the residents in accordance with the provisions of that statement. The statement shall assure each resident of the following:

(1) The right to be fully informed in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act[1] or not covered by the basic per diem rates and of bed reservation and refund policies of the facility;

(2) The right to examine at any time the results which the facility shall post of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility;

(3) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents;

(4)(A) The right to manage his or her own financial affairs or to delegate that responsibility to the licensee but only to the extent of the funds held in trust by the licensee for the resident.

(B) The facility may not require a resident to deposit personal funds with the facility.

(C) However, upon written authorization of a resident, the facility shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

(i) The facility shall establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles or regulations established by the Office of Long-Term Care, of each resident's personal funds entrusted to the facility on the resident's behalf;

(ii) The accounting system established and maintained by the facility shall preclude any commingling of resident funds with facility funds or with the funds of any person other than a resident;

(iii) An annual accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident; and

(iv) The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Ti Act.

EXHIBIT 21

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(D) An annual accounting of any transactions made on behalf of the resident shall be furnished to the resident or to the person responsible for the resident;

(5)(A) The right to freedom of choice in selecting a personal physician, to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act, and to obtain information about and to participate in community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record.

(B)(i) If a resident chooses to use a community pharmacy and if the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents.

(ii) If a resident chooses to use a community unit-dose system and if the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents;

(6) The right to be adequately informed of his or her medical condition and proposed treatment unless the resident is determined to be unable to provide informed consent under Arkansas law, the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being, and except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment unless otherwise indicated by the resident's physician and to know the consequences of such actions;

(7)(A)(i) The right to refuse medication or treatment and to be informed of the consequences of such decisions unless determined unable to provide informed consent under state law.

(ii) When the resident refuses medication or treatment, the facility shall notify the resident or the resident's legal representative of the consequences of such a decision and shall document the resident's decision in his or her medical record.

(B) The facility shall continue to provide other services the resident agrees to in accordance with the residential care plan;

(8) The right to receive adequate and appropriate health care and protective and support services, including social services, mental health services if available, planned recreational activities, and therapeutic and rehabilitative services consistent with the residential care plan, with established and recognized practice standards within the community, and with rules as adopted by the office;

(9) The right to have privacy in treatment and in caring for personal needs, to close room doors and to have facility personnel knock before entering the room except in the case of an emergency or unless medically contraindicated, and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance;

(10) The right to receive notice before the room of the resident in the facility is changed;

(11)(A) The right to be informed of the bed reservation policy for a hospitalization.

(B)(i) The facility shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved

for any single hospitalization for a period up to thirty (30) days, provided that the facility receives reimbursement.

(ii) Any resident who is a recipient of assistance under Title XIX of the Social Security Act or the resident's designee or legal representative shall be informed by the licensee that his or her bed for which there is Title XIX reimbursement available will be reserved up to five (5) days but that the bed will not be reserved if it is medically determined by a physician that the resident will not need it or will not be able to return to the facility or if the office determines that the facility's occupancy rate ensures the availability of a bed for the resident.

(C) Notice shall be provided within twenty-four (24) hours of hospitalization;

(12)(A) The right to be transferred or discharged only for medical reasons or for the welfare of other residents and the right to be given reasonable advance notice of no less than thirty (30) days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the facility or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act.

(B) For nonpayment of a bill for care received, the resident shall be given thirty (30) days' advance notice.

(C)(i) A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes.

(ii) Admission to a facility operated by a licensee may not be conditioned upon a waiver of such a right, and any document or provision in a document which purports to waive or preclude such a right is void and unenforceable.

(iii) Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver of a resident's rights as established herein is subject to disciplinary action as provided in subdivision (a)(16)(A)(ii) of this section.

(D) The resident and the family or representative of the resident shall be consulted in choosing another facility;

(13) For residents of Medicaid-certified or Medicare-certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under Title 42 C.F.R. Part 488.12;

(14)(A) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency.

(B)(i) In the case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter.

(ii) Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety;

(15)(A) The right to retain and use personal clothing and possessions as space permits unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician.

(B) If clothing is provided to the resident by the licensee, it shall be of reasonable fit;

(16)(A)(i) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, provided that such visitors are not disruptive or dangerous, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII and Title XIX of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends.

(ii) Unless otherwise indicated in the residential care plan, the licensee, with the consent of the resident and in accordance with policies approved by the office, shall permit access by recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy to the facility during visiting hours for the purpose of visiting with and providing services to any resident. Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident.

(B) The resident has the right to deny or withdraw consent to access at any time by any entity or individual.

(C) Notwithstanding the visiting policy of the facility, the following individuals shall be permitted immediate access to the resident:

(i) Any representative of the federal or state government, including, but not limited to, representatives of the Department of Human Services, any law enforcement officer, any ombudsman, and the resident's individual physician; and

(ii) Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident;

(17)(A)(i) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person, to recommend changes in policies and services to facility personnel, and to join with other residents or individuals within or outside the facility to work for improvements in resident care, freedom from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(ii) The facility shall allow any ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(B) The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents;

(18) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents;

(19) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents

(20) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decisions which will not be infringed upon and the right to encouragement and assistance from the staff of the facility in the exercise of these rights; and

(21) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(b)(1)(A) The licensee for each long-term care facility shall orally inform the resident of the resident's rights and provide a

copy of the statement required by subdivision (a)(21) of this section to each resident or the resident's legal representative at or before the resident's admission to a facility.

(B) The written statement of rights shall include a statement that a resident may file a complaint with the office or the ombudsman.

(C) The statement shall be in boldface type and shall include the name, address, and telephone numbers of the ombudsman and adult abuse registry where complaints may be lodged.

(2)(A) The licensee shall provide a copy of the residents' rights to each staff member of the facility.

(B) Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section.

(c)(1) Any violation of the residents' rights set forth in this section may constitute grounds for action by the office.

(2) In order to determine whether the licensee is adequately protecting residents' rights, the annual inspection of the facility shall include private, informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the ombudsman in the area in which the long-term care facility is located.

(d) Any person who submits or reports a complaint concerning a suspected violation of the residents' rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from the complaint shall have immunity from civil liability thereof unless that person has acted in bad faith or with malicious purpose or if the court finds that there was a complete absence of a justiciable issue of either law or fact.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK,
AS SPECIAL ADMINISTRATOR OF THE
ESTATE OF KENNY KENDRICK **CLAIMANT**

VS. **CLAIM #14-0154-CC**

STATE OF ARKANSAS
DHS/DBHS **RESPONDENT**

ANSWER

Comes on the Respondent herein by and through counsel and for its answer states:

1. That Respondent denies any and all liability in the above referenced claim and contests this claim. Account information is:

Agency Number:	0710
Cost Center:	418099
Internal Order:	HBTX01XX
Fund:	PWP3500
Fund Center:	896

2. That Respondent denies any and all allegations of the claim not specifically admitted herein;

3. That Respondent denies any and all allegations of negligence, violations of the Medical Malpractice Act, and violations of the Long Term Care Facility Residents Act.

Decedent died of his chronic illnesses and natural causes and not due to any act or negligence of Respondent. Respondent denies that any of the injuries alleged were foreseeable. Respondent denies any allegations of facility deficiencies and staffing shortages. Respondent denies it caused the alleged damages.

The claim fails to state any specific facts or allegations regarding any specific and identifiable mistreatment, abuse, or neglect by Respondent. No specific dates, actors, conduct or

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omissions are set out in the claim. There are only vague, general conclusions.

4. That an independent investigation of the facility was conducted by the Office of Long Term Care following the death and found no deficiencies.

5. That Respondent denies any allegations of malice and denies there is any basis on which to award punitive damages. Further, there is no jurisdiction for an award of punitive damages herein;

6. That Respondent, pleading affirmatively asserts the defenses of comparative fault, estoppel, laches, license, res judicata, statute of limitations, waiver, and failure to state facts upon which relief can be granted.

WHEREFORE, Respondent prays this Commission discharge Respondent from any liability herein, that the claim be dismissed, and for all other just and proper relief.

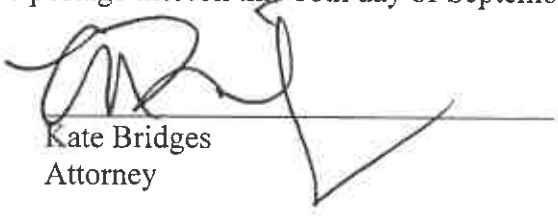
Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF POLICY AND LEGAL SERVICES
ATTORNEYS FOR RESPONDENT

Kate Bridges ABN 2001224
P.O. Box 1437, Slot S260
Little Rock, Arkansas 72203
Telephone # (501) 320-6292

CERTIFICATE OF SERVICE

This is to certify that I have served a copy of the foregoing Answer on Edwards Law Firm, 2109 East 12th Street, Russellville, AR 72802, by depositing same in the U.S. Mail in a properly addressed envelope with adequate postage thereon this 18th day of September, 2013.



Kate Bridges
Attorney

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK, AS SPECIAL ADMINISTRATOR
OF THE ESTATE OF KENNY KENDRICK, DECEASED
AND ON BEHALF OF THE WRONGFUL DEATH
BENEFICIARIES OF KENNY KENDRICK — CLAIMANT

v. — No. 14-0154-CC

STATE OF ARKANSAS,
DEPARTMENT OF HUMAN SERVICES — RESPONDENT

CLAIMANT'S PRE-HEARING BRIEF

Claimant, Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, and on behalf of the wrongful death beneficiaries of Kenny Kendrick, submits the following Pre-Hearing Brief:

OVERVIEW OF THE DEATH OF KENNY KENDRICK

What would you do if your child or grandchild called out from his room – "ACCIDENT!" You would go running and make sure that he was ok, that he was safe, and that he didn't need anything. That is a basic response to a potential deadly situation. You would expect that response from anyone as that is a responsibility that we all have.

This case is about responsibility of caring for those who cannot care for themselves. Kenny Kendrick was one of those persons. And this case is about the preventable death of Kenny Kendrick.

Kenny died on July 15, 2013, while a resident of the Arkansas Health Center, a nursing home run by the State of Arkansas. You can see from his picture included as

Exhibit 1 that he had a bright shining personality and was loved deeply by his mother. Though only forty-one years old, Kenny needed around the clock care due to the fact that he had Duchenne's Muscular dystrophy disease. This disease severely limited his muscle movement; so much in fact that Kenny was totally dependent on other people. Though he could communicate and move his feet just a little, he could not move his body, not move his arms, and required a ventilator machine in order to breathe. As seen in **Exhibit 2**, the ventilator machine hooked directly into his throat by means of a removable cannula. Kenny had been on a ventilator for many many years.

For almost forty-one years, he had been taken care of at home in Russellville by his mother with the assistance of home health aides. With very little training, Kenny's mother took care of Kenny's ventilator and his ventilator needs. When his mother became diagnosed with cancer in the spring of 2013, Kenny was moved to a hospital in Russellville and eventually placed at the Arkansas Health Center nursing home in Benton, Arkansas. Luckily, with chemotherapy and good care, Kenny's mom overcame her cancer. Unfortunately, this happened after Kenny's death.

Kenny was admitted into the Arkansas Health Center nursing home on June 18, 2013. Prior to being admitted, the Arkansas Health Center evaluated Kenny and determined that it could meet his needs; knowing full well that he was 100% dependent on a ventilator to breathe. Kenny was able to talk and was aware of his surroundings. One example is that Kenny liked to have his bed sheet pulled over his head in order to sleep. Though Kenny could not even attempt to move something such as the bed sheet, the staff of the Arkansas Health Center would place the sheet over his head.

According to Kenny's medical records from the Arkansas Health Center, his stay there was fairly uneventful until July 15, 2013. On this day, nurses note document that

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nurses saw Kenny at 8:20 a.m. and he was doing fine. The next note at 11:45 a.m. (which is 3 hours and 25 minutes later), indicates that Kenny activated a bed alarm to notify the staff of the Arkansas Health Center. When the staff called on the intercom into his room, the only word that Kenny said was "**accident**." Despite this fact, no staff went to his room to check on him. In fact, staff did not actually lay eyes on Kenny or check on him until 12:10 p.m. (twenty-five minutes after he said "accident') when they went in to check his blood sugar; a check that was ordered to be done at 11:00 a.m. When they found Kenny at 12:10 p.m., he was blue and cyanotic (meaning his body was lacking oxygen) and his lockable cannula tube had been dislodged from his throat. Because the tube was not connected to Kenny, he was not getting oxygen and had not been getting oxygen. Though he had a pulse around 12:10 p.m., it was too late. Kenny never recovered, never regained consciousness, and was pronounced dead at the Saline Memorial Hospital shortly thereafter.

Though to this day the Arkansas Health Center cannot tell you what happened to Kenny between 8:20 a.m. and 12:10 p.m. and specially cannot tell you what happened during the 25 minutes after Kenny said "accident", what is clear is that Kenny Kendrick's cannula breathing tube was found out of his throat, he was blue from a lack of oxygen, and he subsequently died. Though Kenny Kendrick did not even have the ability to move his arms, his hands, or his head and had no role in either placing or removing his breathing tube, the Arkansas Health Center refuses to take responsibility for this tragic and untimely death. Kenny's mother still grieves to this day and both Kenny and his mother should be given justice.

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KENNY'S CASE

This case is based on the fact that the Arkansas Health Center was negligent and was medically negligent in the care of Kenny Kendrick. The Arkansas Health Center failed to monitor Kenny Kendrick, failed to keep Kenny Kendrick safe, failed to follow Kenny's physician's orders, and failed to ensure that Kenny Kendrick had one of the most basic needs - oxygen. In the complaint, Claimant alleges three causes of action:

- (1) negligence,
- (2) medical negligence, and
- (3) failure to ensure that Kenny Kendrick received his Arkansas statutory Resident Rights set forth in the Arkansas Protection of Long-Term Care Facility Residents Act, Ark. Code §§ 20-10-1201, *et seq.*

As a matter of law, the Estate of Kenny Kendrick will show for the negligence and medical negligence claims that the Arkansas Health Center: (1) breached the duties of care that it owed to Kenny; (2) that these breaches of the basic standards were a proximate cause of Kenny's death; and (3) that Kenny and his mother are entitled to damages. For the Resident Right's claim, Claimant will show that the Arkansas Health Center failed to ensure that Kenny Kendrick received his Arkansas statutory Resident Rights, specifically two rights are at issue in this case: (a) "The right to receive adequate and appropriate health care and protective and support services. . . "and (b) "The right to be treated courteously, fairly, and with the fullest measure of dignity." **Exhibit 21.**

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1. THE DUTIES THAT THE ARKANSAS HEALTH CENTER OWED TO KENNY KENDRICK.

As a nursing home, the Arkansas Health Center owed residents such as Kenny Kendrick many duties. These duties included providing basic care to residents, following its own policies and procedures, following manufacturer recommendations when using certain equipment, following the doctor's orders, and making sure its residents were safe. In order to provide care to its residents, the Arkansas Health Center adopted policies and procedures that all staff members were required to follow – they were mandatory. See **Claimant's Deposition summaries** of Tasha Marshall (depo. pg 15) and Kay Moseley (depo. pg 14). Some of the policies of the Arkansas Health Center included:

- **Exhibit 3** – LTV1100 Ventilator Manual that mandated the use of all critical safety alarms and mandated that all persons on ventilator machines be "constantly monitored."
- **Exhibit 4** – Arkansas Health Center Resident Rights policy that mandated that all residents were entitled to care that enhanced their life and with full dignity and respect.
- **Exhibit 5** – The Arkansas Health Center was to provide "exceptional" nursing home care.
- **Exhibit 6** – Arkansas Health Center Charting and Nurse's Notes policy that required that all care must be documented and is a permanent legal record.
- **Exhibit 7** – Arkansas Health Center Ventilator and Respiratory Care Schedule policy that required that ventilator settings could not be changed without physician orders.

These policies were not just words on paper. As testified to by both Tasha Marshall (depo. pg 15) and Kay Moseley (depo. pg 14), the staff at the Arkansas Health Center were required to follow and adhere to these policies. The Ventilator policy was also mandatory as the equipment representative testified that he expected the Arkansas

Health Center to follow the manual and that they could call him if they had any questions about it. (Deposition of Kevin Ehmann, pg. 22)

In addition, the Arkansas Health Center was required to follow good nursing and care practices, in part, for the safety of patients. This included the requirement that the staff follow physician orders because it was in the patient's best interests that the orders be followed. (Deposition of Paul Mills, pgs. 34-35). Examples of these practices included:

- Having the nurse check on residents such as Kenny Kendrick every hour (see depo of Kay Moseley, pg 40);
- Following physician orders, including order related to blood sugar checks, bathing, providing water, ventilator maintenance, and ventilator alarm settings; and
- Constantly monitoring residents such as Kenny Kendrick in order to make sure that they are safe, including have the nurse check on Kenny every hour.

These policies and basic nursing practices were established and required to be followed in order to assure that residents such as Kenny Kendrick received the care to which he was entitled and to ensure that he had a safe environment. These duties encompass both negligence and medical negligence. The difference is that the simple negligence claim relates to basic custodial care required of the Arkansas Health Center – the care needed to monitor Kenny, the care needed to keep Kenny safe, and the failure to follow its own policies and procedures. See *Bailey v. Rose Care Center*, 307 Ark. 14, 817 S.W.2d 412 (1991) and *McQuay v. Guntharp*, 336 Ark. 534, 986 S.W.2d 850 (1999).

On the other hand, the medical negligence claim relates to the medical failures of the Arkansas Health Center – failing to following physician orders, failing to ensure that Kenny received oxygen, failing to make sure that his cannula / trach was and remained

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connected, failing to properly document care, and failing to ensure that the ventilator alarms were set. As the Arkansas Health Center is a medical care provider pursuant to statute, it is subject to these claims. See Arkansas Code Annotated 16-114-201, *et seq.*

For Kenny's Resident Rights Claim, the Arkansas Health Center had a duty to ensure that Kenny received (a) "adequate and appropriate health care and protective and support services. . ." and (b) was "treated courteously, fairly, and with the fullest measure of dignity." These duties can be seen in **Exhibit 4** and **Exhibit 5** where the Arkansas Health Center made it their policy to ensure that these rights were given to all residents.

In addition to the staff testimony, these duties and their importance were also testified to by both Dr. Loren Lipson and Registered Nurse Kelly Kidd – experts who have testified on behalf of the Claimant. Dr. Lipson and Registered Nurse Kidd both discussed these various duties and also explained that these duties encompassed the standard of care imposed on the Arkansas Health Center. (Deposition of Dr. Lipson at pgs 50, 72, and 75, and Deposition of RN Kelly Kidd at pgs. 66-69, and 71-72). RN Kidd described the monitoring required when she stated that the staff needed to check on him, actually look at him, touch him, talk to him, etc. These duties were elevated for Kenny because he was a vent dependant patient and also liked to have his sheet pulled over his head. These duties are also reflected in the mandatory federal regulations that govern facilities such as the Arkansas Health Center. The citation to these regulations are found on **Exhibit 17** and **Exhibit 19**, the expert disclosures of Dr. Lipson and RN Kidd.

As evident by the policies and the testimony of the staff, the Arkansas Health Center owed many duties to residents such as Kenny Kendrick – residents that were

totally dependent on the Arkansas Health Center for all aspects of life including one of the most basic requirements – oxygen. When these duties are not met, residents are put in danger; danger that can be life threatening.

2. THE ARKANSAS HEALTH CENTER BREACHED THE DUTIES IT OWED TO KENNY KENDRICK.

According to the records and testimony from staff, the Arkansas Health Center breached the duties owed to Kenny Kendrick. Even though policies and basic nursing requirements mandated that certain care be provided to Kenny Kendrick, these requirements were repeatedly disregarded. Examples include:

- The Arkansas Health Center failed to properly and constantly monitor Kenny Kendrick on July 15, 2013:

    a. The nurses notes reflect that the staff failed to monitor and assess Kenny Kendrick from 8:20 a.m. to 12:10 p.m. There is no record that a nurse checked on him hourly, as required by the testimony of Kay Moseley. **Exhibit 8.**
    b. Even though Kenny informed staff of an "accident" at 11:45 a.m., it was not even until 12:10 p.m. that staff laid eyes on Kenny Kendrick and found him blue and cyanotic. **Exhibit 8.**
    c. Though the ventilator manual required constant monitoring of Kenny, there was not constant or continuous monitoring of Kenny on July 15.
    d. The diabetic treatment sheets show that his blood sugar was ordered to be checked at 11:00 a.m. however staff did not attempt to check it until 12:10 p.m., over an hour after it was ordered to be checked. **Exhibit 11.**
    e. Kenny's bowel functions were not followed on the morning of July 15, 2013. **Exhibit 10**
    f. Orders to provide food to Kenny Kendrick were not followed for breakfast or lunch on July 15, 2013**. Exhibit 12.**

- The Arkansas Health Center failed to follow physician orders:

    a. Order to check Kenny's blood sugar at 11:00 a.m. on July 15 was not done or even attempted until 12:15 p.m. **Exhibit 11**
    b. Order to give baths and to document bathing of Kenny Kendrick was not done for numerous days in July 2013 and reflect that Kenny only received one or two baths the entire month of July. **Exhibit 10**
    c. Kenny's bowel functions were not followed on the morning of July 15, 2013. **Exhibit 10**

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d. Orders to provide food to Kenny Kendrick were not followed on July 14 or 15, 2013. **Exhibit 12.**
e. Order to provide water to Kenny were not done on various shifts in July **Exhibit 12**.
f. Orders to change ventilator related equipment on specific days during July were not being followed. **Exhibit 13**

- The Arkansas Health Center failed to ensure that the ventilator alarms were utilized:

a. According to the event trace report, none of the activated alarms on the machine sounded from 6:52 a.m. until 12:44 p.m. on July 15, 2013, even though the staff testified that they unhooked Kenny from the machine around 12:15 p.m. See **Exhibit 14**. Either the alarms were never set or the staff did not find Kenny until 12:44, almost one hour after Kenny told the staff "accident."
b. Though there was no physician order, the staff turned off the low minute volume alarm on Kenny's machine.

These actions breached the duties related to negligence and medical negligence as the Arkansas Health Center was not following its mandatory policies, the ventilator policies, or basic nursing practices. In addition, Dr. Lipson and RN Kidd discussed the breaches in their depositions. This testimony will be discussed further in the next section; however it does not take expert testimony to see that the Arkansas Health Center breached the duties they owed to Kenny Kendrick.

The Arkansas Health Center may argue that they did not physically go look at Kenny after he hit has call light because he had accidentally hit his call light a couple of times in the past. However there is no evidence in the Arkansas Health Center records of this ever happening in the past. None of the nurses ever documented that this happened, even though the nursing policy requires the documentation of unusual occurrence or incidents. Instead of walking just a few feet to actually lay eyes on Kenny Kendrick, the staff chose to ignore this important and significant alarm.

There are also other very disturbing entries in the chart of Kenny Kendrick. These entries indicate that care and services were apparently provided to Kenny even after he was transported to the hospital and died. Some examples include:

- The Arkansas Health Center charted that services were provided to Kenny Kendrick after his death:

    a. Bowel function monitoring sheets were checked for the evening / night of July 15, 2013. **Exhibit 10**.
    b. Water was provided and his cuff was deflated on the evening / night of July 15, 2013. **Exhibit 11**.
    c. Food and snacks were offered to Kenny Kendrick the evening / night of July 15, 2013. **Exhibit 12**.

It is clear that after Kenny Kendrick was pronounced dead, the Arkansas Health Center continued to "chart" that care and services were being provided to Kenny. This is either documentation fraud (in violation of the Arkansas Health Care Center documentation policy found at **Exhibit 6**) or it also supports the Claimant's position that the Arkansas Health Center was not properly monitoring Kenny. No matter which explanation, these after death entries call into question the truthfulness of his entire nursing home record from the Arkansas Health Center. What was actually being done for Kenny either during his life or after his death? Kenny was entitled to dignity, respect, and "exceptional care." These were not given to Kenny.

3. THE FAILURES OF THE ARKANSAS HEALTH CENTER WERE A PROXIMATE CAUSE OF KENNY NOT RECEIVING OXYGEN AND HIS SUBSEQUENT DEATH.

When Kenny Kendrick was found at 12:10 p.m. on July 15, the nurses noted that he was "cyanotic" (**Exhibit 8**) and the respiratory therapist noted that he was "very cyanotic." (**Exhibit 9**). After he was found at 12:10 p.m. he did have a pulse, as noted by the nursing staff. (Deposition of Kay Moseley, pgs 31-35). By their own description,

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when Kenny was found with his cannula dislodged, he was lacking oxygen and his heart was beating. This reflects that he was alive, though he was severely lacking oxygen.

In order to assist the Commission with this case, including the casual aspect, the Claimant has put forth Dr. Lipson and RN Kidd. In order to address their opinions, including opinions related to duties, breaches, and proximate cause, here is a summary of their testimony.

1. Dr. Loren Lipson

Dr. Loren Lipson is a renowned geriatrics physician that has been practicing geriatric medicine in the nursing home setting for over 40 year. His expertise is recognized all over the United States and he is routinely hired by the United States Department of Justice, the New Mexico Attorney General's office, and other State Attorney General's offices to assist in the review and prosecution of cases involving resident neglect in nursing homes. He has held board certifications in: American Board of Internal Medicine, American Board of Quality Assurance and Utilization Review Physicians, and Certificate of Expertise in Geriatric Medicine. **Exhibit 16** (CV of Dr. Loren Lipson) and **Exhibit 17** (Dr. Lipson's Expert Disclosures).

Dr. Lipson has reviewed Kenny's case and has serious concerns about what happened to Kenny at the Arkansas Health Center. Dr. Lipson has opined that what happened to Kenny was neglect and that it caused his untimely death. Specifically, Dr. Lipson has testified that:

- Kenny died because the Arkansas Health Center failed to observe Kenny and provide him the required care, monitoring, and oversight. The Arkansas Health Center had a duty to monitor and observe Kenny Kendrick – duties that were heightened because he was on a ventilator and because he liked having is sheet over his head.

- The staff at the Arkansas Health Center was required to ensure that his cannula was sufficiently locked (it required a 1/8th turn to lock or unlock it) and

it was not properly secured. Kenny Kendrick did not unlock his tube and it would not have come unlocked but for human error at the Arkansas Health Center. (pgs 55,-56, 63-64). If the trach tube was properly locked and situated, it would not have come out. (pgs 66-67)

- In all medical probability, the fact that the trach tube was allowed to be dislodged caused Kenny's death. Kenny was dependant on the trach for oxygen and if the trach was dislodged, Kenny could not get oxygen and was going to die. (pgs 63-64). The lack of oxygen caused his heart to arrest (pg 66). There were no other signs or symptoms on July 15 that Kenny was having any other significant problems that would have cause his death. (pgs 66-67).

- Allowing the trach tube to become dislodged was substandard care. (pg 67). This constitutes neglect and Kenny died as a result. (pg 98).

- Kenny's death was avoidable because but for the trach coming out, he would have lived. (pgs 55-56). Kenny would have lived for another 12 months to three to four years. (pgs 84-85). He would have still be able to think, to talk, and to communicate – he was aware of his surroundings. (pg 86).

- Due to their failures, the Arkansas Health Center violated Kenny Kendrick's resident rights (pgs 88-89)

2. Registered Nurse Kelly Kidd

Nurse Kelly Kidd has been practicing registered nurse (RN) since 1984. She has worked in all types of nursing environments including emergency rooms, critical care areas, at hospitals all over Pulaski County and the State of Arkansas. **Exhibit 18** (Kelly Kidd's CV) and **Exhibit 19** (Nurse Kidd's expert disclosures). Based on her training and over 30 years of providing hands on nursing care, Nurse Kidd agrees that the Arkansas Health Center failed to meet the applicable standard of care in regards to Kenny Kendrick. Her opinions include that the Arkansas Health Center should be held to a standard in which it must follow basic nursing practices and its own policies related to the observation and monitoring of ventilator residents. Nurse Kidd's opinions include the following breaches in the standard of care:

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- Kenny needed continuous monitoring and, at a minimum the nurses were required to check on him every hour. In fact, the nurses did not observe and monitor Kenny every hour as was required, and specifically on July 15 the nurses did not document from 8:20 a.m. until 12:10 p.m. (pgs 67, 69, and 71-72)

- when Kenny hit the alarm and said "accident" the nurses were required to check on him, lay eyes on him, talk to him, find out what was going on, touch hi, and assess his status (pgs 67-69, 92, and 124)

- the nurses were required to check his blood sugar at 11:00 a.m. and failed to even attempt to check it until 12:15 p.m. (pg 73) The Arkansas Health Center was required to follow all physician orders for Kenny Kendrick (pgs 73, 135)

- she had has many years of experience with trach patients, and in her experience for the trach tubing to come out either someone removes it or someone fails to properly lock it (pgs 133-134)

- The vent alarms should not have been turned off and if they are turned off, then the Arkansas Health Center is required to put into place interventions to ensure that there are not problems with Kenny's vent – interventions that were absent from Kenny's care (pgs 108-109)

- Kenny's death would have been prevented if the Arkansas Health Center would have properly assessed and monitored Kenny Kendrick (pgs 126-127)

Based on the descriptions of Kenny from the staff at the Arkansas Health Center when he was found at 12:10 p.m. and the testimony of Dr. Lipson and Nurse Kidd, Kenny Kendrick died from a lack of oxygen because his trach tube dislodged and he was not getting oxygen. Kenny's trach tube should not have been dislodged and would not have been dislodged if the staff properly cared for his equipment and continuously monitored Kenny, especially after he said "accident." Kenny's death was preventable and he would have lived, and possibly still living, but for the failures of the Arkansas Health Center.

KENNY'S DAMAGES

The main damages in this case are Kenny's loss of his life and Lanelle Kendrick's loss of her son. Kenny was a loving son who, even with his disabilities, loved

to joke, loved to talk to people, and wanted to live. Lanelle should never have lost her son, especially since the only reason he was not being taken care of by her was that she was diagnosed with cancer and had to take treatment. She took care of him for almost 41 years and the Arkansas Health Center could not take care of him for one month.

For the loss of Kenny's life, medical bills, and funeral expenses, Claimant requests $250,000.

For Lanelle's loss of her son, the mental anguish and suffering she has had to endure, she should also be awarded $250,000.

In addition, Arkansas DHS and Medicaid should not be entitled to make a claim on any monies it paid for Kenny either during his life or at the Arkansas Health Center.

CONCLUSION

You may hear many excuses put forth by the Arkansas Health Center when it comes to what happened to Kenny Kendrick. The Arkansas Health Center may blame Kenny – he liked having the sheet over his head, he didn't tell us that something bad happened, or that he had a lot of medical problems and his medical problems killed him. The Arkansas Health Center may shrug their shoulders and tell you that it was a simple accident – though they had never seen this type of accident before. The Arkansas Health Center may call one of their doctors – though even their doctor (if they call him) will tell you that he is purely speculating about what may or may not have happened to Kenny Kendrick and he does not know what the policies are or what the standard of care requires. In short, the Arkansas Health Center will present excuses.

Kenny Kendrick and his mother are entitled to more than excuses. There is no excuse for not following the policies, the manuals, the doctor's orders, for not actually

ıying eyes on Kenny, and for not ensuring that his trach was properly locked and ecured. Kenny died because of these failures. Kenny deserves justice – justice that ɔu can provide.

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Respectfully submitted,

LANELLE KENDRICK, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF KENNY KENDRICK, DECEASED

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CERTIFICATE OF SERVICE

I hereby certify that on this 18th of February, 2016, a true and accurate copy of e foregoing document has been served by e-mail upon the following:

Brooks White
Attorney Specialist
Arkansas Department of Human Services
Office of Policy and Legal Services
PO Box 1437, S260
Little Rock, AR 72203

_____
Jeff Priebe

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

Arkansas
State Claims Commission
MAR 02 2016
RECEIVED

LANELLE KENDRICK,
As Special Administrator of the Estate
Of KENNY KENDRICK, Deceased,
And on Behalf of the Wrongful Death
Beneficiaries of KENNY KENDRICK

CLAIMANT

vs.

CLAIM #14-0154-CC

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES

RESPONDENT

RESPONSE TO CLAIMANT'S PRE-HEARING BRIEF

Respondent Department of Human Services ("DHS"), for its Response to Claimant's Pre-Hearing Brief, states as follows:

I. Claimant's Argument That Mr. Kendrick Died of Suffocation Defies Common Sense

Claimant's brief is long on innuendo and vague allegations, but short on actual facts showing that Respondent negligently caused the death of Kenny Kendrick, or any other injury to Mr. Kendrick. That is because there are no facts. Claimant wants the Commission to engage in massive speculation to come to the conclusion that the State owes Claimant and the estate of Mr. Kendrick half a million dollars. Respondent will not attempt to address all of the vague allegations of wrongdoing in this response. Instead, it will focus on why Claimant's theory as to how Respondent wrongfully caused Mr. Kendrick's death is entirely implausible.

Two common-sense realizations are dispositive of Claimant's case. The first realization is that when people cannot breathe, they will persistently summon help until

help arrives. This realization is dispositive of Claimant's argument that Mr. Kendrick suffocated to death because his cannula dislodged. Mr. Kendrick was not in any way impaired mentally. If his trach tube had dislodged and he could not breathe, he would use his call light to call the nurse's station. And if the nurse's station did not respond, he would call again. And again. And again. Yet, Mr. Kendrick did not call a single time after he made the call stating "accident" at 11:45 (more on that call later). There simply is no reasonable explanation for this, other than that he had been rendered unconscious by an acute health event. Indeed, when Dr. Lipson was asked why he made no call, Dr. Lipson had no answer at all. He said, "Well, I don't know," and then launched into a general criticism of the nurses at AHC and the State of Arkansas' procedure for investigation of long term care facility incidents.

Claimant's attempt to overcome this common-sense realization is to theorize that the call in which Mr. Kendrick stated "accident" was a call to alert the staff to a problem with his cannula, rather than an accidental call as attested to by Kay Moseley, who testified that she knew it was an accidental call because Mr. Kendrick had made numerous such accidental calls in the past and said the exact same thing. Claimant's theory is crushed by common sense when you think about what would have to be true for this call to indeed be Mr. Kendrick telling the staff that there was a problem. One would have to conclude that in order to alert the staff to a problem with the tube, Mr. Kendrick simply gave the one-word response "accident." Not, "Yes, there is a problem with my trach tube." Not, "you need to come here". Not even, "I need help." Just "accident." That does not make any sense at all, and Claimant cannot explain why he would just say "accident." Furthermore, to accept Claimant's theory, he would have then inexplicably

made no follow-up call at all when staff did not respond to the call. That makes even less sense.

So, Claimant's theory flunks the test of basic common sense. The only way to explain Mr. Kendrick's failure to use his call light to summon help that day is that Mr. Kendrick had been rendered unconscious by a health event. This is a reasonable conclusion. Claimant's theory is not.

II. Claimant Nonsensically Argues That AHC Was Required to Repeatedly Disturb Mr. Kendrick to Visually Inspect His Trach Tube, Despite Two Warning Systems Being In Place.

For argument's sake we will look past the glaring flaws in Claimant's theory that Mr. Kendrick died of suffocation due to dislodgment of his trach tube, and assume that indeed, he did so die. Claimant argues that Respondent is at fault for such a death because it did not adequately visually inspect Mr. Kendrick's trach tube to make sure that everything was OK. Dr. Lipson testified that the facility should have done this "maybe every fifteen minutes or whatever." The first obvious problem with such an argument is that there would of course be no assurance that any visual inspection routine would have any assurance of making sure the cannula did not stay dislodged, other than refusing to allow Mr. Kendrick to keep a sheet over his head, and assigning a staff person the sole duty of staring at Mr. Kendrick's trach tube 24/7 to make sure that nothing was amiss. Claimant does not argue that this was required, and cannot so argue because Claimant knows it was Mr. Kendrick's preference to keep the sheet over his head.

So, Claimant argues that Respondent was required to periodically disturb Mr. Kendrick and look under his sheet to make sure nothing was wrong, despite the fact that there were *two* warning systems in place in the event anything went wrong with his trach

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tube. First, Mr. Kendrick's call light, which he could, and did, use, any time he needed something. We have already covered why the fact that he did not use it means he did not die of suffocation due to cannula dislodgment. Second, the ventilator's low pressure alarm is designed to sound when the cannula dislodges. Due to a freak occurrence in this case, it did not sound.

So, to accept Claimant's theory that Respondent was negligent, one would have to assume that Respondent had a duty to anticipate: (1) that Mr. Kendrick would inexplicably decline to use his call light and instead suffocate to death without summoning help, and (2) that the low pressure alarm would not sound as it was designed to do, because of a freak occurrence.

III. There Is No Evidence Respondent Did Anything Wrong As to the Ventilator Alarms.

Claimant's brief and her "Deposition Summaries" attempt to muddy the waters as to the ventilator's alarms. It is not complicated, however. Two different alarms are relevant to this case: (1) the low pressure alarm, and (2) the low minute volume alarm. The low pressure alarm was *not* turned off, and there is absolutely no evidence that it was turned off on the date of Mr. Kendrick's death. To the contrary, the Ventilator Flowsheet for July 15, 2013 clearly indicates that the alarm was set (*see* Exhibit "A", Flowsheet). Additionally, the vent trace log which Allied Health ran after Mr. Kendrick's death clearly reports the low pressure alarm sounding at 12:44 p.m, according to the clock on the ventilator. Therefore, the statement on page 9 of Claimant's brief that "either the alarms were never set or the staff did not find Kenny until 12:44" is false. Claimant speculates that the low pressure alarm could have been turned off despite the fact that it is reported as sounding at 12:44 p.m. Claimant's argument is puzzling, to say the least.

The vent trace log reports the low pressure alarm sounding at 12:44 p.m., whereas Mr. Mills, the respiratory therapist, testified that he recalled it sounding when he removed the cannula from Mr. Kendrick's neck when he was discovered, which was earlier than 12:44 p.m. It is not known why the vent trace log does not report a low pressure alarm sounding prior to 12:44 that day, but this unknown does not create the possibility of any wrongdoing. A very likely explanation is that the ventilator's clock did not have the correct time on it, and the sounding reported at 12:44 on the log actually occurred earlier than 12:44. Or, it could be that for some reason the vent trace log did not record all soundings of the alarm that day. Respondent does not know for sure, and neither does Claimant. And Claimant's attempt to spin the vent log into evidence of something sinister should not be entertained.

Then, there is the low minute volume alarm, which was turned off *per doctor's orders*. Claimant has falsely stated that AHC turned off this alarm without a doctor's order. The order is attached as Exhibit "B." Not only was there a doctor's order for the alarm to be turned off, Claimant's expert Dr. Lipson expressly and unequivocally testified that he did *not* fault AHC for turning off the alarm. That testimony is cited both in Respondent's Brief in Support of Motion for Summary Judgment and Respondent's Brief in Support of Objection to and Motion to Strike Plaintiff's Deposition "Summaries." In short, not even Claimant's medical expert believes Respondent did anything wrong as to the low minute volume alarm.

III. Conclusion

For these reasons, Claimant's claim is without merit, and should be dismissed in its entirety.

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CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of March, 2016, I served a copy of the foregoing on the following via email:

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Arkansas
State Claims Commission
FEB 18 2016
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK,
As Special Administrator of the Estate
Of KENNY KENDRICK, Deceased,
And on Behalf of the Wrongful Death
Beneficiaries of KENNY KENDRICK **CLAIMANT**

vs. **CLAIM #14-0154-CC**

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

RESPONDENT'S PRE-HEARING BRIEF

Respondent Department of Human Services ("DHS"), for its Pre-Hearing Brief, states as follows:

I. There Is No Evidence That Mr. Kendrick Died As a Result of Negligence On The Part of Respondent.

A. Respondent Has Failed To Produce Any Evidence of Cause of Death, Negligence, or Causation Between Any Asserted Negligence and the Asserted Cause of Death.

Claimant's primary claim is that Respondent negligently caused the death of Kenny Kendrick at Arkansas Health Center ("AHC"). For the reasons detailed in Respondent's Brief in Support of Motion for Summary Judgment on Wrongful Death Claim being filed simultaneously herewith, Claimant's wrongful death claim fails due to no evidence (1) that Mr. Kendrick died as a result of dislodgment of his inner cannula, (2) that there was any negligence on the part of Respondent in its care of Mr. Kendrick, or (3) that any action which Claimant asserts Respondent was required to do but did not do would have prevented his death even if it is assumed solely for purpose of argument that

he died due to dislodgment of the inner cannula. Respondent will not repeat this detail here, but incorporates by reference the Brief in Support.

B. The Evidence Indicates That Mr. Kendrick Likely Died As a Result of An Acute Health Event, Which In Turn Caused Dislodgment Of The Inner Cannula.

Not only does Claimant have no evidence that Mr. Kendrick died as a result of dislodgment of the inner cannula, the evidence indicates that Mr. Kendrick likely died as a result of an acute health event caused by one of his many health conditions. While it is not possible to know with certainty how Mr. Kendrick died because his family did not request an autopsy, it is likely that Mr. Kendrick died as a result of an acute cardioventricular fibrillation, and that the fibrillation may have caused the cannula to dislodge. Dr. Ed Hill, Respondent's medical expert who treats patients at AHC and personally treated Mr. Kendrick, testified as follows:

> Q: And what do you think was his cause of death?
>
> A: I think his cause of death was one of to (sic) two things. Again, this is all speculation, because that's all we have. We don't have any objective evidence.
>
> Q: And why is that?
>
> A: Because the patient didn't have an autopsy. And even if he had an autopsy, it might not have told us.
>
> Q: Okay.
>
> A: We don't have any eyewitness reports, either.
>
> Q: okay.
>
> A: Not the moment he died, we don't know what moment he died. We know – we have a time frame, but we don't know the exact time he died.
>
> Q: You mentioned one of two things. What are those?

A: Oh, one of two things. He either had a cardiac arrhythmia, which occurs in congestive cardiomyopathies, which he had. I'm talking about ventricular – cardioventricular fibrillation. And he died quickly. Or he had a massive pulmonary embolus, which would also cause him to die quickly.

Q: Which do you think of those is the more likely?

A: The more likely would be that he had a cardiac arrhythmia.

Q: And why is that?

A: Now, when you have people that are 30 and 35 and 40 that don't have Duchenne's muscular dystrophy and they've had heart attacks, they have an ejection fraction of 30 to 35 percent or lower, what – one of the main things that cardiologists do to keep those people alive, because their prognosis is poor, they die from episodes of sudden death. Why? Because a stretched heart, a stressed heart, and a weak heart is more likely to fibrillate and to go into a rhythm that can't sustain life. So, in the last ten or 15 years, we have actually saved quite a few people's lives that would have died from their ventricular dysrhythmias by putting in implantable cardioconverters.

Q: let me ask you. Doctor Lipson testified, did he not, that, in his opinion, he died because his cannula came out and he couldn't breathe? Is that correct?

A: That's not correct

Q: Okay. But that was Doctor Lipson's opinion, wasn't it?

A: Yes.

Q: Okay.

A: Partly, I think.

Q: Right.

MR. PRIEBE: Object to form.

THE WITNESS: Huh?

MR. WHITE: He is just objecting for the record. Don't worry about it.

THE WITNESS: Okay.

BY MR. WHITE

Q: And so, why do you – do you think that's likely that that was the reason he died?

A: No.

Q: And why not?

A: Because we had – we had two systems that he could use -- or that we could rely on. If he got into trouble, there were two ways that we would know he was in trouble. One is that his ventilator would alarm. Now, we all know that when they found him dead, they found the cannula out of his windpipe and in the soft tissue of his neck, which basically did not let the ventilator alarm. There was enough pressure generated by the end of his inner cannula, there is enough pressure generated by the machine that it didn't trigger a low pressure. If you had it out like this, (indicating), the pressure would drop to zero once the air quit going out and the ventilator would go off. That's the low pressure alarm system. But he had a second way to notify us if he got into trouble. And that was with his own personal alarm that he had used. At 11:45 a.m., he activated his alarm. Now, he had to activate it with his feet because his arms weren't strong enough because of his muscular dystrophy. But during the entire time that he was in our institution, which was not very long, unfortunately, and this was a tragic event, he would use his alarm periodically, or frequently, daily, if he needed a drink of water or if he needed something. The alarm was working at 11:45 a.m., which was ten – was 15 or 20 minutes before they found him dead. And when he hit his alarm, he did it accidently. Kay Moseley, the nurse, was at the front desk, she answered him and said, "What is the problem, Kenny," he said, "Sorry, accident." He was able to talk and she was able to hear him over the intercom, "Sorry, accident." So, we know that he used his alarm then. Now, if someone just comes off a ventilator, they don't die acutely. When you

hold your breathe, you don't just keel over and die, do you? No. You don't. And that's a good thing. When you go to sleep at night, you don't die, because your brain keeps your body going. And Kenny's brain was fine. There was no problem with his brain. If he was without oxygen, just like you and I and you and you, he would start getting fidgety, he would be uncomfortable. You have had a bully hold you under the water when you were young. There is always a bully around that wants to see how you can hold your breath underwater. You remember how you fought and struggled when you needed to get oxygen? I mean, it is a terrible thing when you are struggling to get a breath and somebody is holding you down. You are thinking you are going to pass away, and you would if you couldn't get up. In Kenny's case, if the ventilator comes off, then – and he can move a little bit of air, not enough to sustain his life. He has some muscular function. But he couldn't survive off the ventilator. He is laying there and his brain stem works just like ours does, his air hunger is just like ours, and he lays there and he doesn't hit his alarm, and he knows that he is in trouble. That makes no sense whatsoever. The only way that he comes off the ventilator and he doesn't hit his alarm is the alarm happens to fail. For the first time in three and a half weeks, lightning strikes not once with this unusual deal with the inner cath. Again, 35 years, I have never heard of it, I have never read about it. But I mean, I'm sure it happened, that's what they are reporting. But then, number two, his alarm picks this one time – or the first time not to work. It's more likely, given the disease process he had, average life expectancy 25 to 30 years, he is living on borrowed time. And that – that's fine. He needs to live as long as he should live. You know, he should be allowed to enjoy as much life as he possibly can. But he has – you know, he has been cheating the Grim Reaper for numerous years, according to the usual expectations.

Q: Okay. And –

A: Now, to me, it would be more likely that the reason he did not respond is because he couldn't. He died suddenly. He didn't have air hunger because he was dead. Now, what happens with V-tach or V-fib or massive PE? You immediately get a drop in your blood pressure, you can't oxygenate your lungs, and you go out quickly. Now, sometimes – not every time, but sometimes, and I have a

> wife that has vasovagal syncope, and when she falls out because of low blood pressure, she jerks a couple of times. It's almost like a mini seizure. And sometimes when people suffer cardiopulmonary arrest, they will jerk a couple of times, as well. Now, what I think happened is, the cannula being out, yes, it was out, it was in the soft tissue, I don't think that had anything to do with his death. I think that that came out as a result of sudden movement that occurred when his brain became acutely hypoxic or anoxic due to either the stoppage of his heart from V-fib or V-tach or from a massive pulmonary embolus. I think that makes infinitely more sense than him coming off the ventilator and then not alerting to us that he was having trouble.
>
> Q: And how would – that process you just described, how would that cause the cannula to become dislodged?
>
> A: Well, if you jerk or you have a seizure, it increases intraabdominal and intrathoracic pressure, so it puts a backward pressure on the system. Now, the cannula may have been a little bit loose, or the fact that he jerked may have loosened it up. But he increased intrathoracic and intraabdominal pressure and maybe a little twist in the system may have caused it to pop out.
>
> Q: Okay.
>
> A: Again, may. This is all speculation.

(*see* Exhibit "A", Deposition of Dr. Hill, pp. 29-36). Unlike Dr. Lipson, Dr. Hill gave sound reasoning for his conclusion as to the likely cause of death, and pointed out the logical flaw in Dr. Lipson's reasoning, as was revealed by Dr. Lipson's inability to explain why Mr. Kendrick did not make a call to the nurse's station.[1] He also gave an explanation for why the cannula dislodged which is more plausible as Dr. Lipson's theory that it was caused by the motion of Mr. Kendrick's rotating mattress, given the absence of any call to the nurse's station .

[1] See Respondent's Brief in Support of Motion for Summary Judgment on Wrongful Death Claim.

C. The Evidence Will Show That Respondent Acted In Accordance With the Applicable Standard of Care In Its Treatment of Mr. Kendrick.

In addition to the lack of evidence of any breach of the standard of care on the part of Respondent, the evidence, including the testimony of AHC personnel, will show that at all times Respondent acted in accordance with the applicable standard of care in its care and treatment of Mr. Kendrick. The evidence will show that Respondent adequately checked on Mr. Kendrick and attended to his needs, and that no standard of care was breached. As pointed out in Respondent's Brief in Support of Motion for Summary Judgment on Wrongful Death Claim, Claimant's assertions of breach of the standard of care are based solely upon the bald *ipse dixit* assertions of Dr. Lipson and Kelly Kidd, Claimant's supposed experts.

D. The Evidence Indicates That Mr. Kendrick Had No Life Expectancy Of Any Reasonably Certain Length At The Time Of His Death.

Even if one were to (improperly) conclude that Respondent was somehow at fault for Mr. Kendrick's death, given his poor health Mr. Kendrick's life expectancy on July 15, 2013 was nonexistent. At age 41 he had already outlived the life expectancy given to him at birth by over 20 years. Dr. Lipson's life expectancy estimation of four years is, like all of his other opinions, purely arbitrary and speculative, without any evidentiary basis whatsoever. His primary care physician, Dr. Berner, estimated six to twelve months[2], but in the opinion of Dr. Hill, even that is purely speculative. Dr. Hill's opinion is that given his condition, Mr. Kendrick had no reasonable life expectancy (*see* Exhibit "A", Deposition of Dr. Hill, pp. 39-41).

[2] See Exhibit "B", Deposition of Dr. Berner, pp. 19-20.

In sum, the evidence indicates that even if Respondent were found responsible for Mr. Kendrick's death, Mr. Kendrick's death would have occurred in any event very shortly thereafter. This would severely limit the amount of damages both for any survivor claim of Claimant and for any wrongful death claim.

II. There Is No Evidence That Respondent In Any Way Caused Mr. Kendrick To Develop Pneumonia.

A. Dr. Hill's Opinion That Mr. Kendrick Suffered Aspiration Pneumonia Is Purely Speculative.

As he does in opining that Respondent negligently caused Mr. Kendrick's death, Dr. Lipson engages in wild speculation in concluding that as a result of negligent treatment of Mr. Kendrick, he developed pneumonia during his stay at AHC. Respondent does not allege that the pneumonia in any way contributed to his death[3], but apparently does claim it as injury to Mr. Kendrick for which she seeks to hold Respondent liable. Dr. Lipson makes this speculation even though the pneumonia in question was diagnosed less than 24 hours from being admitted to AHC (see Exhibit "A", Deposition of Dr. Hill, p. 21). Dr. Lipson opines that Respondent caused Mr. Kendrick's pneumonia while he was at the facility despite the fact that Mr. Kendrick had a history of pneumonia before he ever arrived at AHC, as indicated by Claimant herself:

> Q: Okay. And besides the muscular dystrophy, what other diagnoses did Kenny get from Doctors as time went on?
>
> A: Well, he had pneumonia quite a few times.
>
> Q: Okay.
>
> A: He had colds and, oh, I can't remember offhand anything except for the pneumonia.

[3] See Exhibit "C", Deposition of Dr. Lipson, p. 32.

Q: Okay.

A: Because he was in the hospital quite a bit with pneumonia.

(*see* Exhibit "B", Deposition of Claimant, pp. 14-15). Additionally, Dr. Lipson's opinion as to the pneumonia reveals the same baseless speculation he engages in as to Mr. Kendrick's death. Dr. Lipson speculates, without *any* evidence whatsoever in the medical records, that he developed the pneumonia as a result of aspirating food, which in turn was because the facility did not inflate his cuff while he was eating per physician's orders (*see* Exhibit "C", Deposition of Dr. Lipson, pp. 16-19). Dr. Lipson acknowledged that there were other possible causes of pneumonia (*Id.*, p. 18).

B. In Any Event, There Is No Evidence of Any Negligence Of Respondent As to Pneumonia.

Indeed, there was a physician's order which provided for the trach tube to be inflated while eating and taking medication. However, the evidence will show that Mr. Kendrick declined to have the cuff inflated while eating, preferring to keep it deflated. A resident in a long term care facility has the right of self-determination[4], and AHC could not legally force Mr. Kendrick to comply with a physician's order if he did not wish to do so. Accordingly, even if one engages in pure speculation to conclude that Mr. Kendrick developed pneumonia as a result of aspirating food, which in turn was because his trach tube was deflated, it was not negligent for the cuff to be deflated if it was Mr. Kendrick's decision to have it deflated.

C. Dr. Hill Explained, With Medical Reasoning, Why Mr. Kendrick's Pneumonia Was Not Caused By Aspiration.

[4] See Exhibit "C", Deposition of Dr. Lipson, pp. 71-72.

Unlike Dr. Lipson's purely speculative opinion that the pneumonia in question was as a result of aspiration of food, Dr. Hill gave a medicine-based opinion as to why the pneumonia in question was not aspiration pneumonia. Dr. Hill explained that there are specific areas of the lung which would have been affected with infiltrate if Mr. Kendrick had aspirated food: the superior segments of the lower lobes, or the posterior segments of the upper lobes, and that none of these sections of the lungs were mentioned to have infiltrate on them on Mr. Kendrick's chest x-ray taken on July 19 (*see* Exhibit "A", Deposition of Dr. Hill, pp. 25-26).

Additionally, there is no evidence that Mr. Kendrick suffered any extensive injury from the pneumonia even if it were concluded that the facility was at fault for it. Accordingly, any damages related to the pneumonia would be minimal.

III. As To The Various Other Miscellaneous Criticisms of Mr. Kendrick's Care By Claimant, There Is No Evidence Of Any Injury.

Claimant also asserts two other criticisms of Mr. Kendrick's care at AHC. First, Dr. Lipson testified about failure to follow certain physician's orders in failing to timely document the giving of a certain medication in AHC's records on a particular day.[5] However, Dr. Lipson could not articulate any injury which Mr. Kendrick suffered as a result of this alleged failure. Likewise, Dr. Lipson criticizes an alleged lack of documentation for a change of Mr. Kendrick's humidifier[6], but admitted he did not know if Mr. Kendrick suffered any damages as a result of this alleged failure. Finally, Dr. Lipson testified about alleged failure on two days (June 29 and June 30)

[5] See Exhibit "C", Deposition of Dr. Lipson, pp. 32-35.
[6] See Exhibit "C", Deposition of Dr. Lipson, pp. 35-36.

to document the performance of certain nursing functions.[7] But as to damages, Dr. Lipson was vague and was unable to articulate any specific injury.

Second, Dr. Lipson appears to somehow blame AHC personnel for Mr. Kendrick's depression, despite the fact that he came into the facility with suicidal ideation and was already being treated with antidepressants.[8] Dr. Lipson's opinion as to why the facility bears some responsibility for Mr. Kendrick's depression is perhaps the most wildly speculative of any of his opinions. He apparently concludes, not surprisingly without any actual evidence, that AHC personnel were "not paying attention to him", which "had the potential of worsening his depression and his suicidal ideation." And it appears that the only basis for his conclusion that staff were "not paying attention to him" is the statement in Mr. Kendrick's care plan that he liked to be talked to, as well as a lack of documented activities for him to do. This opinion by Dr. Lipson perhaps more than any of his other opinions reveals his complete disregard for any actual evidence in opining that Mr. Kendrick suffered injury as a result of Respondent's negligence. In short, there is no evidence whatsoever that the facility did (or did not do) anything to worsen Mr. Kendrick's depression, and Claimant should receive no compensation as to this allegation.

III. Conclusion

For these reasons, Claimant's claim is without merit, and should be dismissed in its entirety.

[7] See Exhibit "C", Deposition of Dr. Lipson, pp. 36-39.
[8] See Exhibit "C", Deposition of Dr. Lipson, pp. 39-46.

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Department of Human Services
Office of Policy and Legal Services
P. O. Box 1437, S260
Little Rock, AR 72203
501-320-6306
Fax: 501-682-1390

By: _____
Brooks C. White, Ark. Bar No. 2000093
Attorney for DHS

CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of February, 2016, I served a copy of the foregoing on the following via email and U.S. Mail:

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_____
Brooks C. White

Kenneth Kendrick

Arkansas Health Center

Ventilator and Tracheostomy Physician's Orders

Ventilator Type: LTV 1150
Mode of Ventilation: SIMV + PS
Set Respiratory Rate: 16
Tidal Volume: 850
Pressure Support: 5
Pressure Control: N/A
Inspiratory Time:
FIO2: 34%
PEEP: 5
High Pressure Alarm: 70
Low Pressure Alarm: 5 low min. volume off when cuff deflated
SpO2 Checks: Q Shift + PRN

Tracheostomy Type: Shiley
Size: #8 extra long
Trach Care: Q Shift
O2FIO2: Titrate to keep SPO2 92% Z
Humidification: heated

Other Respiratory Therapies:
Updraft: N/A
Meter Dosed Inhalers: ALBUTEROL MDI 6 puffs Q 6°
CPT:
Other:

STANDING ORDERS

VENTILATOR SPECIFIC:
SpO2 Checks PRN
Circuits Changes Monthly and PRN
Humidifier Chambers Changed Monthly and PRN
Use Sterile Water Only in Humidifier Chamber
Ventilator Checks and Documentation Every 12 Hours
Bag and Suction PRN, Use Normal Saline Only for Lavage PRN
Change Tracheostomy Tube every 3 months and PRN
Ambu Bag Ready for Use at The Bed Side
2 Extra Trach Tubes Available at the Bedside:
(1) Same Size (1) Size Smaller
Change HME per Manufacturer guidelines
Change In-Line Suction Weekly and PRN

TRACHEOSTOMY ORDERS:
SpO2 Checks PRN
Change Circuit Set Ups Every Other Week and PRN
Use Sterile Water Only in Misty – OX or Humidifier Bottles
Change Tracheostomy Tube EVERY 3 months and PRN
Ambu Bag Ready for Use at the Bedside
2 Extra Trach Tubes Available at the Bedside
(1) Same Size (1) Size Smaller
Bag and Suction PRN, May Use Normal Saline Only For Lavage PRN

EXHIBIT 7 Kidd
PENGAD 800-631-6989

NURSE SIGNATURE: Paul Mills RN DATE 6-18-13

PHYSICIAN'S SIGNATURE: [signature] DATE 6-18-13

Revised 2011

AHC FORM # 1150-C

DISCHARGE ORDERS

D'scharge Diet: 1800 ada

Diet Texture- Solids: Regular

Diet Texture- Liquids: REG

Additional Diet Instructions:
INFLATE CUFF WITH 7-10CC OF AIR WHILE EATING OR GIVING MEDICATIONS.

Fluid Restrictions(ml/day):

Discharge Activity:

Oxygen Orders: continue vent
TRACH 8 EXTRA LONG CUFFED SHILEY - UNFILLED UNLESS EATING OR MEDS GIVEN
SIMV RATE 16. TV 850. P/S 5. PEEP 5. 3L BLEED IN

Weight Monitoring:

Other orders:

Contact physician for worsening symptoms of:chest pain, fever, chills, difficulty breathing, nausea, vomiting, or other concerning symptoms.

ARKANSAS HEALTH CENTER
CARE GUIDE

KENDRICK, KENNETH WM
NH 000 214 113 ADM 6-18-13
DOB 5-21-72
MCD 0634246001
MCR 431829662C1

#2: Communication and Memory

DATE INITIATED: 07/04/2013

I am ventilator dependent but I keep my trach cuff deflated (when I am not eating or taking my medications), so I can speak to you - and my speech is very clear. I am able to make my needs known at all times, but I cannot use my arms/hands to push a call light button. However, I can push my feet together to initiate a "special call light". It fits between my feet and this way I can alert the staff when I need them to assist me. Please check on me as often as needed and make sure that my call light is positioned correctly before you leave my room. Remember that I am alert and know what is going on around me, so talk to me when you are in the room, so that I will feel comfortable with you giving me care and this will also help to keep me from being depressed or anxious. I have been living at home with my family and so coming to this facility is a big change for me. When you talk to me this will let me know that you care about me and will help to reassure me.

•**GOAL:** *I want to remain alert and continue to communicate as well as I do now for as long as my condition will allow.*

PENGAD 800-631-6989

EXHIBIT
DHS
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ARKANSAS HEALTH CENTER
CARE GUIDE

KENDRICK, KENNETH MM
NH 000-214 113 ADM 6-18-13
DOB 5-21-72
MCD 0634246001
MCR

#3: Mental Wellness

DATE INITIATED: 07/04/2013

Diagnosis: Depressive Disorder, NOS; Anxiety Disorder, NOS; Insomnia

Mood and Behavior Changes: I have told my psychiatrist, Dr. Luke Crawford, that I have a history of the above diagnoses and he noted this in my chart. He has recently evaluated me and I told him that I feel depressed at times since I have had to move from my home. I have even told my Social Worker that I have thoughts at times of wishing my life would end. I have several relatives who have also had the same disease that I have and have not lived as long as I have. I miss my mother and worry about her and her illness has made me sad. The doctor has ordered antidepressant, antianxiety and hypnotic medications to help me with my mood, anxiety and trouble sleeping. I also like to keep the sheet pulled over my head when staff is not providing care because I have trouble sleeping, so please remember to ask me if I would like for you to do this for me after you have completed care. Please give me all of my medications as the doctor has ordered and observe for therapeutic / sub-therapeutic effects. My doctor should be notified of any concerns. Please have my doctors routinely review my psychotropic medications, so that any needed revisions may be made.

Suicide: I have voiced thoughts of suicidal ideation since my admission because I want to be back in my home and because I am sad due to my medical condition. Because I have voiced thoughts of suicide, a suicide Assessment should be completed as scheduled and as needed. Please notify the appropriate staff including my psychiatrist of any concerns that indicate an increase in lowered mood.

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EXHIBIT
DHS
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ARKANSAS HEALTH CENTER

CARE AREA NARRATIVE ASSESSMENT
[Supplement To MDS 3.0]

KENDRICK, KENNETH
[illegible] 214-113 ADM 6-18-13
DOB 5/1/72
MCD 063424601
MCR

RESIDENT IDENTIFICATION
000214113

For EACH CAT (Care Area Trigger) Document Relevant Assessment Information Regarding The Resident's Status, Describe: Nature of Condition, Factors Considered to Individualize Care Plan Interventions, Complication and Risk Factors, Need for Referrals, And Where Relevant Information is Located, etc.

CHECK ALL PROBLEM AREAS THAT TRIGGER

	1. Delirium	x	8. Mood State	x	15. Dental Care
	2. Cognitive Loss/Dementia		9. Behavioral Symptoms	x	16. Pressure Ulcer
	3. Visual Function	x	10. Activities	x	17. Psychotropic Drug Use
	4. Communication	x	11. Falls		18. Physical Restraints
x	5. ADL Function/Rehab Potential	x	12. Nutritional Status	x	19. Pain
x	6. Urinary Incont/Catheters		13. Feeding Tube		20. Return to Community
x	7. Psychosocial Well-Being	x	14. Dehydration/Fluid Maintenance		Referral

Kendrick, Kenneth. DATE: 07/01/2013

1. DELIRIUM:

2. COGNITIVE LOSS/DEMENTIA:

3. VISUAL FUNCTION:

4. COMMUNICATION:

5. ADL FUNCTION/REHAB POTENTIAL: This area is triggered due to the resident being totally dependent for completion of all ADL needs. He is a quadriplegia due to Muscular Dystrophy. The resident is able to make his needs known and call for assistance with an adaptive call light. However, all ADL needs are anticipated and appear to be met. We will observe this area closely and make changes in the plan of care as needed. See ADL flow sheet, nurse's summary and notes. Proceed to care plan.

6. URINARY INCONT/CATHETERS: This area is triggered due to the resident being frequently incontinent of bladder. The resident is provided a urinal upon request, but is also incontinent. Staff observes for s/s of urinary-related problems each shift and provides incontinent care q 2 hrs and PRN. See nursing notes and flow sheet. Proceed to care plan.

7. PSYCHOSOCIAL WELL-BEING: This area is triggered due to the resident's loss of role in the community due to his quadriplegia and ventilator dependency. He has a very supportive family – especially his mother who has recently been diagnosed with cancer and can no longer care for him. We will observe for any changes and make revisions in the plan of care as needed. See SW notes. Proceed to care plan.

EXHIBIT DHS 21

PENGAD 800-631-6989

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KENNETH KENDRICK

ARKANSAS HEALTH CTR NURSING

07/01/2013 through 07/31/2013

Physicians Orders

Print Date: 06/25/2013

Order Date	Time Code	Orders
		Other Orders
06/18/2013	N/A	Alternating Pressure low air loss Bariatic bed with bed scale
06/18/2013	N/A	Code Status: Full Code
06/18/2013	N/A	Continue Vent and Trach Standing Orders
06/18/2013	N/A	May participate in Activities Program as tolerated.
06/18/2013	N/A	May substitute medications with generic equivalents unless otherwise specified.
06/18/2013	N/A	May transport to appointments via AHC clinic transport
06/18/2013	N/A	Psychiatric consultation PRN or as ordered.
06/18/2013	N/A	Resident May Have a Sandwich For a Snack Between Meals
06/18/2013	N/A	Resident may have fan at bedside
06/18/2013	N/A	Staff Psychologist to see PRN or as per orders
06/18/2013	N/A	Use Marissa lift with 2 person assist for ALL transfers
		Medication
06/18/2013	NCq1	1-Observe for S/S of Dehydration such as but NOT Limited to: Dry Mouth, Dizziness, Thirst, Poor Skin Turgor, Increased Confusion, Concentrated Urine, Decreased B/P, Increase in Constipation. Document ANY Negative Findings in the Nurses Notes.
06/18/2013	NCq1	2-May Crush or Alter Medications and/or Open Capsules Unless Contraindicated
06/18/2013	BID	Bumetanide (Bumex) 2 mg (1) Tab PO twice daily at 0900 and 2100 (CHF)
06/18/2013	BID	Magnesium Oxide 400 mg (1) Tab PO twice daily at 0900 and 2100 (Hypomagnesemia)
06/18/2013	HS	Melatonin 10 mg (1) Tab PO Q HS (Insomnia)
06/18/2013	BID	Polyethylene Glycol Powder (Miralax) 17 grams - Mix into (8) ounces of water or juice and give PO twice daily at 0900 and 2100 (constipation)
06/18/2013	QD	Esomeprazole Magnesium ER (Nexium) 40 mg (1) Cap PO QD *Do Not Crush* (GERD)
06/18/2013	QOD	Bisacodyl (Dulcolax) 5 mg (2) Tabs PO QOD (constipation)
06/18/2013	QD	Ferrous Sulfate 325 mg (1) Tab PO QD (Anemia)
06/18/2013	QD	Pantaprazole Sodium (Protonix) 40 mg (1) Tab PO QD before breakfast (Gastroparesis)
06/21/2013	QD	Potassium Chloride Liquid 20 mEq / 15 mls - Give 30 mls PO QD (Hypokalemia)
06/21/2013	QID	Metoclopramide (Reglan) 5 mg (1) Tab PO QID *Give with Reglan 10 mg (1) Tab* (Diabetic Gastroparesis)
06/21/2013	QD	Lactulose 10 grams / 15 mls - Give 30 mls PO QD mixed into 8 ounces water or juice (constipation)
06/24/2013	QID	Metoclopramide (Reglan) 10 mg (1) Tab PO QID *Give with Reglan 5 mg (1) Tab* (GERD)
		Diuretic
06/18/2013	QD	Spirolactone (Aldactone) 25 mg (2) Tabs PO QD (CHF)
		Hypnotic
06/18/2013	HS	Zolpidem Tartrate (Ambien) 5 mg (1) Tab PO Q HS (Insomnia)

Phys. Sig. [signature] Date 7/1/13

Above Orders Noted by [signature] Date 7-1-13

Nurse Review [signature] Date 6/26/13

Pharm. Review Date

Resident Name	Resident #	Room / Bed	Current Admit Date	Birth Date	Page
KENNETH KENDRICK	000214113	29 / C	06/18/2013	05/21/1972	1

Resident Status: Admission

Prim. Phys. Name	Phone	Alt. Phys. Name	Phone
Hill, Ed	(50[illegible]		( ) -

PENGAD 800-631-6989

EXHIBIT DHS 22

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Kenneth
Kendrick

Arkansas Health Center

Ventilator and Tracheostomy Physician's Orders

Ventilator Type LTV 1150
Mode of Ventilation SIMV + PS
Set Respiratory Rate 16
Tidal Volume 850
Pressure Support 5 Pressure Control N/A
Inspiratory Time
FIO2 34%
PEEP 5
High Pressure Alarm 70
Low Pressure Alarm 5 low min. volume off when cuff deflated
SpO2 Checks Q Shift + PRN

Tracheostomy Type Shiley Size #8 extra long
Trach Care Q Shift
O2FIO2 Titrate to keep SpO2 92% Humidification heated

Other Respiratory Therapies:
Updraft N/A
Meter Dosed Inhalers ALBUTEROL MDI 6 puffs Q 6°
CPT
Other

STANDING ORDERS

VENTILATOR SPECIFIC:
SpO2 Checks PRN
Circuits Changes Monthly and PRN
Humidifier Chambers Changed Monthly and PRN
Use Sterile Water Only In Humidifier Chamber
Ventilator Checks and Documentation Every 12 Hours
Bag and Suction PRN, Use Normal Saline Only for Lavage PRN
Change Tracheostomy Tube every 3 months and PRN
Ambu Bag Ready for Use at The Bed Side
2 Extra Trach Tubes Available at the Bedside:
(1) Same Size (1) Size Smaller
Change HME per Manufacturer guidelines
Change In-Line Suction Weekly and PRN

TRACHEOSTOMY ORDERS:
SpO2 Checks PRN
Change Circuit Set Ups Every Other Week and PRN
Use Sterile Water Only In Misty – OX or Humidifier Bottles
Change Tracheostomy Tube EVERY 3 months and PRN
Ambu Bag Ready for Use at the Bedside
2 Extra Trach Tubes Available at the Bedside
(1) Same Size (1) Size Smaller
Bag and Suction PRN, May Use Normal Saline Only For Lavage PRN

NURSE SIGNATURE: Paul Mills RN DATE 6-18-13

PHYSICIAN'S SIGNATURE DATE 6-18-13

Revised 2011

AHC FORM # 1150-C

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EXHIBIT
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ARKANSAS HEALTH CENTER NURSING HOME

Nurses' Notes

Date	Hour	Date and Sign All Notes With First And Last Name.
	1200 6/18/13	Received R from St. Mary's hospital by ambulance R up in bed c HOB @ 30° on assist on SLMV Oriented x3 and able to follow commands and ask questions. R states that he is in ↓ pain @ this time. PEERLA Able to move all extremities upon command. Bowel sounds active on RUE. Crackles heard in all 5 lobes and diminished sound heard in all 4 quadrants. Skin team notified, PT notified of arrival. Mother and sister in room c resident. Tube care performed. Call light adapted for R's use. R needs x1 in usual room clean after. Sacral area contains 3 different skin tags in various stages. Skin team notified of skin abnormality. R on low air low pressure setting mattress. B/P 105/59 P 87. Nail blanched in less than 3 sec and pink. R has no other questions or concerns @ this time, sacral area in room. —— Casey Stafford
	6/18/13 1550	Oriented in bed c HOB raised up. Alert able to make his needs known. Said he likes his head raised while awake. Requested the usual. Will continue to monitor for any changes in status. —— Mary Battles RN
	6/18/13 1800	in bed. SLF x2. CL in reach. R very pleasant. —— RGallaway

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8. MOOD STATE: This area is triggered due to the resident's mood related to his medical status and separation from his family. He has verbalized suicidal ideation since admission and this was reported to our staff psychiatrist who will continue to follow him. We will continue to observe this area closely and make changes in the plan of care as needed. See psych, MD, and SW notes. Proceed to care plan.

9. BEHAVIORAL SYMPTOMS:

10. ACTIVITIES: The resident does not prefer to participate in most activities on the unit at this time, but he has just been admitted and still adjusting. Our activities leader visits with him most every day and provides social interaction related to his interests. See Activities notes. Proceed to care plan.

11. FALLS: This area is triggered due to the use of Psychotropic Medication use and the resident's paralysis. He has experienced no falls since his admission. We will continue to observe for any adverse effects to all of the resident's medications. We will observe the resident closely and make revisions to the plan of care as needed. Proceed to care plan.

12. NUTRITIONAL STATUS: The resident is very overweight. We will try to provide food preferences that he will enjoy as well as promote his nutritional status. We will observe the resident closely make revisions to the plan of care as needed. See DT notes. Proceed to care plan.

13. FEEDING TUBE:

14. DEHYDRATION/FLUID MAINT: This area is triggered due to the diuretic that the resident uses. We will provide adequate hydration and observe the resident closely for any related problems. We will make revisions to the plan of care as needed. See DT notes and MAR. Proceed to care plan.

15. DENTAL CARE: This area is triggered due to the resident being dependent for all dental care. Oral care is provided at least twice daily and dental appts yearly and as needed. See Dental consult, nursing flow sheet. Proceed to care plan.

16. PRESSURE ULCER: This area is triggered due to the resident being quadriplegia. He lays on a rotating special mattress to help prevent pressure areas. We turn and reposition every 2 hours and as needed. We will observe the resident closely for any skin problems and make revisions to the plan of care as needed. See MD, DT notes and Nursing Flow Sheet / Summary. Proceed to care plan.

17. PSYCHOTROPIC DRUG USE: This area is triggered due to the use of Psychotropic Medication for anxiety and depression. Our MD routinely reviews the resident's medications and makes changes as needed. We will continue to observe for any adverse effects to all of the resident's medications and revise the POC as needed. We will observe the resident closely and make revisions to the plan of care as needed. Proceed to care plan.

18. PHYSICAL RESTRAINTS:

ARKANSAS HEALTH CENTER NURSING HOME

Nurses' Notes

Date	Hour	Date and Sign All Notes With First And Last Name.
6-19-13	0200	Observed Resident Lying in bed Resting quietly with eyes closed Resp. per vent at 16 breaths per minute. Tracheal Dressing clean dry & intact. No S/S of Acute distress noted at this time. Will continue to monitor.
6/19/13	0330	24 CC. R resting quietly in bed eyes closed. Resp per vent @ Rx settings. Able to make needs known to staff. Tylenol 1000mg given po for c/o pain per prn orders. and Phenergan 25mg po for c/o nausea given @ 2045. No further c/o noted. freq V's made for comfort and safety. T/R q 2hrs per 3 staff members. Chart @ Bedside. — N. Leander
6/19/13	0900	Dr Albey here. Rec'd orders to D/C per Phenergan (2) 25mg Supp PO q 6° per nausea. @ D/C Covenant Pharmacy Contact. R informed. — [illegible]
6/19/13	@0925	Tuberculin 5TU/0.1mL IDT x 1 V.O. Dr. Albey /Jacque Credit, RN — administer R forearm / — Pneumococcal Vaccine 0.5cc IM Q 5yrs per admit order V.O. Dr. Cooper /Jacque Credit, RN — administer (R) deltoid muscle — will continue to monitor — [illegible] Credit RN
6/19/13	1040	R resting in bed. Trach patent to vent @ Rx settings. Trach care provided prn + typ 2°. O S/S of distress noted @ this time. will cont. to monitor. — B Mucker
6-19-13	1535	R observed lying in bed, in supine position. Appears to be dozing but opens eyes to verbal stimuli + responds briefly. Morbidly obese, [illegible]

EXHIBIT 3 Kidd

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Arkansas Health Center

Nurse's Notes

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
6-19-13	1535	Per staff report, R has been awake through the shift, had bed change just recently d/t incontinent episode. Vent dependent, RR @16 per Rx settings. No acute respiratory distress noted. No c/o nausea or emesis so far this shift. VS [illegible]
6/19/13	2130	Teach patient to vent @ Rx settings, PO meds taken s difficulty, Ø s/s of distress noted. [illegible], LPN
6/19/13	2300	Tyl x2 given PO for HA 5/10. [illegible], LPN
6/20/13	0050	240 cc — PRN effective [illegible], LPN
6/20/13	0745	
6.20.13	1500	[illegible] to vent @ Rx settings. PO meds taken s difficulty. [illegible] Ø s/s of distress noted. [illegible] Will cont to monitor. [illegible]
6.20.13	1535	Unable to start [illegible] order until [illegible] answer from pharmacy. Will apply when [illegible] [illegible]
6/20/13	1915	HOB ↑ Teach patient to vent @ Rx settings c O2 [illegible] Oxi [illegible] care [illegible] RT - no s/s distress noted [illegible]
6/20/13	2100	BS 178 18 units [illegible] s/s - [illegible] per order [illegible]
6/21/13	0100	240 cc [illegible]
6/21/13	0410	Sleep note R slept approx 3° waking for personal care [illegible]
6-21-13	0710	Dr Albey here; reviewed lab results; orders received + noted; onsite called to order [illegible]; family + R notified of new orders [illegible] when spoke to Mother she stated R's [illegible] that [illegible]

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Arkansas Health Center

Nurse's Notes

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
6/21/13	0710 1011	bed at home does not turn, will cont on low air loss rotating mattress for pressure relief [illegible]
6/21/13	@0830	TST Reading (L) forearm 0mm - negative, no distress noted. [illegible]
6/21/13	0900	HOB↑. SR↑x2. trach patent to vent @ Rx settings. incont. care q 2° & prn per staff. Ø S/S of distress noted. clarification order for potassium Chloride 20mEq (2) QD, Reglan 10mg & 5mg given together QID, lactulose 10mg/15ml give 30ml QD & spirolactone 50mg (1) QD. new Rx orders for Remedy ~~Nyst~~ antifungal to folds [illegible]
6/21/13	1300	Zofran 4mg. D/C'd. mother + R informed [illegible]
6/21/13	2100	FSBS 230 @ this time ADM Humalog 21 units SQ to ~~(L)~~ LLQ per sliding scale. Will monitor — [illegible] RN
6/22/13	0230	24° Chart ✓ - Trach patent to vent @ Rx settings c O2 bled in line HOB↑ all meds PO. Total care given Q2° & PRN. Able to make needs known. Ø S/S adverse reaction from med Δ Ø @ this time. Call light within reach. Will continue to monitor — [illegible] RN
6/22/13	0600	FSBS 189 @ this time ADM Humalog 18 units SQ to RLQ per sliding scale orders [illegible] RN
6/22/13	1000	R in bed Ø S/S of distress, trach patent to vent, Will maintain comfort [illegible]

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Nurses Notes
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Nurse's Notes

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DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
6/22/13	2040	R awake & alert. Trach patent to vent @ Rx settings. R requested pain meds for headache throbbing @ pain level 5. Med nurse notified. R able to communicate & make needs known. Call light within reach. Will check on R
6/22/13	2045	C/O throbbing HA LOP 5 on 0-10 pain scale. ADM Ibuprofen 600mg PO per PRN order. Will continue to monitor — Tulu Spaulding LPN
	2130	C/O nausea @ this time. ADM Zofran 8mg PO per PRN orders. Will continue to monitor — Tulu Spaulding LPN
	2230	Ø further C/O HA or nausea reported. PRNs Ibuprofen & Zofran effective @ this time. Trach patent to vent @ Rx settings c O2 @ 3L bled in line. HOB↑. All meds PO c difficulty. Assist. c urinal & bedpan provided PRN. Total care provided @ 2° & PRN. Ø S/S acute distress noted @ this time. Able to make needs known. Call light within reach. Will continue to monitor - T. Spaulding LPN
	2330	C/O ↑ anxiety @ this time. pt asked "can I please get an Ativan?" ADM Ativan 1mg PO per PRN order. Will continue to monitor — Tulu Spaulding LPN
6/23/13	0030	24° Chart ✓ — Ø further C/O anxiety voiced. OV closed. Will continue to monitor - T. Spaulding LPN
6/23/13		R in bed, trach patent to vent
6/23/13	1030	Resp even & unlabored. Ø C/O discomfort/pain @ this time. Will

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Nurse's Notes

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
6/24/13	0325	24°CC done. Trach patent to vent @ Rx settings. Pt requested and recieved Ativan 1mg po @ 2230 for anxiety. Able to make needs known to staff. freq V/S made. C/L @ bedside. ——— [illegible]
6/24/13	1105	Dr Cooper rounds earlier, reviews speech rec's order received & noted to change diet to [illegible] changed, also. D/C KCl tabs and change to KCl liquid @ pt request; mother had phoned earlier & spoke c̄ T. Robertson & mother was updated on orders [illegible]
6/24/13	1505	T 98.4 30 SpO2 X2 C/L in reach. Trach patent to vent @ Rx settings c̄ O2 bled inline. PO meds c̄ diff. Incont care q 2° & prn. Able to make needs known. Cont on Levaquin c̄ A&E noted. Will cont to monitor ——— [illegible] LPN
6/24/13	0030	24°CC ——— Tyl x2 for HA & Zofran for nausea given PO, Trach patent to vent, ∅ s/s of distress, C/L in reach. ——— [illegible] LPN
6/25/13	0800	Dr Cooper rounds, reviews meds & Rx needs on meds; order received & noted to [illegible] family notified of orders [illegible]
6/25/13	1500	T 98.4 30 SpO2 x2 C/L in reach. Trach patent to vent @ Rx settings c̄ O2 bled inline. PO meds c̄ diff. Uses urinal & Incont care q 2° & prn. Cont on Levaquin c̄ A&E noted. Will cont to monitor [illegible] LPN
6/26/13	0045	24°CC ——— Trach patent to vent, Tyl x 2 for HA, Incontinent care q 2° & PRN, ∅ s/s of distress ——— [illegible] LPN

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Nurses Notes
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Nurse's Notes

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
6-26-13	0250	Called to Resident's Room by Staff to Assess Coccyx Area. Upon Examination 4 nickel size Red open area was noted to Coccyx. Instructed LPN to make Skin team notifications. Pericare given by Staff. Antifungal Cream applied by Staff. Will continue to monitor [signature]
6-26-13	1330	R in bed, ø s/s of distress, trach patent to vent, access to [illegible] tx completed [illegible] Nerayanpon
6/27/13	0345	24° Chart Check done. Trach patent to vent. Tylenol 500mg ii tabs @ 2310 for complaints of Headache. No further complaints @ this time. [signature]
6/27/13	0900	R in bed ø s/s of distress Trach patent [illegible]
6/28/13	0330	24° Chart ✓. Trach patent to vent c̄ O2 inline no c/o pain or discomfort. tolerated po meds well will cont. to monitor prn. [signature]
6/28/13	1525	HOB ↑ 30°. Sh ↑ x2. CL in reach. Trach patent to vent @ Rx settings c̄ O2 bled inline. PO meds s̄ diff. ADM Tylenol x2 tabs for c/o HA. Use urinal c̄ assist. Incont care q 2° prn. Will cont to monitor [signature] RN
6/29/13	0100	24° CC — Trach patent to vent @ Rx settings, Incontinent care q2° & PRN; ø s/s of distress. [signature], LPN
6/29/13	1545	Trach patent to vent @ Rx Setting. Incont care q 2° & prn. Will monitor [signature]

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Nurse's Notes

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AUM 6-18-13

MCD 0634246001

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
6/29/13	2330	c/o heartburn, PRN tums given PO, Trach patent to vent @ Rx settings. —— R [illegible], LPN
6/30/13	0000	24° cc — c/o nausea, PRN Zofran given PO —— R [illegible], LPN
6/30/13	0020	c/o HA, PRN Tyl x2 given PO. —— R [illegible], LPN
6/30/13	0130	PRNs effective, resting c̄ eyes closed. —— R [illegible], LPN
6/30/13	1050	Tx complete per orders. Trach patent to vent @ Rx settings c̄ O2 bled inline. Pomeds s̄ diff. Incont care q 2° & prn Uses urinal c̄ assist. Will cont to monitor —— [illegible], LPN
7/1/13	0100	24° cc —— R [illegible], LPN
7-1-13	0030	R in bed s̄ s/s of distress, trach patent to vent, tx to [illegible] completed, incont care prn, no c/o discomfort @ this time. Will cont to monitor —— [illegible]
7/1/13	1300	[illegible] chart c̄ RT, order clarification c̄ Δ [illegible] [illegible] XLT [illegible] q 3 months or PRN —— [illegible]
7-1-13	2030	c/o ↑ anxiety & requested Ativan by name @ this time. ADM Ativan 1mg PO per PRN order. Will continue to monitor — Tyler Spaulding, LPN
	2130	No further c/o anxiety noted. PRN Ativan effective —— Tyler Spaulding, LPN
	2230	c/o back pain LOP 5 on 0-10 pain scale @ this time. ADM Tylenol 500mg (2) tabs PO per PRN order @ pt request. Will continue to monitor —— Tyler Spaulding, LPN
	2330	No further c/o back pain voiced. Eyes closed @ this time. PRN Tylenol effective —— Tyler Spaulding, LPN

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Nurse's Notes

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IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
7/2/13	0200	24° Chart V - Trach patient to vent @ Rx settings c O2 bled in line. HOB↑ All PO meds s difficulty. Total care provided Q2° & PRN per staff. ⊘ S/S acute distress noted @ this time. Call light within reach. Will continue to monitor — [illegible] RN
7/2/13	@0915	#2 Tuberculin 5TU/0.1mL IDT x 1 V.O. Dr. Albey /Jacque Credit, RN administer (L) forearm no adverse reaction noted will continue to monitor [illegible]
7.2.13	1330	New orders per Dr Crawford noted. Social worker given copy, New meds & labs noted [illegible]
cont		R in bed ⊘ S/S of distress, trach patent to vent, tx completed to labs, no c/o discomfort @ this time [illegible]
7/3/13	0130	24° Chart V. R has slept well [illegible] thus far. No adverse reaction from D/C [illegible]. R took AHS meds s diff. Trach patent to vent @ Rx settings c O2 bled inline. No distress noted. Will cont. to monitor PRN. [illegible]
7/3/13	2130	c/o nausea, PRN zofran given PO, Trach patent to vent @ Rx settings, ⊘ s/s of distress, c/L in reach. [illegible], LPN
7/4/13.	0030	24° CC [illegible], LPN

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Nurses' Notes
Form No. [illegible]

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Nurse's Notes

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DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
7/4/13	1040	R in bed ∅s/s of distress trach patent to vent, incont care given. no c/o discomfort @ this time — [illegible signature]
7-4-13	1735	TB skin test to L) FA read, Result is negative (∅ mm). — [illegible signature]
7/5/13	0030	24° cc — ∅ s/s of ASE to med's — [illegible signature], LPN
7-5-13	1240	R in bed ∅s/s of distress, ∅ c/o discomfort @ this time trach patent to vent, meds po's accurately, incont care given, call light in reach @ all times — [illegible signature]
7-6-13	0445	24° cc — [illegible signature], LPN
	0500	Tylenol & Neurontin ineffective @ 2200. ∅ further complaints — [illegible signature]
7/6/13	2015	C/O itching @ this time. ADM Benadryl 25mg PO per PRN order. Will monitor — [illegible signature]
	2100	FSBS 261 @ this time. ADM Humalog 2 units SQ to LLQ per sliding scale. Will continue to monitor. — [illegible signature]
	2115	No further C/O itching noted. PRN Benadryl effective — [illegible signature]
7/7/13	0145	24° Chart ✓ - Trach patent to vent @ Rx settings c O2 @ 3 LPM placed in line. HOB ↑ All meds PO's difficulty. Total care given O2° & PRN per order. ∅ s/s acute distress noted. Call light within reach. Will continue to monitor — [illegible signature], LPN
7/7/13	0400	Sleep Note: eyes closed most of night. Awake during total care ∅ s/s insomnia noted — [illegible signature]

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Arkansas Health Center

Nurse's Notes

[illegible] ADM 6-18-13
DOB [illegible]
MCD [illegible]
MCR [illegible]
IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
7/7/13		C/O generalized pain WOP 7 on 0-10 pain
	0645	scale. ADM Neurontin 200mg PO & Tylenol
		500mg PO per PRN order. Will continue to
		monitor ——— Tyler Spaulis LPN
	0745	Ø further C/O pain noted PRN Neurontin
		& Tylenol effective @ this time - T Spaulis LPN
	0905	Trach patient to vent @ RX settings c̄
		O2 @ 3Lpm bled in line HOB↑ Total care
		given Q2° & PRN per staff. Ø S/S acute
		distress noted. Call light within reach
		Will continue to monitor - Tyler Spaulis LPN
	2045	C/O itching @ this time ADM Benadryl
		25mg PO per PRN order. Will continue
		to monitor ——— Tyler Spaulis LPN
	2100	FSBS 185 @ this time ADM Humalog
		18 units per sliding scale SQ to LLQ
		Tyler Spaulis LPN
	2145	Ø further C/O itching noted. PRN Benadryl
		effective ——— Tyler Spaulis LPN
7/8/13		24° Chart CK - ET tube patent to vent @ RX
	0310	settings c̄ O2 @ 3L bled in line. HOB↑ All
		meds PC s̄ difficulty. Total care provided
		Q2° & PRN per staff. Ø Sx acute distress
		Call light within reach. Will continue to
		monitor ——— Tyler Spaulis LPN
	0600	FSBS 158 @ this time. ADM Humalog 18 units
		SQ to RLQ per sliding scale orders - T Spaulis LPN
7-8-13	0630	Order received & noted ℞ D/C Humalog when current bottle
		depleted & start Novolog c̄ current SS insulin order
		R notified [illegible]

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Nurse's Notes

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME
7-8-13	0800	Dr Hill also while here reviews pharmacy/ insurance fees; order received & noted to DC prn Zofran & change to phenergan prn 96°; Nick @ Allcare phoned & relays that phenergan may ↑ EPS when pt taking Reglan; will speak c̄ Dr Hill on AM rounds to clarify if order still needs to be carried out. [signature]
7/8/13	2300	PRN ativan given PO for anxiety. [signature], LPN
7/9/13	0110	240cc [signature], LPN
7-9-13	0810	Dr Hill rounds, reviewed order from yesterday and pharmacy notification - order received and noted to disregard order from yesterday on continue Zofran 4mg po prn q6° for nausea; pt & family notified of order [signature]
7/9/13	2300	c/o anxiety, PRN ativan given PO, tolerated well. Trach patent to vent, C/L in reach, ⊘ s/s of distress, denies further needs. [signature], LPN
7/10/13	0030	24°cc [signature], LPN
7-10-13	0730	Clarification orders received & noted for meds clarified as per dispensed by pharmacy pt aware of meds & orders [signature]
7-10-13	1000	R in bed. [illegible] c/o back pain [illegible] & [illegible] given NFC @ this time, trach patent to vent @ [illegible] settings, call light in reach, [illegible] care given [illegible]
7/10/13	2100	FSBS 176 @ this time ADM Humalog 18 units SQ to LLQ per sliding scale orders - [signature]

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Nurse's Notes

IDENTIFICATION PLATE

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
7/11/13	0200	24° Chart CK - ET tube patent to vent @ Rx settings c O2 @ 3Lpm bled in line. HOB↑ All PO meds taken s difficulty. Total care provided Q2° & PRN per staff. Ø Sx acute distress noted. Call light within reach. Will continue to monitor. — Tyler Spaulding LPN
7-12-13	0340	24° CC - ET tube patent to vent at Rx settings c O2 @ 3 lpm bled in line - HOB ↑ All po meds taken s difficulty. All needs met per staff - CL in easy reach + Resident able to make needs known — [illegible]
7-12-13	1300	per dietary rec, order received + noted for Prostat [illegible] po BID, family + R notified of order — [illegible]
	1420	Trach stoma patent to vent @ Rx settings HOB ↑. Ø c/o pain [illegible] or discomfort noted. Peri care offered q2 hrs and PRN. Will cont to monitor. — [illegible]
7/13/13	0145	24° CC — R[illegible] LPN
7-13-13	1310	R refused shower, states "I don't feel like taking one today." Will administer if R changes mind. — [illegible]
7/14/13	0100	24° CC, Ø new orders. Resting quietly. Trach patent to vent @ Rx settings. Incont of bowel + bladder. Total care provided by staff. Will cont to monitor. [illegible]
7/14/13	1330	bed bath given to done. vent trach patent to vent. Ø s/s of distress noted — RGalloway

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Nurses' Notes
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Nurse's Notes

IDENTIFICATION PLATE
[illegible] ADM [illegible]-18-13

DATE	HOUR	DATE AND SIGN ALL NOTES WITH FIRST AND LAST NAME.
7/15/13	0020	24° CC —— [illegible], LPN
7-15-13	0820	R in bed, NSIS of distress, trach patent to vent, no c/o discomfort @ this time, call light in reach @ L elbow —— [illegible] LPN
7-15-13	1145	I was sitting at nurses station & R's call light sounded - when I answered the R responded "accident" —— [illegible]
7-15-13		@1150 RT in room & checked R's vent monitor, not alarming, @1210 went into R's room to check his BS, spoke out to R several times, R unresponsive. I uncovered R's head R pale & cyanotic, [illegible] side of R face noted to be purple, lips & all extrem. noted to be cyanotic, [illegible] RT & Kay RN immediately notified, RT assessed reported inner cannula popped out, unable to detect O2 sat or HR on pulse oximeter, I palpated HR via carotid artery, less than 10 bpm, @1214 backboard placed Code Blue & CPR initiated @1215 911 called & Dr Hill notified per Jackie LPN CPR continued until 1224 AED applied c̄ no shock advised several times continued CPR @1231 MEMS arrived to transfer to SMT, Kristy PSO secretary notified, @ 1234 mother notified per Kay, 1910 completed & PSO notified @1536 [illegible]
cont.		R noted he did not use his call light between 1145 & 1210 when R found [illegible]

MNS-[illegible](2/88)

(over)

Nurses Notes
Form No. 1160 (REV 6/85)

129

7-15-13 1212 I was sitting at Nurses Station charting. Tasha Lenard, LPN approached me and stated that A needed to come to B's room as ½ of his face was blue. We went to B's room. When I entered B's room, RT, Paul Mills was at bedside manual bagging B per trach; pox was on place on (L) finger. When I entered room pulse ox was not tracking, but then began to track C O2 + HR both in 40's; additional O2 tanks obtained and J. Robertson instructed to call 911. T. Lenard was attempting to obtain carotid pulse. Pulse less than 10, 3rm palpable. Rotating bed was put on CPR mode and I started compressions while RT, Paul Mills, continued manual bagging per trach; after approx 1 (one) minute of CPR, B's color became more pink but Ø increase of HR noted; pink color then turned cyanotic again and continued to have no pulse. Switched compressors approx every 2 min awaiting 911 personnel. AED placed at approx 5 minutes to code. Ø rhythm detected on AED and continued until Medtran arrived. transferred to Medtran crew & continued CPR & manual bagging to trach. taken to ambulance for transport to SMH.

130

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES
THERAPY RECORD

KENDRICK, KENNETH WM
MM 0[illegible] 214 113 ADM 6-18-13
[illegible] 5 [illegible] 72 [illegible]
MCD 0634246001
MCR 4318296620 1

IDENTIFICATION STAMP

EXHIBIT 4 Kidd

PENGAD 800-631-6989

Type of Therapy: ______
Frequency: ______
Medications: ______
Pressure: ______
Special Instructions: ______

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 1835	MDI	[illegible]	91	16	SpO2 = 99%	3L	/	[illegible]
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
[illegible] crackles no Δ			HOB ↑	None	←			Poor Fair Good (circled) — Therapist: [illegible]
6/18/13 2200	MDI	[illegible] puffs Albuterol	125	16	SpO2 = 98%	3L	/	SXN large [illegible] yellow
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
↓ c̄ crackles Ø Δ			HOB ↑	Ø	Trach care done			Poor Fair Good (circled) — Therapist: [illegible] RN
6/19/13 0115	MDI	[illegible] puffs Albuterol	106	16	SpO2 = 99%	3L	/	SXN large thin yellow
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
↓ c̄ crackles Ø Δ			HOB ↑	Ø	―			Poor Fair Good (circled) — Therapist: [illegible] RN
6/19/13 1000	MDI	Albuterol x 6 puffs	71	16	SpO2 = 98%	3Lpm	/	SXN large amount of thick yellow secretions
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
coarse crackles no Δ			HOB ↑	None	trach care done			Poor Fair Good (circled) — Therapist: [illegible]
6/19/13 1450	MDI	Albuterol x 6 puffs	98	16	SpO2 = 95%	3Lpm	/	Refused SXN
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
coarse crackles no Δ			HOB ↑	None	―			Poor Fair Good (circled) — Therapist: [illegible]
6/19/13 [illegible]	MDI	Alb 6P	98	16	SpO2 98%	2L/m	/	SXN mod amt yellow
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
coarse crackles Ø Δ			HOB ↑	Ø	trach care done			Poor Fair Good (circled) — Therapist: [illegible]
6/20/13 0700	MDI	Albuterol x 6 puffs	72	16	SpO2 = 95%	2Lpm	/	moderate amount of thick yell secretions
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
coarse crackles no Δ			HOB ↑	None	↑ cuff while [illegible] trach care done			Poor Fair Good (circled) — Therapist: [illegible]

MHS-3835 (R.8/97) Page 1 of 2

Form # 1156

ADM 6-13-13

MCD 06542460001
MCR 4318296621

ARKANSAS HEALTH CENTER

Benton, Arkansas

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/20/13 1350	MDI	Albuterol x6puffs	83	16	SpO2 = 97%	RA	/	SxN moderate amount pale yellow sputum
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
Coarse crackles no D			HOB↑	None	—			Poor Fair (Good)
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	**Therapist:**
6/20/13 1550	MDI	albuterol x6 Puffs	80	16	SpO2 96%	RA	/	Describe: Cough-Sputum Sxn moderate amt pale yellow
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
Coarse crackles no D			HOB↑	none	—			Poor Fair Good
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	**Therapist:** Matthew
6/21/13 0830	MDI	Albuterol 4puffs	82	16	SpO2 = 98%	3L	/	Describe: Cough-Sputum
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			SxN Large amt thick yellow
Coarse crackles			HOB↑	None	Trach care done			**Tolerated**
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	Poor Fair Good
6/21/13 1315	MDI	Albuterol 4puffs	87	16	SpO2 = 99%	3L	/	**Therapist:**
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Describe: Cough-Sputum**
Crackles No D			HOB↑	None	—			SxN Large amt thick yellow
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	**Tolerated**
6/21/13 2011	MDI	Alb 6P	82	16	SpO2 98%	3L/m	—	Poor Fair Good
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Therapist:**
Crackles D			HOB↑	D	Trach care done			**Describe: Cough-Sputum**
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	SxN mod amt pale yellow
6/21/13 2400	MDI	Alb 6P	80	16	SpO2 97%	3L/m	—	**Tolerated**
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			Poor Fair Good
Crackles D			HOB↑	D	—			**Therapist:**
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	**Describe: Cough-Sputum**
6/22/13 0830	MDI	4puffs Albuterol	94	16	SpO2 = 99%	3L	/	SxN Large amt thick yellow
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Tolerated**
Coarse crackles			HOB↑	None	Trach care + tube feeds done			Poor Fair Good
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	**Therapist:**
6/22/13 1825	MDI	4puffs Albuterol	87	16	SpO2 99%	3L	/	**Describe: Cough-Sputum**
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			SxN mod thick yellow
Coarse No D			HOB↑	None	—			**Tolerated**
Date/Time	**Treatment**	**Medications**	**Heart Rate**	**Respiratory Rate**	**Peak Flow (Pre-Post)**	**F1/O2**	**Volume**	Poor Fair Good
6/22/13 1945	MDI	Alb 6P	80	16	SpO2 96%	3L/m	—	**Therapist:**
Breath Sounds (Pre-Post)			**Pt's Position**	**Adverse Reactions**	**Comments:**			**Describe: Cough-Sputum**
Coarse			✓	D	Trach care done			**Tolerated**
								Poor Fair Good
								Therapist:

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES THERAPY RECORD

[illegible] KENNETH WM
[illegible] ADM 6-18-13
DOB 5 21 72
MCD 06342460001
MCR 4318296626 1

IDENTIFICATION STAMP

Type of Therapy: _____
Frequency: _____
Medications: _____
Pressure: _____
Special Instructions: _____

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/24/13 0930	MDI	Albuterol 6-8	80	16	SPO2	3L/m		SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Diminished			HOB↑	None				Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/23/13 0830	MDI	Albuterol	84	16	SPO2 = 99%	3L	1	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB↑	None	Trach care done			Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/23/13 1250	MDI	Albuterol	89	16	SPO2 = 99%	3L	1	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB↑	None				Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/23/13 2025	MDI	6 puffs Albuterol	86	16	SPO2 = 100%	3L	1	SXN large pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles Δ			HOB↑	Ø	Trach care done			Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/24/13 0715	MDI	6 puffs Albuterol	81	16	SPO2 = 100%	3L	1	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles Δ			HOB↑	Ø				Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/24/13 0920	MDI	Albuterol 6 puffs	82	16	SPO2 = 99%	3Lpm	1	SXN Moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Coarse crackles No Δ			HOB↑	None	trach care done as ordered			Poor Fair Good
								Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/24/13 1420	MDI	Albuterol 6 puffs	80	16	SPO2 = 98%	3Lpm	1	SXN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Coarse crackles Δ			HOB↑	None	Pt Asked about trach care & refused			Poor Fair Good
								Therapist: [illegible]

ARKANSAS HEALTH CENTER

Benton, Arkansas

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/24/13 2010	MDI	Albuterol	96	16	Spo2 97%	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
clear - - - - - - - - - -			HOB↑	Ø	Trach Care done			Poor Fair Good Therapist: Aletta
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/25/13 0115	MDI	Albuterol	91	16	—	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
clear clear			HOB↑	Ø	Spo2 99%			Poor Fair Good Therapist: Okeshia
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/25/13 1130	MDI	Albuterol x 6 puffs	80	16	SpO2 = 99%	3Lpm	/	SKN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles noD			HOB↑	None	oral care/trach care done			Poor Fair Good Therapist: Valorie
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/25/13 1440	MDI	Albuterol x 6 puffs	87	16	SpO2 = 99%	3Lpm	/	Scr moderate amount of thick white secretions
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles noD			HOB↑	None	—			Poor Fair Good Therapist: Valorie
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/25/13 2055	MDI	Albuterol	87	16	Spo2 97%	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
clear - - - - - - - - - -			HOB↑	Ø	Trach Care done			Poor Fair Good Therapist: Okeshia
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/26/13 0115	MDI	Albuterol	92	16	—	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
clear - - - - - - - - - -			HOB↑	Ø	Spo2 98%			Poor Fair Good Therapist: Aletta
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/26/13 0815	MDI	Albuterol	88	12	SPO2 = 99%	3L	/	Scr mod thick white
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles noD			HOB↑	None	Trach care done			Poor Fair Good Therapist: Okeshia
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/26/13 1250	MDI	6 puffs Albuterol	99	16	SPO2 = 99%	3Lpm	/	SKN moderate amount
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
crackles noD			HOB↑	None	—			Poor Fair Good Therapist: Okeshia
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/26/13 2005	MDI	6 puffs Albuterol	92	16	SPO2 = 99%	3L	/	SKN large amount pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
clear noD			HOB↑	Ø	Trach care done			Poor Fair Good Therapist: Okeshia

Arkansas Heart Hospital
Benton, Arkansas

RESPIRATORY CARE SERVICES
THERAPY RECORD

[illegible] ADM 6-18-13

MR# 5426001
IDENTIFICATION STAMP

Type of Therapy:
Frequency:
Medications:
Pressure:
Special Instructions:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 0830	MDI	6 puffs Albuterol	94	16	SpO2=98%	3L	/	SKN moderate pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - - Diminished - - -		HOB↑	Ø					Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 0840	MDI	6 puffs Albuterol	104	16	SpO2=99%	3L	/	Small amount of pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - - Crackles - - -		HOB↑	None	Tracheostomy done				Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 1330	MDI	6 puffs Albuterol	92	16	SpO2=99%	3L	/	SKN moderate amount of pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - - Coarse Crackles - - -		HOB↑	None					Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 1650	MDI	6 puffs Albuterol	86	16	SpO2=99%	3L	/	SKN large pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - - Crackles - - -		HOB↑	Ø	Tracheostomy done				Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/18/13 2105	MDI	6 puffs Albuterol	88	16	SpO2=100%	3L	/	SKN moderate pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - - Crackles - - -		HOB↑	Ø					Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/19/13 -1610	MDI	Albuterol X 6 puffs	100	16	SpO2=98%	34pm	/	SKN moderate amount of pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - Coarse crackles - - -		HOB↑	NONE	tracheostomy done				Poor Fair Good
								Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/19/13 1310	MDI	Albuterol X 6 puffs	68	16	SpO2=99%	34pm	/	SKN moderate amount of pale yellow
Breath Sounds (Pre-Post)		Pt's Position	Adverse Reactions	Comments:				Tolerated
- - Coarse Crackles - - -		HOB↑	NONE					Poor Fair Good
								Therapist:

MHS-3815 (R-1/07) Page 1 of 2

Form # 1158

ARKANSAS HEALTH CENTER

Benton, Arkansas

[illegible] 218-13

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/28/13 2030	MDI	Combivent Albuterol	85	16	SpO2 100%	3L	[illegible]	small pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
CTB [illegible]	Head	Ø	Trach Care done	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/29/13 0100	MDI	Combivent Albuterol	72	16	SpO2 99%	3L	—	small pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
CTB [illegible]	HOB	Ø	—	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/29/13 0845	MDI	Albuterol x 4 puffs	99	16	SpO2 = 98%	3Lpm	/	

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
coarse crackles [illegible]	HOB ↑	None	trach care done	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/29/13 1530	MDI	Albuterol x 4 puffs	89	16	SpO2 = 98%	3Lpm	/	

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
coarse crackles [illegible]	HOB ↑	None	—	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/29/13 2020	MDI	Combivent Albuterol	90	16	SpO2 100%	3L	—	small pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
CTB [illegible]	HOB	Ø	Trach Care done	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/30/13 0925	MDI	Albuterol x 4 puffs	108	29/16	SpO2 = 98%	3Lpm	/	Spu: moderate amount of pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
coarse crackles [illegible]	HOB ↑	None	trach care/oral care done	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/30/13 1405	MDI	Albuterol x 4 puffs	92	16	SpO2 = 99%	3Lpm	/	Spu Moderate amount of pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
coarse crackles [illegible]	HOB ↑	None	—	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
6/30/13 2025	MDI	Combivent Albuterol	98	16	SpO2 98%	3L	—	small pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
crackles [illegible]	HOB	Ø	Trach Care done	Poor Fair Good (Good circled) Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/1/13 0120	MDI	Combivent Albuterol	90	16	SpO2 100%	3L	—	small pale yellow

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated
CTB [illegible]	HOB	Ø	—	Poor Fair Good (Good circled) Therapist: [illegible]

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES
THERAPY RECORD

KENDRICK, KENNETH WM
NM 000-214 113 ADM 6-18-13
DOB 5-21-72
MCD 0634246001
MCR 4318296621

IDENTIFICATION STAMP

Type of Therapy:
Frequency:
Medications:
Pressure:
Special Instructions:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/1/13 0840	MDI	Ventolin	106	16	SPO2 = 99%	3L	1	Small amt thick yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Coarse No Δ			HOB↑	None	Trach care done			Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/1/13 0815	MDI	Ventolin	99	16	SPO2 = 99%	3L	1	Small amt thick yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Coarse Crackles No Δ			HOB↑	None				Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7-1-13 2100	MDI	Ventolin	92	16	SPO2 99%	3Lpm	1	Sm mod light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles Δ			HOB	Ø	Trach Care Done			Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7-2-13 0210	MDI	Ventolin	90	16	SPO2 99%	3L pm	1	Sm, moderate light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB	Ø				Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/2/13 0815	MDI	Ventolin	105	16	SPO2 = 98%	3L	1	Sm amt thick yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Coarse Crackles			HOB↑	None	Trach care done			Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/2/13 0835	MDI	Ventolin	96	16	SPO2 99%	3L	1	Sm mod thick yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB↑	None				Poor Fair Good
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/2/13 1020	MDI	Ventolin	103	16	SPO2 = 99%	3L	1	Sm amt thick yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles Bases			HOB↑	Ø	Trach care done			Poor Fair Good

KENDRICK, KENNETH WM
NM 000 214-11 ADM 6-18-13
DOB 5-21-72
MCD 0636266001

ARKANSAS HEALTH CENTER

Benton, Arkansas

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/3/13 0130	MDI	6 puffs Albuterol	93	16	SpO2 99%	3L	/	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - Crackles - - - -			HOB↑	Ø	—			Poor Fair (Good) Therapist: RRT, RN
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/3/13 1015	MDI	Albuterol x 6 puffs	82	16	SpO2 = 97%	3lpm	/	SXN large amount of pale yellow.
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- coarse crackles - - - - - no Δ			HOB↑	NONE	Trach cleaned once daily			Poor Fair (Good) Therapist: Vicki Tarby
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/3/13 1400	MDI	Albutero x 6 puffs	103	16	SpO2 = 100%	3lpm	/	SXN large amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - coarse crackles - - - - no Δ			HOB T	NONE	—			Poor Fair (Good) Therapist: Vicki Tarby
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7-3-13 2030	MDI	6 puffs Albuterol	88	16	SpO2 = 98%	3LPM	/	SXN Mod pale yellow secretions
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - Crackles - - - - - Δ			HOB↑	Ø	Trach + oral care			Poor Fair (Good) Therapist: Stacy RT
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/4/13 1115	MDI	Albuterol x 6 puffs	103	16	SpO2 = 99%	3lpm	/	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - coarse crackles - - - - no Δ			HOB T	NONE	trach care/oral care done			Poor Fair (Good) Therapist: Vicki Tarby
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/4/13 1420	MDI	Albuterol x 6 puffs	106	16	SpO2 = 98%	3lpm	/	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - coarse crackles - - - - no Δ			HOB T	NONE	—			Poor Fair (Good) Therapist: Vicki Tarby
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/4/13 2010	MDI	6 puffs Albuterol	103	16	SpO2 98%	3LPM	/	SXN Large amt pale yellow.
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- Coarse crackled Δ			HOB↑	Ø	Trach + oral care			Poor Fair (Good) Therapist: Stacy RT
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/5/13 0840	MDI	6 puffs Albuterol	93	16	SpO2 99%	3L	/	SXN moderate pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - - - Coarse - - - - - No Δ			HOB↑	None	Trach care done			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/5/13 1315	MDI	6 puffs Albuterol	94	16	SpO2 99%	3L	/	SXN mod thick pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - - Crackles - - - - - No Δ			HOB↑	None	—			Poor Fair (Good) Therapist: [illegible]

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES
THERAPY RECORD

Type of Therapy: _____
Frequency: _____
Medications: _____
Pressure: _____
Special Instructions: _____

KENDRICK, KENNETH W
NH 000-214-113 ADM 4-18-13
DOB 5-21-72
MCD 0634246001
MCR 4318296620 1

IDENTIFICATION STAMP

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/5/13 1435	MDI	6 puffs albuterol	91	16	SpO2=100%	Blow by	/	Small amt pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles BA			HOB↑	Ø	Trach care done			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/6/13 0145	MDI	6 puffs albuterol	95	16	SpO2=100%	3L	/	Small amt pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles BA			HOB↑	Ø	—			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/6/13 0845	MDI	6 puffs albuterol	94	16	SpO2=100%	3L	/	Sm mod amt light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No A			HOB↑	None	Trach care & tx done			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/6/13 1325	MDI	6 puffs albuterol	89	16	SpO2=99%	3L	/	Sm mod amt light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No A			HOB↑	None	—			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/6/13 1940	MDI	6 puffs albuterol	93	16	—		/	Sm mod amt light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles Ø Δ			HOB↑	Ø	SpO2=98%			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/7/13 0820	MDI	6 puffs albuterol	89	16	SpO2=99%	3L	/	Sm mod amt light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB↑	None	Trach care done			Poor Fair (Good) Therapist: [illegible]
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/7/13 1310	MDI	6 puffs albuterol	79	16	SpO2=99%	3L	/	Sm mod amt light yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
Crackles No Δ			HOB↑	None	—			Poor Fair (Good) Therapist: [illegible]

KENDRICK, KENNETH
AH 000 214 113 ADM 6-18-13
DOB 5-27-72
MCD 0634246001

ARKANSAS HEALTH CENTER

Benton, Arkansas

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/7/13 1950	MDI	Albuterol 6 puffs	94	16	SpO2 = 99%	3LPM	/	Sxn large amt pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse ↓			HOB↑	0	Teach Care done			Poor Fair (Good)
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/8/13 1000	MDI	Albuterol x 6 puffs	100	16	SpO2 = 98%	3Lpm	/	Sxn moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles no ↓			HOB↑	None	teach care/ oral care done			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/8/13 1250	MDI	Albuterol x 6 puffs	98	16	SpO2 = 98%	3Lpm	/	Sxn moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles no ↓			HOB↑	None	—			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/8/13 2035	MDI	Combivent	93	16	SpO2 99%	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
crackles ↓			HOB↑	0	Teach Care done			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/9/13 0120	MDI	Combivent	100	16	SpO2 99%	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
crackles ↓			HOB↑	0	—			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/9/13 1020	MDI	Albuterol x 6 puffs	100	16	SpO2 = 98%	3Lpm	/	Sxn moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles no ↓			HOB↑	None	teach, care/ oral care done			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/9/13 1410	MDI	Albuterol x 6 puffs	102	16	SpO2 = 99%	3Lpm	/	Sxn moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
coarse crackles no ↓			HOB↑	None	—			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/9/13 2045	MDI	Combivent	99	16	SpO2 99%	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
crackles ↓			HOB↑	0	Teach Care done			Poor Fair (Good) Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/10/13 0120	MDI	Combivent	100	16	—	3Lpm	—	mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
crackles ↓			HOB↑	0	SpO2 99%			Poor Fair (Good) Therapist:

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES
THERAPY RECORD

[redacted]
MCD 063424[redacted]
MCR 431629062C1
IDENTIFICATION STAMP

Type of Therapy: _____
Frequency: _____
Medications: _____
Pressure: _____
Special Instructions: _____

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/10/13 0815	MDI	4 puff albuterol	98	16	SPO2 = 100%	3L	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse -- NO Δ			HOB ↑	None	Tolerated well			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/10/13 1300	MDI	4 puff albuterol	96	16	SPO2 = 100%	3L	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse -- NO Δ			HOB ↑	None	—			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/11/13 0815	MDI	4 puff albuterol	81	16	SPO2 = 100%	3L	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse Crackles --			HOB ↑	None	Tolerated well			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/11/13 1240	MDI	4 puff albuterol	87	16	SPO2 = 100%	3L	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Crackles -- NO Δ			HOB ↑	None	—			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/12/13 0815	MDI	Albuterol 4 puffs	84	18 / 16	SpO2 = 98%	3Lpm	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse crackles -- NO Δ			HOB ↑	NONE	Tolerated treatment by CF			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/12/13 1400	MDI	Albuterol 4 puffs	72	16	SpO2 = 99%	3Lpm	1	SxN moderate amount of pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse crackles -- NO Δ			HOB ↑	None	—			Poor Fair Good Therapist:
Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/12/13 2050	MDI	[illegible]	98	16	Spo2 98%	3Lpm	1	[illegible]
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
-- Coarse crackles -- Δ			HOB ↑	None	Tolerated well			Poor Fair Good Therapist:

ARKANSAS HEALTH CENTER

Benton, Arkansas

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/13/13 0120	MDI	Albuterol	90	16		3L/m		mod pale yellow
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			Tolerated
- - CNS - crackles - - - -			HOB↑	∅	Spo2 100%			Poor Fair Good
Therapist:								
7/13/13 0445	MDI	Albuterol x 6 puffs	74	16	SpO2 = 98%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			SxN moderate amount of pale yellow
- - - coarse crackles - - - -			HOB↑	None	Mask removed for			Tolerated
Therapist:								Poor Fair Good
7/13/13 1445	MDI	Albuterol x 6 puffs	76	16	SpO2 = 97%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			SxN moderate amount of pale yellow
- - - coarse crackles - - - -			HOB↑	None				Tolerated
Therapist:								Poor Fair Good
7/13/13 2015	MDI	Albuterol	78	16	SpO2 99%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			mod pale yellow
- - CNS - crackles - - - -			HOB↑	∅	Mask Care done			Tolerated
Therapist:								Poor Fair Good
7/14/13 0120	MDI	Albuterol	89	16	SpO2 99%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			mod pale yellow
- - CNS - crackles - - - -			HOB↑	∅				Tolerated
Therapist:								Poor Fair Good
7/14/13 0950	MDI	Albuterol x 6 puffs	77	16	SpO2 = 99%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			SxN moderate amount of pale yellow
- - Coarse - - - - - - - -			HOB↑	None	Mask, nasal drop/oral suction			Tolerated
Therapist:								Poor Fair Good
7/14/13 1445	MDI	Albuterol x 6 puffs	76	16	SpO2 = 99%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			SxN moderate amount of pale yellow
- - coarse - - - - - - - -			HOB↑	None	error			Tolerated
Therapist:								Poor Fair Good
7/14/13 2025	MDI	Albuterol	89	16	SpO2 98%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			mod pale yellow
- - - CNS crackles - - -			HOB↑	∅	Mask Care done			Tolerated
Therapist:								Poor Fair Good
7/15/13 0125	MDI	Albuterol	80	16	SpO2 98%	3L/m		Describe: Cough-Sputum
Breath Sounds (Pre-Post)			Pt's Position	Adverse Reactions	Comments:			mod pale yellow
- - crackles - - - -			HOB↑	∅				Tolerated
Therapist:								Poor Fair Good

KENDRICK, KENNETH WM
NH 000-214-113 ADM 6-18-13
DOB 5-21-72
MCD 0634246001
MCR 431829662C1

IDENTIFICATION STAMP

Arkansas Health Center

Benton, Arkansas

RESPIRATORY CARE SERVICES THERAPY RECORD

Type of Therapy: ______

Frequency: ______

Medications: ______

Pressure: ______

Special Instructions: ______

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum
7/15/13 0820	MDI	[illegible] albuterol	95	16	SPO2 98%	3L	/	[illegible] mod [illegible] lt yell

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
Crackles [illegible]	HOB ↑	None	Trach care done	Good (circled); Therapist: [illegible]

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

Date/Time	Treatment	Medications	Heart Rate	Respiratory Rate	Peak Flow (Pre-Post)	F1/O2	Volume	Describe: Cough-Sputum

Breath Sounds (Pre-Post)	Pt's Position	Adverse Reactions	Comments:	Tolerated: Poor Fair Good
				Therapist:

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administrative	Resident Observation	AP 406

PURPOSE. The purpose of this policy is to provide guidelines for monitoring residents for medical or behavioral reasons.

SCOPE. This policy is applicable to all Arkansas Health Center (AHC) personnel.

POLICY. All AHC residents requiring medical or behavioral observation will be accounted for as determined by the physician's order. There are three levels of documented monitoring. These levels range in degree of staff to resident observation. The use of one to one observation, line of sight or visual contact and time check observation of residents will be provided for medical or behavioral reasons when ordered by a physician. Note: In cases of emergency when a physician is unable to be obtained within the first 15 minutes of the event, a nurse may institute this procedure. However, a physician's order must be obtained via telephone before the end of that nurses' shift or the resident will not remain on an ordered observation. Once the physician's verbal order has been obtained, it must be signed by the physician within 7 days.

A. Time Check Observation is the observation of a resident at least every 15 or 30 minutes for the purpose of monitoring the resident's behavioral and/or medical condition. Time check observation will require the assignment of a staff member to observe and briefly evaluate the resident at least every 15 or 30 minutes as ordered by the physician.

B. Line of Sight Supervision or Visual Contact is the continuous observation of up to three residents by one staff member for the purpose of monitoring the behavioral and/or medical conditions. There is no defined distance between the observer and residents, but the observer must be able to see the actions of all residents assigned at all times.

C. One-to-One Observation is the constant observation of a resident by staff for the purpose of continuous monitoring of the resident's behavioral and/or medical condition. One-to-one observation will require the assignment of staff to be within close proximity (approximately within arm's length) and have constant visual observation of the resident at all times, unless otherwise specified by a physician order.

   One to One Observation may be modified by a physician' order according to the individual resident in cases where arm's length is determined to cause agitation, aggression, or anxiety. When performing one to one observation, staff should NEVER leave the resident alone regardless of the amount of space deemed appropriate between the assigned staff member and the resident. One to one observation is ordered for the purposes of ensuring safety of the resident and others. The assigned staff member should be aware of the resident's behavioral

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EXHIBIT
DHS 30

and/or medical status at all times so they can intervene in a quick and effective manner when necessary.

PROCEDURE.

A. The use of time check observation, line of sight/visual contact observation, or one-to-one observation will be based upon the clinical assessment of the resident by the physician and will require a physician's order.

B. The physician's order will include the specific level of observation, the duration of the observation and reason for the observation.

C. The physician must reassess the resident within 72 hours of the initial order for the specified type of observation. The physician will write a one to one modification order if one to one continues to be required and arms length proximity is determined to be too close for medical or behavioral reasons.

D. The physician will document in the Physician Notes the rationale for use of the specific observation technique.

E. The order will stand as written and will be reviewed at least every seven days after the initial 72 hour reassessment period.

F. The assigned staff (Nursing, Social Work or Psychology) will monitor the resident for suicidal ideation or attempt, escape intent or attempt, or any other behavioral or medical problems, and report any occurrences of the above to the nurse immediately. The assigned staff will document the resident's behavior every 15 minutes on the AHC 1160-C.

G. Nursing personnel will document the status of the resident at least one time per shift in the Nurse's Notes.

H. The nurse will document on the Behavior Report Form what interventions were utilized and the resulting outcomes.

I. A resident on one-to-one observation is restricted to the building except for medical emergencies or appointments unless otherwise specified in the physician's orders (e.g. smoking privileges).

J. One to one resident observation orders written by a physician are to be verified by the on duty RN or LPN supervisor before the staffing coordinator assigns extra staff to any building on any shift.

(1) The unit nurse on duty will contact the designated RN or LPN Supervisor to advise of the number of CNA's present on the unit and to request additional assistance as needed to comply with the physician's order.
(2) The RN or LPN supervisor will direct the staffing coordinator to assign staff as available.
(3) The "pulled" or agency staff member will be instructed by the unit nurse what behaviors or medical issues are to be addressed, observed and reported to the nurse.

K. If the time check observation, line of sight/visual contact or one-to-one observation does not appear to provide the level of protection required, the assigned staff will notify the nurse who will notify the physician.

L. If a resident requires indefinite or long term one-to-one observation for medical purposes such as prevention of falls, they should be assessed by appropriate medical professionals for alternate sources of safety (e.g. obtain a physician's order for an evaluation by the appropriate rehabilitation professional, etc.). The procedure should be utilized to attempt the least restrictive protective devices. The physician should write an order for a modified one to one if this type of observation continues to be required, but there is no reason for the assigned staff to be within arms length.

M. If a resident requires indefinite or long term one-to-one observation for behavioral purposes such as aggressive behaviors, suicidal ideation or attempt, self-injurious behaviors, etc., then the resident should be referred for appropriate behavioral interventions (Social Services or Psychology Consult Services). This procedure should be utilized to attempt the least restrictive services.

N. All residents requiring time check observations, line of sight/visual contact observation or one-to-one observation should be reviewed on a weekly basis at the Care Team Meeting with the goal of attempting to find alternative methods of treating the resident and providing a safe environment for the resident and the other residents of the unit.

Jay Weed
AHC Director

11/29/12
Date

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administration	Accounting for Residents	AP 500

1. PURPOSE: The purpose of this policy is to establish procedures to insure the safety and accountability of all residents

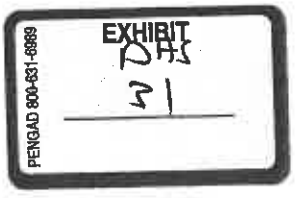
2. SCOPE: Nursing, Activities, Social, Rehabilitation Therapy, Administrative Assistants, Maintenance, Public Safety Officers, Administrative Staff, Physicians, Psychology and Supervisory Staff of All Departments.

3. POLICY: It is the policy of Arkansas Health Center to maintain accountability for all residents.

4. PROCEDURE:

1. Nursing personnel will conduct rounds and document on the Resident Check list every 2 hours from 7 a.m. to 7 p.m. and every hour from 7 p.m. to 7 a.m. to account for all residents on the assigned unit. The on-coming nurse will be informed of any resident on leave of absence or off the unit.
2. A Therapeutic Leave of Absence Form will be kept at the nurse's station. Residents leaving the unit for activities, appointments, therapy, or therapeutic leave will be signed out on the Therapeutic Leave of Absence Form and will be signed back in upon return to the unit. The person taking the resident off the unit will sign the resident out and the person returning the resident to the unit will sign the resident in. This includes but is not limited to the following:
    a. Pathfinders
    b. Therapy
    c. Activities
    d. Arts and Crafts
    e. Dentist
    f. X-ray
    g. Clinic Appointments
    h. Out on pass with family (dinner, shopping, home, etc)
3. Residents requiring a security alarm bracelet to alert staff of attempts to leave the unit without supervision:
    a. The nurse will obtain an order from the physician for the security alarm bracelet
    b. The family or representative will be notified of the need for the bracelet
    c. Prior to placing the security alarm on the resident, the nurse will test the alarm by activating the alarm on exit doors of the unit to insure proper functioning.
    d. Each resident who has a security alarm will have that number logged in the nursing service office in the security alarm bracelet book
    e. Security alarm bracelet placement checks will be conducted every shift and recorded on the Special Device Flow-sheet.
    f. Nursing will check each resident's alarm bracelet weekly to insure the alarm activates exit doors on the assigned unit. Alarm checks will be recorded on the special device flow sheet. In the event the alarm does not activate, a new bracelet will be tested and then placed on the resident.

Revised March, 2012
Effective: July 10, 2007
Replaces NS-105



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g. In the event the door alarm is activated, staff will immediately respond to determine what activated the alarm. Authorized staff will de-activate the alarm and notify the RN or LPN on duty. If the cause for the alarm is not readily determined and corrected, assigned staff will immediately account for all unit residents with security alarm bracelets.

h. Nursing, Agency, Social Services, Rec. Activity, Hab/Rehabilitation Therapy, Public Safety Officers, Administrative Assistants, Maintenance personnel, Psychology, Physicians, Administrative Staff and Supervisory Staff of all Departments are authorized to turn off or re-set door alarms. All other disciplines **MAY NOT** turn off or re-set an alarm.

i. Any malfunction with the door alarm will be reported to the maintenance department. In the event the door alarm does not activate (due to activation of a fire alarm or malfunctioning) an employee will be assigned to monitor each exit door to prevent residents from exiting the unit unsupervised.

j. A maintenance representative will go unit to unit every Friday and check door alarms to ensure proper functioning. It will be announced prior to the alarm testing. This person will be allowed to reset the alarm upon testing.

AHC Facility Director

3/11/12
Date

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Ventilator/Respiratory Care Schedule	NS 602

1. PURPOSE: The purpose of this policy is to ensure continuity of care for residents in the respiratory care unit/Willow.

2. SCOPE: Performed by specifically trained licensed staff or Respiratory Therapist

3. POLICY: These standards of care are to be followed and maintained unless otherwise ordered by the physician.

4. PROCEDURE:
   A. Tracheostomy care will be done each shift or as ordered by the physician. The use of sterile water for trach care instead of sterile normal saline is permitted.

   B. Trach changes are done as deemed necessary or every 3 months. Check for placement, air leakage, and proper functioning every shift and be constantly alert to signs of malfunctioning or reduced ventilation to resident.

   C. Circuit changes are to be made monthly and PRN. Vent/Circuit checks will be done every 12 hours and PRN. This will be documented on the vent check sheet

   D. Chamber changes are to be made monthly and PRN. Temperature should be set so that inspired gas delivered is 28-37 degrees C.

   E. If indicated, suctioning is to be done using five to ten cc's of normal saline lavage with intermittent breathing either by vent or ambu bag. If plugging or excessive thick secretions are present, deep breaths by ambu bag will be more effective. Suction PRN. Yankauers may be used for oral suctioning. Discard weekly or as needed. Do NOT ever suction oral cavity and move to trach suctioning without changing the catheter.

   F. Suction canisters are to be changed weekly and PRN.

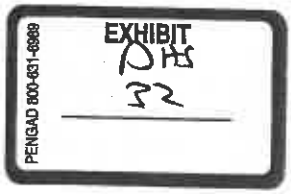
   G. Suction tubing is to be changed weekly and PRN.

   H. In-line suction catheters are to be changed once weekly.

   I. Sighing is deep manual breaths by ambu bag. This is done PRN for signs of distress or at the request of the resident. Sighing during suctioning will help to remove secretions and aid in lung expansion. Sighing is done as ordered to prevent pneumonia and maintain resident comfort.

   J. Residents will be on room air unless oxygen is ordered by the physician. If oxygen concentrator machine is used, the filters on it must be removed, washed with soap and water, dried, and replaced every week.

   K. Ventilator settings are done by respiratory therapist or licensed nurse. These settings are changed only when directed to do so by a physician.



L. Sp02 check is to be done with Pulse Oximeter as ordered by the physician. The level may be checked on a resident anytime they show signs of distress or for reassurance of resident or staff. Guidelines are present on the machine.

M. Do NOT change or adjust ventilator settings without a physician order.

N. Keep ventilator carts free of excess materials and dust.

5. DOCUMENTATION:

A. Document in the Respiratory Therapy Notes if the resident has required ambu-bag use.

B. Document in the Respiratory Therapy Notes results of Sp02.

Director of Nursing	Lisa Campbell RN	**Date** 4/26/12
Director	Jay Hill	**Date** 6/01/12
	M Ally	5/12/12

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Charting/Nurse's Notes	NS 1301

1. PURPOSE: It is the purpose of this policy to establish a mechanism for communication among members of the health care team; to provide pertinent, accurate, and current information about the resident; to assure a mechanism for the evaluation of individual resident care; to provide a permanent legal record of the care provided to the resident; to improve the quality of nursing documentation; to maximize the nurse's time for high quality care; to improve quality of professional practice; and to prevent duplication of information. Professional responsibility and accountability are among the most important reasons for accurate documentation. Documentation is a part of the nurse's total responsibility of care. The purpose of documentation is to describe the nursing care of the resident outcome. The medical record facilitates care, enhances continuity of care, and helps to coordinate the treatment and evaluation of the resident.

2. SCOPE: All licensed staff.

3. POLICY:

A. Every caregiver places the date and time of each entry in the Nurses' Notes and signs their name and title at the end of each note.

B. All documentation is to be neat and legible.

C. Only black ballpoint pen is to be used for writing in the medical record.

D. Ink eradicators are not to be used.

E. Narrative nursing notes on the resident's current status and progress toward achievement of goals include:

1. Applicable comments made by the resident that address his or her goal achievement (subjective data).
2. Data observed by the licensed nurse regarding the resident's problem/behavior/goal achievement: examples: physical assessment data, lab data, etc. (objective data).
3. A description of the nurse's approaches used to attain the goal and/or manage the identified problem(s)/behavior(s).
4. An assessment of the effectiveness of the approaches used to manage the identified problem(s)/behavior(s).
5. A modification of the identified goal and/or approaches based upon nursing assessment is documented when applicable.

F. There is at least a 2 week narrative nursing note describing the resident's mental status during the previous two weeks.

G. There is at least a 2 week narrative-nursing note describing the resident's response to changes in medications and/or treatments that were implemented during the previous two weeks.

H. There is at least a 2 week narrative nursing note summarizing the usage of physical and/or chemical restraints during the previous two weeks.

I. Each resident's medical record has a narrative nursing note completed by a night shift licensed staff member at least every 2 weeks that focuses on the resident's night time behavior, sleep patterns, activity, pain, continence, etc.

J. During the 2 week narrative, a complete picture of all aspects of daily living, nursing care provided etc. will be documented on each resident.

K. Daily or PRN charting will be done when the following occurs on any resident:

1. Episodes of acute illness occur – these will be documented every shift until the illness is resolved.
2. Doctor visits or out-to-doctor office visits (time left and returned with notation of new orders) will be documented.
3. Completed lab work will be documented.
4. When a resident is out on pass, the time they left, returned and the destination will be documented. List medications by the name and number of each medication sent out with the resident. Upon return, medications are to be listed and number returned documented.
5. Refusal of medication, treatments, meals, baths, etc. should be documented.
6. Change in condition including notification of physician and family or responsible party should be documented.
7. When a PRN IM medication is given, the site of injection and effectiveness after 30-60 minutes of injection should be documented in the medical record.
8. Unusual occurrences, incidents and accidents will be followed up on and documented on for at least 48 hours or as long as necessary.
9. H.S. snacks for residents receiving therapeutic diets will be documented in the chart.
10. Variances from regular appetites will be recorded.
11. Indwelling catheters, catheter irrigation and urine output may be documented on appropriate flow sheets unless there are abnormal findings and then it will be documented in the nurse's notes
12. Treatments may be documented on the appropriate flow sheet unless there are abnormal findings and then it will be documented in the nurse's notes
13. Any variances in mental status will be documented.
14. Weight gains or losses in excess of 5% in 1 month, 7.5% in 3 months and/or 10% in 6 months.

L. Legal Aspects of Charting:

1. Write neatly and legibly.
2. Use proper spelling and grammar.
3. Document in black ink and use military time.
4. Use a minimal of authorized abbreviations.
5. Make sure the resident's name is on every sheet in the medical record.
6. Transcribe orders carefully. Although other licensed staff may transcribe orders, the RN has the ultimate responsibility for the accuracy of the transcription.

Guidelines for the transcription of orders include:

a. Think through the orders and question inappropriate ones.
b. If a physician's order is unclear, ask the physician who wrote the order to clarify it.

7. Document complete information about medications. For each medication administered, document the date, time and your initials. Document sites for all intramuscular and subcutaneous injections. Document the reason why medications were omitted. Document the reason that led up to a decision to withhold a medication. If you are unable to reach the physician and decide to withhold a medication, write in the nurse's notes that you attempted to reach the physician and your reason for withholding the medication (e.g. withholding Digoxin due to a pulse rate of 48).

8. Document promptly. Chart as close as to the time you make an observation or provide care as possible.
9. Chart after the delivery of nursing care.
10. Identify late entries correctly. The procedure for adding late entries is:
    a. Add the entry to the first available line.
    b. Label the entry "Late Entry" to indicate it is out of sequence.
    c. Record the time and date of the entry.
    d. In the entry, record the time and date it should have been made.
11. Correct mistaken entries properly. Procedure for correcting mistaken entries:
    a. Draw a single line through the entry so that it is still readable.
    b. Write the words "mistaken entry or M.E." above the original entry.
    c. Place the date and your initials next to the words mistaken entry/M.E.
12. Do not tamper with medical records. Tampering with the medical record involves:
    a. Adding to the existing record at a later date without indicating the addition is a late entry.
    b. Placing inaccurate information into the record.
    c. Omitting significant facts.
    d. Dating a record to make it appear as if it were written at an earlier time.
    e. Rewriting or altering the record.
    f. Destroying records.
    g. Adding to someone else's notes.
13. Chart only care you provide or supervise (A.M. care provided by J. Doe, C.N.A.).
14. Avoid using the medical record to criticize nurses, physicians or other professionals.
15. Fill in appropriate blanks on flow sheets.
16. Avoid using words that reveal negative attitudes toward the resident such as lazy, demanding, nasty, and disagreeable, etc.
17. Be precise in documenting the information you report to the physician. It is a legal "must" to chart every substantive conversation you have with a physician about a resident. Always document on the record the time of a phone call informing a physician of a change in the resident's condition or a critical abnormal laboratory value, etc. After notifying the physician, write, "Dr. Smith notified of resident's symptoms: BP 90/40, pulse 120, pale, clammy skin. No new orders received."

M. INFORMATION THAT SHOULD BE INCLUDED IN NURSES' NOTES:

1. Record information on the nurses notes that IS NOT already recorded on flow sheets. Flow sheet information needs to be included in the nurses notes only when there is a change in the resident's condition such as a change in BP, nausea and/or vomiting, change in appearance of urine from a catheter, change in IV site, foul smelling drainage from decubitus, etc.
2. Document resident's response to nursing interventions that are addressed on the care plan (e.g. decubitus shows no signs of infection, resident has shown no aggressive behavior this shift, etc.).
3. Identify a specific time for each entry NO BLOCK CHARTING.
4. Physician's visits are to be recorded in the nurse's notes.
5. Use specific, definitive words when describing a resident's condition or status. Document objective and subjective observations.

6. Avoid the use of phrases such as "had a good day." Use professional, objective language.
7. When documenting a problem always describe the nursing intervention. (E.g. Shortness of breath, oxygen started at 4 liters).
8. Describe the follow through on a request for medical or nursing orders.
9. Describe follow through on abnormal diagnostic findings (lab, x-ray, TB skin test, accu checks, etc.). Document the physician was notified and the response to the interventions if applicable.
10. Fully describe symptoms that indicate the need to change medications or other interventions (0730 – Resident does not respond to verbal stimuli. Vital signs are: BP 90/40, Respirations 12, and Pulse 58. Dr. Smith notified. Order received to withhold Haldol until further notice).
11. When any of the following occurs, it must be documented on all residents at the time of occurrence and follow up will be required on each shift according to the resident's condition:
    a. Episodes of acute illness. Charting will be done at a minimum of every shift until the resident's condition improves.
    b. Doctor visits or appointments outside the facility, to include the time left and returned and notation of new orders.
    c. Lab work completed and by whom.
    d. Out on pass_____ Time left, time returned and the destination. Medication taken with the resident will be listed by name, number of tablets, capsules, etc. Upon return, the medication will be listed by name and the number of each that were returned.
    e. Refused medication. The RN on duty will be notified and the physician will be notified at their discretion.
    f. Refused treatments, baths, meals, etc.
    g. Change in the resident's condition. Include notification of physician and family.
    h. PRN medications, medication strength, time, reason for administration, route of administration, and the effectiveness, will be documented on the PRN medication sheet. (The injection site will be documented in the Nurses Notes).
    i. Unusual occurrences, accidents, and incidents will be followed up each shift for at least 24 hours, or longer as deemed necessary, to include treatment provided, if the resident is transferred to the hospital or taken to a physician's office, etc.

6. Documentation
    a. Document daily in the nurse's notes as necessary and according to skill level per Regulatory Requirement.
    b. A nursing summary flow sheet & sleep note is to be completed every 2 weeks on each resident

Director of Nursing	Teena Campbell	**Date** 7/3/12
Director	Jay Hill	**Date** 6/14/12
Medical Director	M. Gallego	**Date** 6/14/12

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Head To Toe Assessment Criteria	NS 302

1. PURPOSE. A Full MDS Assessment, the first step in the nursing process, is completed on each Resident on admission, quarterly, annually, and when a change in condition occurs.

2. SCOPE. MDSC

3. POLICY. The Minimum Data Set (MDS) Form is used to record patient information obtained during the nursing assessment & initial 24 hour MDS assessment. The MDS Form becomes a permanent part of the medical record.

4. PROCEDURE

   A. A registered nurse initiates a nursing assessment on newly admitted Residents.
   B. The MDS Form is used as baseline information for initiation of the Nursing Care Plan.
   C. Information, which must be obtained over a period of time, is added to the assessment form by the nurse obtaining the information.
   D. Initial 24 hour care plan assessment must be completed with in 24 hours of admission
   E. MDS and care plan must be completed within 21 days of admission.
   F. Nurses on all shifts are requested to participate in the Resident assessment process as needed.
   G. The Care Area Assessment Summary (CAA) of the MDS is completed within the first fourteen (14) days by the MDSC.
   H. The Care Area Assessment Narrative (Form #1047) is completed and placed in the medical records with the MDS.
   I. For each 90-day review by the team, the quarterly MDS and review must be completed by the MDSC. The care plans are updated and review notes are written by each discipline.
   J. The MDS Form is placed in the medical record with the care plan.
   K. The MDS Assessment is required annually (365 days or less) on each resident.
   L. All MDS and Care Plan information for each individual resident is kept in individual binders at the nurses' station.

5. Head To Toe Assessment

   A. General Appearance
      1. Observation – age, race, nutritional status, development
      2. Color – pink, pale, red, jaundiced, mottled, blanched, cyanosis
      3. Skin – pigmentation, vascularity, temperature, texture, turgor, lesions (type, color, size, shape, distribution), bruises, bleeding, scars and edema.

   B. Vital Signs
      1. Temperature
      2. Pulse – apical, radial (others when appropriate)
      3. Respirations
      4. Blood Pressure – supine, sitting, right and left arms
      5. Height and weight

C. Head and Face
1. Size, contour, symmetry, color, pain, tenderness, lesions, edema
2. Scalp – color, texture, scales, lumps, lesions inflammation
3. Face – movement, expression, pigmentation, acne, tics, tremors, scars

D. Eyes
1. Acuity – visual loss, glasses, contacts, prosthesis, diplopia, photophobia, color vision, pain and burning
2. Eyelids – color, ptosis, edema, styes and exophthalmos
3. Extra ocular movement – position and alignment of eyes, strabismus nystagmus
4. Conjunctiva – color, discharge, vascular changes
5. Iris – color, markings
6. Sclera - color vascular, jaundice
7. Pupils – size, shape, equality, reaction to light

E. Ears
1. Acuity – hearing loss, aid, pain, tinnitus, sensitivity to sound
2. External ear – lobe, auricle, canal
3. Inner ear – vertigo

F. Nose
1. Smell – nasal size, symmetry, flaring, sneezing, deformities
2. Mucosa – color, edema, exudate, bleeding, furuncles, pain, tenderness
3. Sinus tenderness – pain

G. Mouth and Throat
1. Odor, pain, ability to speak, bite, chew, swallow, taste
2. Lips –color, symmetry, hydration, lesions, crusting, fever blisters, cracking, swelling, numbness, drooling
3. Gums – color, edema, bleeding, retraction, pain
4. Teeth – number, missing, caries, caps, dentures, sensitivity to heat and cold
5. Tongue – symmetry, color, size hydration, markings, protrusion, ulcers, burning, swelling, coating
6. Throat – gag reflex, soreness, cough, sputum, hemopytsis
7. Voice – hoarseness, loss, change in pitch

H. Neck
1. Symmetry, movement, range of motion, masses, scars, pain, stiffness
2. Trachea – deviation, scars
3. Thyroid - size, shape, symmetry, tenderness, enlargement, nodules, scars
4. Vessels (carotid, jugular – quality, strength and symmetry of pulsation, bruits, venous distention
5. Lymph nodes – size, shape, mobility, tenderness, enlargement

I. Chest
   1. Size, shape, symmetry, deformities, pain, tenderness
   2. Skin – color, rashes, scars, hair distribution, turgor, temperature, edema
   3. Breasts – contour, symmetry, color, size, shape, inflammation, scars, masses (location, size, shape, mobility, tenderness), pain, dimpling, swelling
   4. Nipples – color, discharge, ulceration, bleeding, inversion, pain
   5. Axillae – nodes, enlargement, tenderness, rash, inflammation

J. Lungs
   1. Breathing patterns – rate, regularity, depth, ease, normal, use of accessory muscles
   2. Sounds – normal, intensity, pitch, quality, duration, equality vocal resonance

K. Heart
   1. Cardiac patterns – rate, rhythm, intensity, regularity, skipped or extra beats
   2. Implanted pacemaker

L. Abdomen
   1. Size, color, contour, symmetry, fat, muscle tone, turgor, hair distribution, scars, umbilicus, striae, fetus, rashes, distention, abnormal pulsation
   2. Sounds – absent, hypoactive, hyperactive, normal, bruit
   3. Liver – gastric air bubble, air fluid, muscle spasm, rigidity, masses, guarding, tenderness, pain, rebound, bladder distention

M. Kidney
   1. Urinary output (amount, color, odor, sediment), frequency, urgency, hesitancy, burning, pain, dribbling, incontinence, hematuria, nocturia, oliguria

N. Genitalia
   1. Female – labia majora, minora, urethral and vaginal orifices, discharge, swelling, ulceration, nodules, masses, tenderness, pain
   2. Male – penis: discharge, ulceration, pain; scrotum: color, size, nodules, swelling, ulceration, tenderness; testes: size, shape, swelling, masses, absence

O. Rectum
   1. Pigmentation, hemorrhoids, excoriation, rashes, abscess, pilonidal cyst, masses, lesions, tenderness, pain, itching, burning

P. Extremities
1. Size, shape, symmetry, range of motion, temperature, color, pigmentation, scars, hematoma, bruises, rash, ulceration, numbness, paresis, swelling, prosthesis, fracture
2. Joints – symmetry, active and passive mobility, deformities, stiffness, fixation, masses, swelling, fluid, bogginess, pain, tenderness
3. Muscles – symmetry, size, shape, tone, weakness, cramps, spasms, rigidity, tremor

Vessels – symmetry and strength of pulses, venous filling, varicosities, phlebitis

Q. Back
1. Scars, sacral edema, spinal abnormalities, kyphosis, scoliosis, tenderness, pain

6. Predisposition for falling forms, assessment for Altered Skin Integrity, and the list of approved Nursing Diagnosis will be used as needed.

Director of Nursing	[signature]	**Date** 4/26/12
Director	[signature]	**Date** 5/2/12

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Vital Signs and Weights	NS 901

1. PURPOSE. It is the purpose of this policy to ensure that accurate vital signs and weights are taken routinely, and when there is change in the resident's medical status.

2. SCOPE. All Nursing Staff

3. POLICY. Vital signs will be taken at the time of admission and every shift for the first week. The weight will be taken at the time of admission.

   A. Vital signs will be taken every shift or PRN until afebrile for 48 hours on residents receiving antibiotic therapy.

   B. Vital signs will be taken and documented at least once a shift, or as ordered by the MD / RN, anytime there is a change in a resident's condition.

   C. Temperature will be taken and recorded at least every shift, or as ordered by the MD / RN, on any resident with a temperature elevation. It is recommended the temperature will be taken rectally using a rectal thermometer.

   D. Blood pressure and apical pulses will be taken as required by the medication regime.

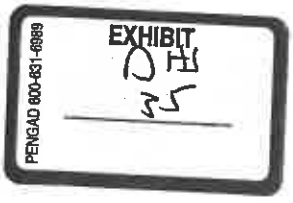
   E. Vital signs will be taken and recorded, in the Nurses' Notes, Vital Sign Flow-sheet, and the Accident or Injury report Form, any time there is an injury or accident.

   F. Routine vital signs, to include temperature, pulse, respiration, pulse ox and blood pressure, will be taken and recorded weekly, or as ordered by the physician or RN on all residents.

   G. Routine weights will be taken monthly and/or ordered by the physician or RN on all residents. Residents returning from the hospital will be weighed the day they return to the unit and this weight will be documented.

4. PROCEDURE.

   A. Assemble equipment
      1. Thermometer (Temp Plus II, Portable Rosie Machine, or disposable thermometer)
      2. Lubricant, if applicable
      3. Ivac cover
      4. Paper Towels
      5. Gloves
      6. Stethoscope
      7. Sphygmomanometer
      8. Alcohol sponges



Documentation

a. Document on the appropriate flow sheet (Vital sign record, weight form etc)
b. Nurse will document abnormal findings in the nurses notes and notify the MD
c. Update care plan as needed

Director of Nursing — Date 7/3/12

Medical Director — Date 6/21/12

Facility Director — Date 6/18/12

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	**BLOOD SUGAR MONITORING**	NS 205

1. PURPOSE: To monitor blood glucose levels

2. SCOPE: All licensed personnel (RN & LPN)

3. POLICY: INSERT AND FOLLOW THE MANUFACTURER'S INSTRUCTIONS FOR THE TYPE OF EQUIPMENT USED IN THE FACILITY. NOTE: BLOOD GLUCOSE LEVELS FOR RESIDENTS WITH DIABETES VARY, DEPENDING ON FOOD INTAKE, INSULIN DOSE, AND EXERCISE. TARGET GLUCOSE LEVELS SHOULD BE ESTABLISHED BY THE RESIDENT'S ATTENDING PHYSICIAN.

4. PROCEDURE:
   A. Gather Equipment
      * Tissues
      * Disposable gloves
      * Alcohol wipes
      * Accu-check machine
      * PDI Super Sani-cloth wipes

   B. Check physician's order for blood sugar testing.
   C. Explain procedure and provide privacy
   D. Wash hands before and after procedure
   E. Put on gloves.
   F. Follow manufacturer's directions for the equipment used in your facility.
   G. Discard used lancet in container of used needles.
   H. Check puncture site to be sure bleeding has stopped.

5. DOCUMENTATION:
   1. Document on the Diabetic Flow sheet the Date, time (or shift), and glucose level as appropriate.
   2. Document on the Diabetic Flow sheet (if insulin is ordered based on a sliding scale, or as scheduled) the type and amount of insulin administered and the site of injection.
   3. Document in the nurses notes if blood glucose level is above or below normal range, document the time the physician was notified.
   4. Document on the diabetic flow sheet signature and title.

GENERAL INFECTION CONTROL GUIDELINES

1. Observe (standard) universal precautions.
2. Wash your hands before and after all procedures.
3. Clean and dry skin well before procedure.
4. Dispose of disposable equipment appropriately.
5. Thoroughly clean all equipment used and return to appropriate storage area.
6. Dispose of soiled linen appropriately.
7. Dispose of needles and sharps appropriately.

Revision Date: June 2012
Effective Date: September, 1998 (REPLACED/SUPERSCEDES NS 205 NOSE BLEEDS)

SIGNATURE PAGE:

Director of Nursing — Date: 7/3/12

Medical Director — Date: 6/21/12

Facility Director — Date: 6/18/12

Revision Date: June 2012
Effective Date: September, 1998 (REPLACED/SUPERSCEDES NS 205 NOSE BLEEDS)

ARKANSAS HEALTH CENTER
VENTILATOR FLOWSHEET

Identification Stamp

PHYSICAN ORDERS			
VENT:	LTV	PEEP:	+5
MODE:	SimV	INSP. TIME:	1.0
RATE:	16	SET VT / INSP PRESSURE:	—
TIDAL VOLUME:	850	HI PRESSURE:	70
FI O2:	3Lpm	LO PRESSURE:	5
SpO2 CHECKS:	—	OTHER:	

LICENSED STAFF SIGNATURE	INITIALS
[illegible]	KC
[illegible]	Dr
Paul [illegible]	PM

DATE	7/13/13	7/13/13	7/14/13	7/14/13	7/15/13											
TIME	1000	2035	950	2025	0820											
VENT	LTV	LTV	LTV	LTV	LTV											
MODE	SimV/5	SIMV/5	SimV/+5	SimV/+5	SimV +PS											
SET RATE	16	16	16	16	16											
ACTUAL RATE	16	16	16	16	16											
TIDAL VOLUME	553	597	527	599	253											
SET VT / INSP PRESSURE	850	850	850	850	850											
INSP. TIME	1.0	1.0	1.0	1.0	1.0											
FI O2	3Lpm	3Lpm	3Lpm	3L/m	3L											
PIP	39	40	41	27	28											
PEEP	+5	5	+5	5	5											
SENSITIVITY	2	2	2	2	2											
PRESSURE ALARM HI	70	70	70	70	70											
PRESSURE ALARM LO	5	5	5	5	5											
WATER LEVEL	✓	✓	✓	✓	✓											
TUBES DRAINED	✓	✓	✓	✓	✓											
AIRWAY TEMP	35	35°	35°	35°	35°											
Sp O2	99%	99%	96%	98%	98%											
BREATH SOUNDS	coarse	dim	coarse	dim	[illegible]											
INITIALS	KC	Dr	KC	Dr	PM											

4BV

AHC FORM 1156-C

PENGAD 800-631-6989 EXHIBIT "A"

Kenneth Kendrick

Arkansas Health Center

Ventilator and Tracheostomy Physician's Orders

Ventilator Type LTV 1150
Mode of Ventilation SIMV + PS
Set Respiratory Rate 16
Tidal Volume 850
Pressure Support 5 Pressure Control N/A
Inspiratory Time
FIO2 34%
PEEP 5
High Pressure Alarm 40
Low Pressure Alarm 5 low min. volume off when asst detected
SpO2 Checks QShift + PRN

Tracheostomy Type Shiley Size #8 extra long
Trach Care QShift*
O2FIO2 Titrate to Keep SpO2 92% Humidification heated

Other Respiratory Therapies:
Updraft N/A
Meter Dosed Inhalers ALBUTEROL MDI 6 puffs QL°
CPT
Other

STANDING ORDERS

VENTILATOR SPECIFIC:
SpO2 Checks PRN
Circuits Changes Monthly and PRN
Humidifier Chambers Changed Monthly and PRN
Use Sterile Water Only In Humidifier Chamber
Ventilator Checks and Documentation Every 12 Hours
Bag and Suction PRN, Use Normal Saline Only for Lavage PRN
Change Tracheostomy Tube every 3 months and PRN
Ambu Bag Ready for Use at The Bed Side
2 Extra Trach Tubes Available at the Bedside:
(1) Same Size (1) Size Smaller
Change HME per Manufacturer guidelines
Change In-Line Suction Weekly and PRN

TRACHEOSTOMY ORDERS:
SpO2 Checks PRN
Change Circuit Set Ups Every Other Week and PRN
Use Sterile Water Only In Misty – OX or Humidifier Bottles
Change Tracheostomy Tube EVERY 3 months and PRN
Ambu Bag Ready for Use at the Bedside
2 Extra Trach Tubes Available at the Bedside
(1) Same Size (1) Size Smaller
Bag and Suction PRN, May Use Normal Saline Only For Lavage PRN

NURSE SIGNATURE: Paul Mills RRT DATE 6-18-13
PHYSICIAN'S SIGNATURE DATE 6-18-13

Revised 2011

AHC FORM # 1150-C

EXHIBIT "B"

PENGAD 800-631-6989

ALLIANCE
HOMECARE EQUIPMENT

8612 Kanis RD., Little Rock, AR
Phone (501) 221-1214 ~ Fax (866) 872-3830

Delivering proactive care, follow up and monitoring for respiratory patients.

Date: 7-24-13
To: Kay Moseley
Fax Number: 1-501-860-0884
From: Nikki
Total number of pages: 5

Message:

APPROVED MEDICARE APPROVED

The Respiratory Provider of Choice

The attached fax contains Protected Health Information (PHI). Federal law requires this document be handled in accordance with the guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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EXHIBIT 1

PENGAD 800-631-6989

EVENT TRACE:190:VENT 1 E 1 C 1 06/18/2013 11:08:03.000 64 = VER 05.08.06
EVENT TRACE:191:LOW VE 1 E 47 C 1 06/18/2013 11:09:35.695
EVENT TRACE:192:LOW VE 1 E 47 C 16 06/18/2013 11:15:03.771
EVENT TRACE:193:LO PRES1 E 49 C 1 06/18/2013 11:10:07.509
EVENT TRACE:194:LO PRES1 E 49 C 15 06/18/2013 11:15:06.835
EVENT TRACE:195:LO PRES0 E 50 C 1 06/18/2013 11:11:37.563
EVENT TRACE:196:LOW VE 0 E 48 C 1 06/18/2013 11:12:54.015
EVENT TRACE:197:LO PRES0 E 50 C 4 06/18/2013 11:14:38.433
EVENT TRACE:198:LOW VE 0 E 48 C 2 06/18/2013 11:13:52.457
EVENT TRACE:199:HOUR MTR E 3 C 1 06/18/2013 11:15:05.967 12538.4 hours
EVENT TRACE:200:HOUR MTR E 3 C 1 06/18/2013 11:15:08.785 12538.4 hours
EVENT TRACE:201:VENT 0 E 2 C 1 06/18/2013 11:15:11.001 0
EVENT TRACE:202:VENT 1 E 1 C 1 06/18/2013 11:15:19.000 64 = VER 05.08.06
EVENT TRACE:203:LO PRES1 E 49 C 1 06/18/2013 11:15:36.457
EVENT TRACE:204:LO PRES0 E 50 C 1 06/18/2013 11:15:39.103
EVENT TRACE:205:LOW VE 1 E 47 C 1 06/18/2013 11:15:39.153
EVENT TRACE:206:HI PRES1 E 42 C 1 06/18/2013 11:15:39.757
EVENT TRACE:207:HI PRES0 E 43 C 1 06/18/2013 11:15:39.923
EVENT TRACE:208:LOW VE 0 E 48 C 1 06/18/2013 11:15:45.891
EVENT TRACE:209:HI PRES1 E 42 C255 07/15/2013 06:52:17.403
EVENT TRACE:210:HI PRES0 E 43 C255 07/15/2013 06:52:17.567
EVENT TRACE:211:LO PRES1 E 49 C146 07/15/2013 12:44:42.281
EVENT TRACE:212:LOW VE 1 E 47 C 3 06/18/2013 11:16:12.225
EVENT TRACE:213:LO PRES0 E 50 C147 07/15/2013 12:44:40.957
EVENT TRACE:214:TBN ZERO E 45 C 1 06/19/2013 14:48:02.899
EVENT TRACE:215:TBN ZERO E 45 C 27 07/14/2013 22:48:12.289
EVENT TRACE:216:HI PEEP1 E 75 C 1 06/22/2013 09:13:40.273. Mon PEEP = 27.2 cm
EVENT TRACE:217:HI PEEP0 E 76 C 1 06/22/2013 09:13:44.015
EVENT TRACE:218:HI PEEP1 E 75 C 6 07/07/2013 19:42:21.561. Mon PEEP = 32.5 cm
EVENT TRACE:219:HI PEEP0 E 76 C 6 07/07/2013 19:42:22.747
EVENT TRACE:220:HIGH DIS E 8 C 1 06/26/2013 04:12:22.833 1
EVENT TRACE:221:DISC 0 E 10 C 1 06/26/2013 04:12:26.387
EVENT TRACE:222:HIGH DIS E 8 C 33 07/15/2013 06:05:01.635 1
EVENT TRACE:223:DISC 0 E 10 C 37 07/15/2013 06:05:03.577
EVENT TRACE:224:LOW DIS E 9 C 1 06/30/2013 15:48:38.605 1
EVENT TRACE:225:LOW DIS E 9 C 5 07/06/2013 09:19:19.489 1
EVENT TRACE:226:HOUR MTR E 3 C 1 07/15/2013 12:42:16.675 13187.8 hours
EVENT TRACE:227:HOUR MTR E 3 C 1 07/15/2013 12:44:40.879 13187.9 hours
EVENT TRACE:228:VENT 0 E 2 C 1 07/15/2013 12:44:43.001 0
EVENT TRACE:229:VENT 1 E 1 C 1 07/16/2013 12:42:12.000 64 = VER 05.08.06
EVENT TRACE:230:EXT LST1 E 15 C 1 07/16/2013 12:42:13.013
EVENT TRACE:231:HOUR MTR E 3 C 1 07/16/2013 12:42:13.013 13187.9 hours
EVENT TRACE:232:HOUR MTR E 3 C 1 07/16/2013 12:53:23.715 13188.1 hours
EVENT TRACE:233:LO PRES1 E 49 C 1 07/16/2013 12:43:45.095

EVENT TRACE:234:LO PRES0 E 50 C 1 07/16/2013 12:43:47.467
EVENT TRACE:235:LO PRES1 E 49 C 25 07/16/2013 12:52:53.229
EVENT TRACE:236:LO PRES0 E 50 C 18 07/16/2013 12:52:55.577
EVENT TRACE:237:HI PRES1 E 42 C 1 07/16/2013 12:45:41.233
EVENT TRACE:238:HI PRES0 E 43 C 1 07/16/2013 12:45:41.409
EVENT TRACE:239:HI PRES1 E 42 C 6 07/16/2013 12:45:59.487
EVENT TRACE:240:HI PRES0 E 43 C 6 07/16/2013 12:45:59.651
EVENT TRACE:241:VENT 0 E 2 C 1 07/16/2013 12:53:26.001 0
EVENT TRACE:242:VENT 1 E 1 C 1 07/17/2013 18:29:35.000 64 = VER 05.08.06
EVENT TRACE:243:HIGH DIS E 8 C 1 07/17/2013 18:29:35.909 1
EVENT TRACE:244:EXT LST1 E 15 C 1 07/17/2013 18:29:36.011
EVENT TRACE:245:HOUR MTR E 3 C 1 07/17/2013 18:29:36.011 13188.1 hours
EVENT TRACE:246:LO PRES1 E 49 C 1 07/17/2013 18:29:36.305
EVENT TRACE:247:DISC 0 E 10 C 1 07/17/2013 18:29:39.417
EVENT TRACE:248:HIGH DIS E 8 C 4 07/17/2013 18:29:47.123 1
EVENT TRACE:249:DISC 0 E 10 C 2 07/17/2013 18:29:43.171
EVENT TRACE:250:LO PRES1 E 49 C 2 07/17/2013 18:29:47.519
EVENT TRACE:251:HOUR MTR E 3 C 1 07/17/2013 18:29:48.091 13188.1 hours
EVENT TRACE:252:VENT 0 E 2 C 1 07/17/2013 18:29:51.001 0
EVENT TRACE:253:VENT 1 E 1 C 1 07/17/2013 18:30:01.000 64 = VER 05.08.06
EVENT TRACE:254:HOUR MTR E 3 C 1 07/17/2013 18:30:01.107 13188 1 hours
EVENT TRACE:255:HIGH DIS E 8 C 1 07/17/2013 18:30:01.903 1
EVENT TRACE:256:EXT LST1 E 15 C 1 07/17/2013 18:30:02.015
EVENT TRACE:257:HOUR MTR E 3 C 1 07/17/2013 18:30:03.053 13188.1 hours
EVENT TRACE:258:LO PRES1 E 49 C 1 07/17/2013 18:30:02.299
EVENT TRACE:259:BAT LOW1 E 13 C 1 07/17/2013 18:30:03.053
EVENT TRACE:260:VENT 0 E 2 C 1 07/17/2013 18:30:04.001 0
EVENT TRACE:261:VENT 1 E 1 C 1 07/18/2013 16:30:49.000 64 = VER 05.08.06
EVENT TRACE:262:HOUR MTR E 3 C 1 07/18/2013 16:30:52.887 13188.1 hours
EVENT TRACE:263:VENT 0 E 2 C 1 07/18/2013 16:30:55.001 0
EVENT TRACE:264:VENT 1 E 1 C 1 07/18/2013 16:31:05.000 64 = VER 05.08.06
EVENT TRACE:265:VENT CHK E 4 C 1 07/18/2013 16:31:05.025
EVENT TRACE:266:VENT 0 E 2 C 1 07/18/2013 16:37:22.000 0
EVENT TRACE:267:VENT 1 E 1 C 1 07/18/2013 16:37:27.000 64 = VER 05.08.06
EVENT TRACE:268:HI PRES1 E 42 C 1 07/18/2013 16:37:35.895
EVENT TRACE:269:TBN ZERO E 45 C 1 07/18/2013 16:37:36.395
EVENT TRACE:270:HI PRES0 E 43 C 1 07/18/2013 16:37:36.441
EVENT TRACE:271:HI PRES1 E 42 C 10 07/18/2013 16:38:09.523
EVENT TRACE:272:TBN ZERO E 45 C 9 07/18/2013 16:38:06.271
EVENT TRACE:273:HI PRES0 E 43 C 9 07/18/2013 16:38:06.369
EVENT TRACE:274:LOW DIS E 9 C 1 07/18/2013 16:38:02.027 1
EVENT TRACE:275:DISC 0 E 10 C 1 07/18/2013 16:38:05.181
EVENT TRACE:276:LOW DIS E 9 C 3 07/18/2013 16:38:09.525 1
EVENT TRACE:277:HOUR MTR E 3 C 1 07/18/2013 16:38:07.579 13188.1 hours
EVENT TRACE:278:HOUR MTR E 3 C 1 07/18/2013 16:38:09.611 13188.1 hours
EVENT TRACE:279:DISC 0 E 10 C 2 07/18/2013 16:38:12.685

EVENT TRACE:280:VENT 0 E 2 C 1 07/18/2013 16:38:12.001 0
EVENT TRACE:281:VENT 1 E 1 C 1 07/18/2013 16:38:49.000 64 = VER 05.08.06
EVENT TRACE:282:HI PRES1 E 42 C 1 07/18/2013 16:38:57.867
EVENT TRACE:283:TBN ZERO E 45 C 1 07/18/2013 16:38:58.367
EVENT TRACE:284:HI PRES0 E 43 C 1 07/18/2013 16:38:58.413
EVENT TRACE:285:HI PRES1 E 42 C 11 07/18/2013 16:39:35.267
EVENT TRACE:286:TBN ZERO E 45 C 10 07/18/2013 16:39:32.037
EVENT TRACE:287:HI PRES0 E 43 C 10 07/18/2013 16:39:32.117
EVENT TRACE:288:HOUR MTR E 3 C 1 07/18/2013 16:39:35.317 13188.1 hours
EVENT TRACE:289:VENT 0 E 2 C 1 07/18/2013 16:39:38.001 0
EVENT TRACE:290:VENT 1 E 1 C 1 07/18/2013 16:40:17.000 64 = VER 05.08.06
EVENT TRACE:291:HOUR MTR E 3 C 1 07/18/2013 16:40:21.919 13188.1 hours
EVENT TRACE:292:VENT 0 E 2 C 1 07/18/2013 16:40:24.001 0
EVENT TRACE:293:VENT 1 E 1 C 1 07/18/2013 16:40:54.000 64 = VER 05.08.06
EVENT TRACE:294:HOUR MTR E 3 C 1 07/18/2013 16:40:57.277 13188.1 hours
EVENT TRACE:295:VENT 0 E 2 C 1 07/18/2013 16:41:00.001 0
EVENT TRACE:296:VENT 1 E 1 C 1 07/18/2013 16:41:13.000 64 = VER 05.08.06
EVENT TRACE:297:HOUR MTR E 3 C 1 07/18/2013 16:41:13.939 13188.1 hours
EVENT TRACE:298:VENT 0 E 2 C 1 07/18/2013 16:41:16.001 0
EVENT TRACE:299:VENT 1 E 1 C 1 07/18/2013 16:41:24.000 64 = VER 05.08.06
EVENT TRACE:300:HOUR MTR E 3 C 1 07/18/2013 16:41:25.009 13188.2 hours
EVENT TRACE:301:VENT 0 E 2 C 1 07/18/2013 16:41:28.001 0
EVENT TRACE:302:VENT 1 E 1 C 1 07/18/2013 16:41:37.000 64 = VER 05.08.06
EVENT TRACE:303:HOUR MTR E 3 C 1 07/18/2013 16:41:39.545 13188.2 hours
EVENT TRACE:304:VENT 0 E 2 C 1 07/18/2013 16:41:42.001 0
EVENT TRACE:305:VENT 1 E 1 C 1 07/18/2013 16:41:52.000 64 = VER 05.08.06
EVENT TRACE:306:HOUR MTR E 3 C 1 07/18/2013 16:41:53.553 13188.2 hours
EVENT TRACE:307:VENT 0 E 2 C 1 07/18/2013 16:41:56.001 0
EVENT TRACE:308:VENT 1 E 1 C 1 07/18/2013 16:42:04.000 64 = VER 05.08.06
EVENT TRACE:309:HOUR MTR E 3 C 1 07/18/2013 16:42:05.905 13188.2 hours
EVENT TRACE:310:VENT 0 E 2 C 1 07/18/2013 16:42:08.001 0
EVENT TRACE:311:VENT 1 E 1 C 1 07/18/2013 16:42:18.000 64 = VER 05.08.06
EVENT TRACE:312:VENT CHK E 4 C 1 07/18/2013 16:42:18.025
EVENT TRACE:313:SET DATE E 53 C 1 07/18/2013 16:57:26.383
EVENT TRACE:314:SET DATE E 53 C 2 07/18/2013 16:57:25.642
EVENT TRACE:315:SET TIME E 54 C 1 07/18/2013 16:58:10.060
EVENT TRACE:316:SET TIME E 54 C 2 07/18/2013 16:58:03.154
EVENT TRACE:317:VENT 0 E 2 C 1 07/18/2013 17:01:49.250 0
EVENT TRACE:318:VENT 1 E 1 C 1 07/18/2013 17:07:45.000 64 = VER 05.08.06
EVENT TRACE:319:HI PRES1 E 42 C 1 07/18/2013 17:07:53.889
EVENT TRACE:320:TBN ZERO E 45 C 1 07/18/2013 17:07:54.389
EVENT TRACE:321:HI PRES0 E 43 C 1 07/18/2013 17:07:54.429
EVENT TRACE:322:HI PRES1 E 42 C 2 07/18/2013 17:07:57.711
EVENT TRACE:323:TBN ZERO E 45 C 2 07/18/2013 17:07:58.211
EVENT TRACE:324:HI PRES0 E 43 C 2 07/18/2013 17:07:58.319
EVENT TRACE:325:HOUR MTR E 3 C 1 07/18/2013 17:12:21.731 13188.3 hours

EVENT TRACE:326:VENT 0 E 2 C 1 07/18/2013 17:12:24.001 0
EVENT TRACE:327:VENT 1 E 1 C 1 07/18/2013 17:12:35.000 64 = VER 05.08.06
EVENT TRACE:328:HOUR MTR E 3 C 1 07/18/2013 17:12:36.881 13188.3 hours
EVENT TRACE:329:VENT 0 E 2 C 1 07/18/2013 17:12:39.001 0
EVENT TRACE:330:VENT 1 E 1 C 1 07/19/2013 12:31:08.000 64 = VER 05.08.06
EVENT TRACE:331:HOUR MTR E 3 C 1 07/19/2013 12:31:08.077 13188.3 hours
EVENT TRACE:332:HIGH DIS E 8 C 1 07/19/2013 12:31:08.903 1
EVENT TRACE:333:EXT LST1 E 15 C 1 07/19/2013 12:31:09.013
EVENT TRACE:334:HOUR MTR E 3 C 1 07/19/2013 12:31:09.795 13188.3 hours
EVENT TRACE:335:LO PRES1 E 49 C 1 07/19/2013 12:31:09.299
EVENT TRACE:336:DISC 0 E 10 C 1 07/19/2013 12:31:11.577
EVENT TRACE:337:HIGH DIS E 8 C 2 07/19/2013 12:31:11.775 1
EVENT TRACE:338:VENT 0 E 2 C 1 07/19/2013 12:31:12.001 0
EVENT TRACE:339:VENT 1 E 1 C 1 07/24/2013 11:17:11.000 64 = VER 05.08.06
EVENT TRACE:340:VENT CHK E 4 C 1 07/24/2013 11:17:11.025

Event Codes

This section includes a list of the event codes that can be recorded in the Event Trace.

Event Codes by Code

Code	Event Name	Event	Associated Alarm
01	VENT 1	Power on	None
02	VENT 0	Power off	None
03	HOUR MTR	Set hour meter	None
04	VENT CHK	Set vent check	Entered VENT CHECK mode
05	APNEA 1	Apnea mode entered	APNEA
06	APNEA 0	Apnea mode exited	APNEA
07		N/A	
08	HIGH DIS	High side disconnect	DISC/SENSE
09	LOW DIS	Low side disconnect	DISC/SENSE
10	DISC 0	Circuit disconnect exited	DISC/SENSE
11	BATMPT1	Internal battery empty occurred	BAT EMPTY
12	BATMPT0	Internal battery empty exited	BAT EMPTY
13	BATLOW1	Internal battery low occurred	BAT LOW
14	BATLOW0	Internal battery low exited	BAT LOW
15	EXT LST1	External power lost occurred	POWER LOST
16	EXT LST0	External power lost exited	POWER LOST
17	EXT LOW1	External power low occurred	POWER LOW
18	EXT LOW0	External power low exited	POWER LOW
19	XDC FLT1	XDCR fault occurred	XDCR FAULT
20	XDC FLT0	XDCR fault exited	XDCR FAULT
21	O2 LOW 1	O_2 pressure low occurred	LOW O2 PRES
22	O2 LOW 0	O_2 pressure low exited	LOW O2 PRES
23	O2 HI 1	O_2 pressure high occurred	HIGH O2 PRES
24	O2 HI 0	O_2 pressure high exited	HIGH O2 PRES
25	DEFAULTS	Defaults, or Set Defaults occurred	DEFAULTS / DEFAULTS SET
26	NO CAL	No calibration data found	NO CAL DATA
27	FAN FLT1	Fan fault occurred	HW FAULT
28	FAN FLT0	Fan fault exited	HW FAULT
29		N/A	
30		N/A	
31	INTRRPT1	Spurious interrupt occurred ms	RESET 1
32	INTRRPT2	Spurious interrupt occurred ls	RESET 1
33	AD MMTCH	ADC mismatch	HW FAULT
34	AD MTCH1	ADC mismatch occurred	HW FAULT
35	AD MTCH0	ADC mismatch cleared	HW FAULT
36	SYNCER1	Stepper motor lost sync occurred	HW FAULT

EXHIBIT 2
PEMGAD 800-431-6969

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Code	Event Name	Event	Associated Alarm
37	SYNCER0	Stepper motor lost sync exited	HW FAULT
38	HOME ER1	Stepper motor home failure occurred	HW FAULT
39	HOME ER0	Stepper motor home failure exited	HW FAULT
40	EEPROM	EEPROM degraded	HW FAULT
41	CRC	Memory CRC check failed	RESET
42	HI PRES1	High pressure occurred	HIGH PRES
43	HI PRES0	High pressure exited	HIGH PRES
44	TBN ISTP	Turbine immediate stop occurred	HIGH PRES
45	TBN ZERO	Turbine set to zero flow occurred	HIGH PRES
46	TBN ESTP	Turbine emergency stop occurred	HIGH PRES
47	LOW VE 1	Low minute volume occurred	LOW MIN VOL
48	LOW VE 0	Low minute volume exited	LOW MIN VOL
49	LO PRES1	Low peak pressure occurred	LOW PRES
50	LO PRES0	Low peak pressure exited	LOW PRES
51	CLR EVNT	Event log cleared	N/A
52	CLR CTRL	Control settings cleared	N/A
53	SET DATE	Date set	N/A
54	SET TIME	Time set	N/A
55		N/A	
56	STACK	Stack overflow detected	RESET
57	POST	POST failure	RESET
58	RUNAWAY	Code runaway detected	RESET
59	WDOG TST	Watchdog test run	Inop
60	CLR CAL	Calibration records cleared	N/A
61	XDCR NAR	Differential pressure transducer - Narrow channel fault	XDC FLT1
62	XDCR WID	Differential pressure transducer - Wide channel fault	XDC FLT1
63	XDCR BI	Differential pressure transducer - Bi-directional channel fault	XDC FLT1
64	XDCR AIR	Airway pressure transducer fault	XDC FLT1
65	ADC1 VAL	AD mismatch primary channel fault value	HW FAULT
66	TBN HSTP	Turbine Hold Stop occurred	HIGH PRES
67	LN VENT1	Shutdown for other than pressing **On/Standby** button	RESET
68	FLUSH ER	A problem is detected writing data to the EEPROM during system shutdown.	HW FAULT
69	RAC ERR1	Problem detected with primary and/or redundant audible alarm circuitry	HW FAULT
70	RAC ERR0	Recovery from problem detected with primary and/or redundant audible alarm circuitry	HW FAULT
71	SNDRERR1	Alarm sounder error	HW FAULT

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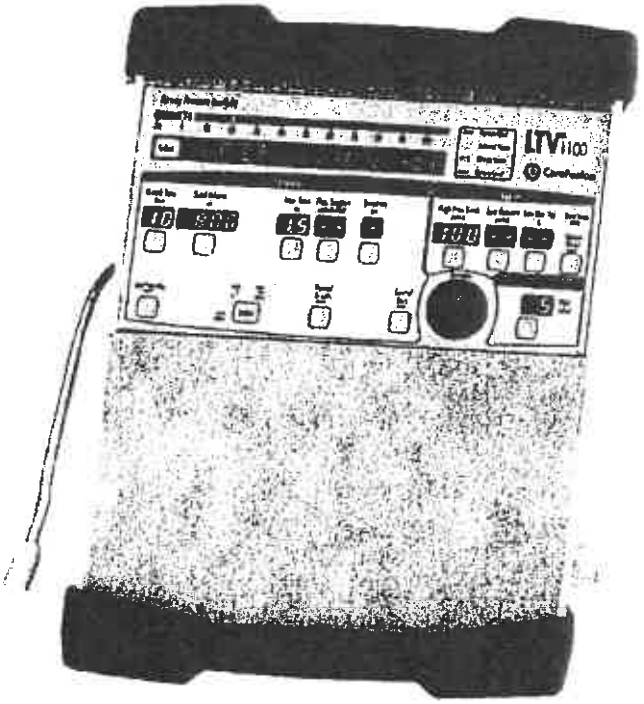
Code	Event Name	Event	Associated Alarm
72	SNDRERR0	Recovery from alarm sounder error	HW FAULT
73	HIGH f1	High breath rate alarm occurred	HIGH f
74	HIGH f0	High breath rate alarm recovered	HIGH f
75	HI PEEP1	Monitored PEEP	HIGH PEEP
76	HI PEEP0	Monitored PEEP	HIGH PEEP
77	HI SBTf1	Total Breath Rate	SBT > f
78	HI SBTf0	Total Breath Rate	SBT > f
79	LO SBTf1	Total Breath Rate	SBT < f
80	LO SBTf2	Total Breath Rate	SBT < f
81	HI f/VtT1	Rapid Shallow Breathing Index	SBT > f/Vt
82	HI f/VtT0	Rapid Shallow Breathing Index	SBT > f/Vt
83	LO f/VtT1	Rapid Shallow Breathing Index	SBT < f/Vt
84	LO f/VtT0	Rapid Shallow Breathing Index	SBT < f/Vt
85	SBT1	N/A	N/A
86	MON f/Vt	f/Vt value at SBT exit	N/A
87	SBT0	SBT exit reason	N/A
88	CLR BREC	Reclaims all incorrectly recognized bad EEPROM records	N/A
89	LO PEEP1	Monitored PEEP	LOW PEEP
90	LO PEEP0	Monitored PEEP	LOW PEEP
91	NEW PTNT	New patient setup	N/A
92	CIRCUIT	New patient circuit selection	N/A

Event Codes by Event Name

Event Name	Code	Event	Associated Alarm
AD MMTCH	33	ADC mismatch	HW FAULT
AD MTCH0	35	ADC mismatch cleared	HW FAULT
AD MTCH1	34	ADC mismatch occurred	HW FAULT
ADC1 VAL	65	AD mismatch primary channel fault value	HW FAULT
APNEA 0	06	Apnea mode exited	APNEA
APNEA 1	05	Apnea mode entered	APNEA
BATLOW0	14	Internal battery low exited	BAT LOW
BATLOW1	13	Internal battery low occurred	BAT LOW
BATMPT0	12	Internal battery empty exited	BAT EMPTY
BATMPT1	11	Internal battery empty occurred	BAT EMPTY
CIRCUIT	92	New patient circuit selection	N/A
CLR BREC	88	Reclaims all incorrectly recognized bad EEPROM records	N/A
CLR CAL	60	Calibration records cleared	N/A
CLR CTRL	52	Control settings cleared	N/A
CLR EVNT	51	Event log cleared	N/A
CRC	41	Memory CRC check failed	RESET
DEFAULTS	25	Defaults, or Set Defaults occurred	DEFAULTS / DEFAULTS, SET
DISC 0	10	Circuit disconnect exited	DISC/SENSE
EEPROM	40	EEPROM degraded	HW FAULT
EXT LOW0	18	External power low exited	POWER LOW
EXT LOW1	17	External power low occurred	POWER LOW
EXT LST0	16	External power lost exited	POWER LOST
EXT LST1	15	External power lost occurred	POWER LOST
FAN FLT0	28	Fan fault exited	HW FAULT
FAN FLT1	27	Fan fault occurred	HW FAULT
FLUSH ER	68	A problem is detected writing data to the EEPROM during system shutdown.	HW FAULT
HI f/VtT0	82	Rapid Shallow Breathing Index	SBT > f/Vt
HI f/VtT1	81	Rapid Shallow Breathing Index	SBT > f/Vt
HI PEEP0	76	Monitored PEEP	HIGH PEEP
HI PEEP1	75	Monitored PEEP	HIGH PEEP
HI PRES0	43	High pressure exited	HIGH PRES
HI PRES1	42	High pressure occurred	HIGH PRES
HI SBTf0	78	Total Breath Rate	SBT > f
HI SBTf1	77	Total Breath Rate	SBT > f
HIGH DIS	08	High side disconnect	DISC/SENSE
HIGH f0	74	High breath rate alarm recovered	HIGH f
HIGH f1	73	High breath rate alarm occurred	HIGH f

Event Name	Code	Event	Associated Alarm
HOME ER0	39	Stepper motor home failure exited	HW FAULT
HOME ER1	38	Stepper motor home failure occurred	HW FAULT
HOUR MTR	03	Set hour meter	None
INTRRPT1	31	Spurious interrupt occurred ms	RESET 1
INTRRPT2	32	Spurious interrupt occurred ls	RESET 1
LN VENT1	67	Shutdown for other than pressing On/Standby	RESET
LO f/VtT0	84	Rapid Shallow Breathing Index	SBT < f/Vt
LO f/VtT1	83	Rapid Shallow Breathing Index	SBT < f/Vt
LO PEEP0	90	Monitored PEEP	LOW PEEP
LO PEEP1	89	Monitored PEEP	LOW PEEP
LO PRES0	50	Low peak pressure exited	LOW PRES
LO PRES1	49	Low peak pressure occurred	LOW PRES
LO SBTf1	79	Total Breath Rate	SBT < f
LO SBTf2	80	Total Breath Rate	SBT < f
LOW DIS	09	Low side disconnect	DISC/SENSE
LOW VE 0	48	Low minute volume exited	LOW MIN VOL
LOW VE 1	47	Low minute volume occurred	LOW MIN VOL
MON f/Vt	86	f/Vt value at SBT exit	N/A
NEW PTNT	91	New patient setup	N/A
NO CAL	26	No calibration data found	NO CAL DATA
O2 HI 0	24	O_2 pressure high exited	HIGH O2 PRES
O2 HI 1	23	O_2 pressure high occurred	HIGH O2 PRES
O2 LOW 0	22	O_2 pressure low exited	LOW O2 PRES
O2 LOW 1	21	O_2 pressure low occurred	LOW O2 PRES
POST	57	POST failure	RESET
RAC ERR0	70	Recovery from problem detected with primary and/or redundant audible alarm circuitry	HW FAULT
RAC ERR1	69	Problem detected with primary and/or redundant audible alarm circuitry	HW FAULT
RUNAWAY	58	Code runaway detected	RESET
SBT0	87	SBT exit reason	N/A
SBT1	85	N/A	N/A
SET DATE	53	Date set	N/A
SET TIME	54	Time set	N/A
SNDRERR0	72	Recovery from alarm sounder error	HW FAULT
SNDRERR1	71	Alarm sounder error	HW FAULT
STACK	56	Stack overflow detected	RESET
SYNC ER1	36	Stepper motor lost sync occurred	HW FAULT
SYNCER0	37	Stepper motor lost sync exited	HW FAULT
TBN ESTP	46	Turbine emergency stop occurred	HIGH PRES
TBN HSTP	66	Turbine Hold Stop occurred	HIGH PRES
TBN ISTP	44	Turbine immediate stop occurred	HIGH PRES
TBN ZERO	45	Turbine set to zero flow occurred	HIGH PRES

Event Name	Code	Event	Associated Alarm
VENT 0	02	Power off	None
VENT 1	01	Power on	None
VENT CHK	04	Set vent check	Entered VENT CHECK mode
WDOG TST	59	Watchdog test run	Inop
XDC FLT0	20	XDCR fault exited	XDCR FAULT
XDC FLT1	19	XDCR fault occurred	XDCR FAULT
XDCR AIR	64	Airway pressure transducer fault	XDC FLT1
XDCR BI	63	Differential pressure transducer - Bi-directional channel fault	XDC FLT1
XDCR NAR	61	Differential pressure transducer - Narrow channel fault	XDC FLT1
XDCR WID	62	Differential pressure transducer - Wide channel fault	XDC FLT1



LTV® 1100 Ventilator

Operator's Manual

CareFusion

P/N 21106-001
Rev. E

EXHIBIT

176

Warnings

WARNING

Untrained Personnel – Only properly trained personnel should operate the ventilator. The LTV® 1100 ventilator is a restricted medical device designed for use by Respiratory Therapists or other properly trained and qualified personnel under the direction of a physician and in accordance with applicable state laws and regulations.

Leak Testing the Patient Breathing Circuit – The patient circuit must be leak tested in the **VENT CHECK** mode before connection to the patient. In addition, the Ventilator Checkout mode should be used to check for correct operation of the ventilator alarm, displays and controls. Harm to the patient or ineffective ventilation may result from failure to leak test the patient breathing circuit before connection to a patient. When using a heated humidifier, include it in the circuit when performing leak testing.

Adjustable and Critical Alarms – For safety purposes, all adjustable alarms and all critical alarms must be checked to insure proper operation.

Alarms Function Verification - All alarms must be verified as functioning properly on a daily basis. If any alarm malfunctions, immediately contact a certified CareFusion service technician or CareFusion.

Patient Monitoring - Patients who are dependent on a ventilator should be constantly monitored by qualified personnel. Such personnel should be prepared to address equipment malfunctions and circumstances where equipment becomes inoperative. An alternative method of ventilation should be available for all patients dependent on the ventilator, and qualified personnel should be fully familiar with emergency ventilation procedures.

Alternative Ventilation - It is recommended that an alternative means of ventilating the patient be available at all times and that all ventilator operators be fully familiar with emergency ventilation procedures.

Fire or Explosion - Operation of the LTV® 1100 ventilator in the presence of flammable gases could cause a fire or explosion. Under no circumstances is the ventilator to be operated when explosive gases are present. The presence of nitrous oxide or flammable anesthetics presents a danger to the patient and operator.

Patient Breathing Circuit Disconnection - Inadvertent disconnection of the patient from the patient breathing circuit can be dangerous.

Critical Alarms - Failure to set the critical alarms such as the Low Minute Volume alarm and the Low Pressure alarm may cause non-detection (no alarm) for a disconnection of the lower sense line or the exhalation valve drive line.

Exhalation Valve Diaphragm – Patient ventilation may be ineffective or dangerous if the exhalation valve diaphragm is damaged or worn out. The exhalation valve diaphragm must be inspected on a daily basis and replaced whenever necessary.

Sustained HIGH PRES Alarm - During a sustained High Pressure alarm condition (**HIGH PRES**), the ventilator's turbine is stopped and gas is not delivered to the patient. Disconnect the patient from the ventilator and ventilate the patient using an alternative method. See *Chapter 15 - Troubleshooting, Alarms* for additional information concerning the **HIGH PRES** alarm.

BAT EMPTY Alarm - A **BAT EMPTY** alarm indicates the internal battery is almost depleted. Connect the ventilator to an external power source immediately.

WARNING

Ventilation Variables and O_2 Consumption - Variations in the patient's minute ventilation, I:E ratio and/or ventilator setting changes or equipment status (i.e. circuit leaks) affect the consumption rate of oxygen. When warranted by a patients condition, it is recommended that a back-up cylinder or alternative source of oxygen be available at all times.

Before Using Automobile Cigarette Lighter or Power Outlets - Before using Automobile Cigarette Lighter or Power Outlets as a power source for the LTV® 1100, assure that the ventilator's internal battery is in good condition and fully charged. Poor cigarette lighter or power outlet connections, electrical system defects (battery, charging system, etc.), or use of vehicle accessories (air conditioner, high current lights, high power audio equipment, etc.) could result in less than the required voltage being delivered to the ventilator, generate a **POWER LOST** alarm and switch the ventilator's power source to the internal battery.

Unauthorized Parts or Accessories – Serious harm to the patient may result from the use of unauthorized parts or accessories. Only items expressly approved by CareFusion may be used in conjunction with the LTV® 1100 ventilators.

Unapproved Adapters – Only CareFusion Accessories should be used to connect the ventilator to Patient Assist Call Systems. These accessories incorporate safety features to reduce the risk of shock. Do not attempt to modify these accessories in any way.

Patient Assist Call Connector – Do not apply more than 25V rms or 32VDC to the Patient Assist Call connector.

Ventilator Service and Repair - All servicing or repair of the LTV® 1100 ventilator must be performed only by a service technician certified by CareFusion.

Patient Circuits – CareFusion Patient Circuits, Exhalation Valve Assemblies and Water Traps are shipped clean, not sterile.

Ultra Violet Light Sensitivity – The material used in the tubing of the Reusable Patient Circuits is not UV stable. Avoid exposure of the tubing to UV light.

Mounting Screws - Refer to the information contained in CareFusion Replacement Screws Kit, P/N 11149, to determine the appropriate accessories mounting screws or accessories replacement screws location, type and length to use when removing or exchanging external accessories on an LTV® ventilator.

Mounting Screw Use – Internal damage to the ventilator may result if the wrong length mounting screws are used when installing or removing external accessories.

Patient Circuit Accessories - The use of accessories such as Speaking Valves, Heat-Moisture Exchangers and Filters create additional patient circuit resistance and in the event of a disconnection, may impede the generation of a Low Pressure alarm. Ensure that the Low Pressure alarm settings accommodate these types of accessories when used in combination with patient circuits.

Low Minute Volume Control Settings - The **Low Min. Vol.** control should be set to its highest clinically appropriate value. If there is a clinical need to set the Low Minute Volume alarm to lower values or off ("- - -"), perform a clinical assessment to determine if an alternative monitor (i.e. a Pulse Oxymeter with an audible alarm, or a Cardio Respiratory Monitor) should be used.

ARKANSAS HEALTH CENTER MEMORANDUM
Office of Risk Management/Quality Assurance
QA REPORT

TO: Teena Campbell, DON
Shelley Burchfield, ADON
Melba VanZandt, ADON
Angela McCutcheon, ADON
Megan Edwards, Psy. D., Clinical Director
Risk Management File

CC: Jay Hill, AHC Director
Gary Gipson, AHC Administrator

FROM: Marsha Smith, Risk Management Director
Connie Styles RN QA Coordinator
Sonya Smith, RN QA Nurse

RE: Secondary issues - Kenneth Kendrick QA Death Review - Final

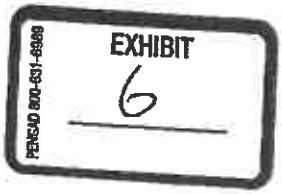
DATE: September 30, 2013

Because of circumstances involved in Mr. Kendrick's death, a full investigation was conducted to determine if there were any avoidable factors or any maltreatment/neglect that may have contributed to his demise. The investigation was completed, and results were forwarded to OLTC with the determination of no evidence of maltreatment. The OLTC Complaint Unit also visited AHC and reviewed this case (Complaint #18549), as well as other matters, and exited with no deficiencies cited regarding Mr. Kendrick's care at AHC.

Secondary issues identified during the investigation of this death are noted below and are being referred to Administration for appropriate follow up.

- Information regarding specific circumstances surrounding the discovery of Mr. Kendrick's distress was limited in the initial death report received in Risk Management, and there were no accompanying witness statements. Although this may have been due to the death occurring away from AHC, witness statements and additional details would be helpful in Risk Management's submission of comprehensive death reports to OLTC via IRIS entries. QA RN Coordinator Styles was successful in obtaining additional information through contact with the administrator and unit staff, which was included in the initial IRIS death report, # 50297.

- The Speech Pathologist had identified no problems with Mr. Kendrick eating with the tracheostomy cuff deflated; however, because inflation during oral intake had been suggested by a previous care provider, she elected to recommend continuation of the procedure, until or unless Mr. Kendrick experienced related problems, or expressed opposition. Nursing staff reported that Mr. Kendrick sometimes refused cuff inflation; that information, however, was not relayed to the Speech Therapist. (As noted, and per Speech Therapy recommendation, Mr. Kendrick's preferences in this regard were honored.)



- Although no relevance to Mr. Kendrick's demise was identified, a physician's order for cuff inflation for medications and meals was on the Respiratory Therapy order sheet. The cuff inflation order was not reflected on the MAR for nursing documentation. Some nursing staff confirmed awareness and implementation of related orders. Chart checks of ventilator-dependent residents were completed by 7/19/13 with no similar issues noted.

- Mr. Kendrick had recently been admitted, and his Interdisciplinary Care Plan was due July 8, 2013. Only the admission/24-hour Plan of Care was found on the chart on the morning of chart review on 7/16/2013. The Interdisciplinary Care Plan on the T drive at that time was incomplete. A copy of the completed Interdisciplinary Care Plan was provided to Risk Management that afternoon (7/16/13.)

- Mr. Kendrick's social history information noted his preference of having his bed sheet pulled over his head. Upon follow up with the Social Worker, however, it could not be determined if that information was obtained as a matter of historical information, or was unique to this placement. Knowledge of his historical preferences in this regard would have been helpful in determining if the 'sheet-over-his-head' behavior was a long-standing practice, or related to some issue unique to this placement. This was discussed with the Social Worker, who expressed agreement and intentions to seek and incorporate details regarding historical habits and preferences in future social history information.

- Being mindful that related recommendations are relative to preferences and reasons which will vary per individual, it is also suggested that:

    - Per standard, existing protocol, should resident preferences be deemed to present significant safety risks, a nd exploration and negotiation produce no suitable alternative, referral to the Human Rights Committee for rights' restriction consideration may be indicated, as well as seeking court order or resident relocation if determined appropriate.

- The Risk Management Department defers to those with related expertise regarding any indicated revisions in policies regarding Respiratory Therapy services. (Per nursing administration, a nursing policy revision was made.)

- Regarding the type of inner cannula that had been used with this resident, the corrective actions accomplished in replacing this type of inner cannula in use with for other AHC residents, and discontinuing their use at AHC, is certainly supported by our department.

In addition to the Risk Management investigation and QA review, ADON VanZandt devised and implemented a related Corrective Action Plan. These actions are appreciated and supported by our Department.

* WHAT IS THE PURPOSE OF HAVING AN ET T OR INNER CANNULA VS ONE WITHOUT AN INNER CANNULA

762 Narrative

Willow Court resident, Mr. Kenneth Kendrick, passed away at Saline Memorial Hospital at approximately 12:49pm on 07/15/13 following an unsuccessful code which was initiated at AHC and discontinued at Saline Memorial Hospital. Mr. Kendrick was 41 years of age. He had resided at Arkansas Health Center since June 18, 2013.

Review of Mr. Kendrick's death has been completed as directed. Details regarding the death revealed no indicators of a "suspicious" death or wrongdoing by involved staff. Due to the unusual circumstances of this case, however, a full investigation was pursued to determine if there were any unavoidable factors, or any possibility of maltreatment/neglect, contributing to Mr. Kendrick's death.

In accordance with resulting consultation with Administrator Gipson, additional IRIS entry #50362 was made on 7/23/13 reflecting the upgrade of this review to investigative status. (The death was initially reported in IRIS # 50297 on 7/16/13.) Mr. Kendrick's mother was informed that we are looking into the matter, and that she will receive notification of the results, once finalized. She was also informed that results will also be shared with OLTC. Condolences were also extended to her regarding the loss of her son.

No perpetrators have been identified at this time, and no administrative leave has been initiated.

Witness statements were gathered, interviews conducted, with additional ones pending. Current findings and determinations follow.

Mr. Kendrick had Muscular Dystrophy and had been ventilator dependent for the past 18 years. He had multiple health concerns, and his diagnoses included: History of Chronic Respiratory Failure; Tracheostomy; Ventilator Dependence; Quadriplegia; Diabetes Mellitus; History of Pneumonia; Gastroesophageal Reflux; Duchenne's Muscular Dystrophy; Morbid Obesity; History of Congestive Heart Failure; Iron Deficiency Anemia; Insomnia; Depression; Anxiety; Hypomagnesaemia; and Constipation.

His care plan includes information regarding his diagnosed Respiratory Failure Related to Duchenne Muscular Dystrophy (DMD), which is a hereditary disease linked to the X chromosome. It affects approximately 1 in 3,600 boys. The disease results in muscle degeneration and eventual death, usually at an early age, before 25 years. Progressive proximal muscle weakness of the legs and pelvis associated with a loss of muscle mass is observed first. Eventually, this weakness spreads to the arms, neck, and other areas. As the condition progresses, muscle tissue experiences wasting and is eventually replaced by fat and fibrotic tissue, which was the biggest factor in his morbid obesity. Later symptoms may include abnormal bone development that leads to skeletal deformities, including curvature of the spine. Due to progressive deterioration of muscle, loss of movement occurs, eventually leading to paralysis and eventually affecting all voluntary muscles, including the heart and breathing muscles in later stages. Mr. Kendrick was in the later stages of this disease, having suffered respiratory failure with resulting dependence upon a ventilator. There is no cure or medication for this disease, although medications can help manage the effects of the disease on various body parts.

Mr. Kendrick had resided at home prior to admission to AHC. Due to recent problems with home care, a decision was made that skilled care was needed to ensure his health care needs were being met, resulting in his placement at AHC. He was dependent on caregivers for his needs. He was able to verbally communicate and, despite Quadriplegia, could contact the nurses' station for assistance with the call light placed between his feet, where it was placed routinely.

On 7/15/13 at 12:10pm, as Willow Court staff approached Mr. Kendrick for scheduled blood sugar check, Mr. Kendrick was observed to be cyanotic; check of vital signs revealed irregularities. The Respiratory Therapist and RN responded to the room. CPR was initiated, and the AED was applied. No shock was recommended or administered. During this process, other staff made a 911 call.

Emergency medical personnel arrived and assumed CPR. CPR was continued, and Mr. Kendrick was transported to the local emergency room.

Per hospital information later obtained, pulseless electrical activity was noted when ambulance personnel connected monitors to Mr. Kendrick. Continued attempts at resuscitation were unsuccessful, and Mr. Kendrick's death was pronounced by the Saline County Coroner at Saline Memorial Hospital. The Emergency Room reported that Mr. Kendrick had cardio pulmonary arrest. Mr. Kendrick's attending physician at AHC, Dr. Hill, dictated a discharge summary on 07/16/2013, listing cause of death as cardiac arrest due to unknown causes.

All appropriate notifications followed. Mr. Kendrick's body was reportedly released from the hospital to the funeral home designated by his family. Funeral arrangements are pending.

Per RN Moseley and confirmed by Administrator Gipson, the Coroner later met with administrative AHC staff, because of the family's distress regarding Mr. Kendrick's death. Coroner Will Bearden said he suggested an autopsy because of their concerns. After reviewing Mr. Kendrick's diagnoses, Mr. Bearden informed AHC staff that the Medical Examiner's Office declined autopsy, indicating that one would only be performed at the family's expense. The family is unable to afford such.

Mr. Bearden visited with staff for details of the events surrounding Mr. Kendrick's death for his follow up with the family. Per Administrator Gary Gipson, Saline County Coroner Bearden indicated understanding of the situation and satisfaction with the rapid response by AHC.

One of the family's complaints to Mr. Bearden was that Mr. Kendrick had told them that staff did not come into his room for extended periods of time. His family was actively involved and never made any complaints to AHC staff. Willow Court RN Supervisor Moseley completed a timeline to show the frequency of routine staff visits to Mr. Kendrick's room. The data reflected frequent and regular staff visits to Mr. Kendrick's room.

During investigative follow up with Coroner Bearden, he confirmed information noted above. He said he identified no need for further investigation into these matters.

Investigative Findings

- **Per LPN Tasha Lenard's and CNA Tasha Marshall's** witness statements, they entered Mr. Kendrick's room at 12:10pm to obtain his blood sugar. They said they spoke to Mr. Kendrick, but he was unresponsive. Mr. Kendrick had a preference of keeping the sheet pulled over this head. They reported uncovering his head and finding him pale/cyanotic. They said the left side of his face was purple, and all extremities were cyanotic. RT Paul Mills was notified, as well as RN Kay Moseley, and they immediately reported to Mr. Kendrick's room. They were unable to obtain an O2 sat, and Mr. Kendrick's pulse was less than 10. CPR was initiated and continued by AHC staff until the ambulance arrived in response to the 911 call initiated by the LPN supervisor, Ms. Jackie Robertson; at that point, CPR was assumed by responding EMT's, and Mr. Kendrick was transported to the local hospital.

- **Interview with LPN Lenard was** consistent with her written witness statement.

- **Interview with CNA Marshall** remained consistent with her written witness statement.

- **Interview with CNA Kristy Beach** was consistent with her written witness statement. She reported Mr. Kendrick appeared sleepy when breakfast trays were being passed, and he declined his breakfast, stating he would eat later. She reporting asking that the he use the call light to notify her if/when he decided to eat, to which he agreed. She indicated this was consistent with Mr. Kendrick's usual habits.

- **RT Paul Mills' provided a witness statement** and clarified some of that information in interview. He was called to Mr. Kendrick's room by CNA Marshall, who reported Mr. Kendrick was unresponsive. He stated when he entered the room, he observed Mr. Kendrick to be cyanotic. He said Mr. Kendrick was blue on one side of his face. When he pulled the sheet down past jaw level, he said he observed the inner cannula of Mr. Kendrick's tracheostomy tube had dislodged and was against his neck. The low minute volume alarm was not sounding, because Mr. Kendrick's low pressure alarm was turned off due to his cuff being deflated. (He explained this is routine with a deflated endotracheal cuff [cuff], because if the alarm were on with the cuff deflated, the low pressure alarm would sound continuously.) Mr. Mills said the circumstance of the inner cannula against Mr. Kendrick's neck/chin resulted in the ventilator continuing to pressurize, preventing the high pressure alarm from sounding, which would normally have alerted staff of a ventilation problem. Mr. Mills reported immediately reinserting the inner cannula, locking it, and performing bag to tracheostomy ventilation with O2. Code blue was initiated, and CPR continued until paramedics arrived and assumed related functions.

  RT Mills reported he had changed and locked Mr. Kendrick's inner cannula at 8:20am that morning. He said Mr. Kendrick was awake and alert at that time, and had seemed fine when he performed the 8:20am tracheostomy care. Upon task completion, he reported re-covering Mr. Kendrick's head with the sheet per his request, and asked that Mr. Kendrick call if he needed anything. (As noted, Mr. Kendrick was able to use the call light placed between feet, which was its routine placement.)

  Mr. Mills also reported being in Mr. Kendrick's room attending one of his roommates at 11:50am. He reported observing Mr. Kendrick from across the room at that time and noting nothing out of the ordinary. He said the ventilator was functioning normally. He said the sheet was completely covering Mr. Kendrick's head at that time.

  RT Mills stated Mr. Kendrick always requested to have the sheet pulled over his head. Care plan review revealed that this preference was specified in Mr. Kendrick's plan of care.

  Mr. Mills reported the type of cannula used for Mr. Kendrick was a twist-lock, which only required 1/8 turn to unlock. He stated the inner cannula could possibly become unlocked for various reasons, such as bed rotation which was used for Mr. Kendrick; he added, however, that no such problems with Mr. Kendrick's cannula had been noted prior to the incident since his admission.

  Mr. Kendrick's preference to have the sheet over his head would prevent immediate visualization of the area connecting to the vent. However, under usual circumstances, the ventilator equipment would be expected to alarm if the cannula dislodged, alerting staff of a ventilation problem that needed attention. As noted, the particular circumstances of this event prevented that precautionary function.

  RT Mills said he performs ventilator checks for each ventilator-dependent resident at least once per shift, and diligently monitors the residents and machines. Frequent suctioning is required and completed, as well as trach care on these residents. Mr. Mills said Mr. Kendrick's ventilator settings have been unchanged since admission.

  Mr. Mills reported that Mr. Kendrick is normally alert, able to use his call light, and verbalizes his wants and needs. He said Mr. Kendrick had reported no distress, and he, therefore, believes Mr. Kendrick experienced some type of medical event, such as a cardiac event or seizure, rendering him unable to call the nurse's station with his call light. Mr. Mills stated he has worked at AHC for almost 4 years and has been a Respiratory Therapist for almost 31 years.

Mr. Mills said his post evaluation of the incident raised concerns to him about continued use of the flexible type of inner, removable cannulas, such as had been used with Mr. Kendrick. As a precautionary measure to deter recurrence, a QA action plan was devised: Changes in the cannulas of other residents were made as applicable; and suggested policy revisions are being sent for administrative review. Mr. Mills is recommending that residents with a deflated cuff, while not being monitored directly by staff, no longer have a trach tube that has a removable, inner cannula.

Mr. Mills said it is standard protocol to have orders regarding inflating and deflating a cuff. He also stated that it is standard procedure to turn the low-minute volume alarm off when the cuff is deflated, requiring no related, special order. He also said there is no policy regarding deactivating low-minute volume alarms, and that those decisions are at the discretion of the respiratory therapist.

- **ADON Melba Van Zandt and unit supervisor RN Kay Moseley were present** during Mr. Mills' interview. ADON VanZandt interjected speculation of Cardiac Tamponade as a possible cause of the episode.

- Some differences in understanding of cuff deflation and inflation orders were identified during the investigation. Mr. Mills said Mr. Kendrick's cuff was constantly deflated, but Mr. Kendrick had a physician's order for cuff inflation during meals and medication administration. Because RT Mills does not perform those functions, he had not been involved in cuff inflations. Nursing staff who are involved in these functions, however, indicated awareness of the order, and indicated that the cuff was inflated for medications and meals as Mr. Kendrick allowed. RN Moseley and LPN's Stacey Riley and Tasha Lenard indicated that although initially agreeing, Mr. Kendrick had begun to decline having the cuff inflated for meals and medication administration, expressing the valid complaint that the inflation interfered with his speech.

- **Speech Pathologist Julie Brandon** had conducted a swallow study, indicating that Mr. Kendrick experienced no swallowing problems regardless of the cuff's inflation or deflation status. Because a practice of inflating the cuff for meals and medication administration had been effected prior to Mr. Kendrick's admission here, Ms. Brandon recommended continuation of that practice, with re-assessment to occur if Mr. Kendrick did not tolerate the cuff. He had previously chosen to have the cuff deflated for meals, but had expressed willingness to use it at the time of the evaluation. As noted, Mr. Kendrick had become less tolerant of the procedure, which was to be referred to the Care Plan Team.

- Per Respiratory Therapist Mills, Director of Nursing Teena Campbell, Speech Pathologist Brandon and attending physician, Dr. Ed Hill, the status of cuff inflation or deflation would not have affected connection of Mr. Kendrick's inner cannula to the ventilator tubing, and is, therefore, not deemed pertinent to his death or the related investigation.

- **Unit RN supervisor, Kay Moseley's witness statement, interview, and relevant chart documentation** supported previously-noted information about notification, response, and intervention to the code called for Mr. Kendrick.

  Ms. Moseley said Mr. Kendrick had been under the sheet, apparently sleeping, when she made initial rounds at the beginning of her shift that morning. At approximately 11:45am, she reported answering Mr. Kendrick's call light, and Mr. Kendrick stating the call had been an "accident." (She reported remembering the time, because she had been working on documentation for another resident's hospital transfer at the time.) She said this was not an uncommon occurrence for Mr. Kendrick or others. Her account of her being called and assisting with CPR remained consistent with hers and witness statements of others. She reported observing Mr. Kendrick's call light to be in place between his feet, in accordance with the Care Plan, at the time of the emergency intervention.

Upon entering Mr. Kendrick's room, Ms. Moseley reported finding RT Mills at Mr. Kendrick's bedside, manually bagging him via his tracheostomy. She stated the pulse oximeter was not initially tracking, but then began to read; and that Mr. Kendrick's heart rate and O2 saturation were both in the 40's at one point during the resuscitative process. LPN Supervisor Jackie Robertson was instructed and called 911. At one point during the procedure, LPN Lenard also reported obtaining carotid pulse of less than 10. Mr. Kendrick's rotating bed was placed on CPR setting prior to initiation of CPR. After 1 minute of CPR, Mr. Kendrick's color began to turn pink, but recurrent cyanosis followed. The AED was placed on him with no shock advised. CPR continued until the ambulance and staff arrived and assumed related functions, and Mr. Kendrick was transported to the hospital at that point.

RN Moseley said Mr. Kendrick and staff seemed to get along well, with no related problems noted. He indicated appreciation for the care and services provided him.

- CNA's assisting with his care that morning indicated no irregularities or indications of distress from Mr. Kendrick. He verbally declined care at one of the rounds, and as noted, chose not to have breakfast that morning. CNA's Kristi Calvert and Gwen McClendon reported hearing Mr. Kendrick talking, apparently via the call light connection between 9:30 and 10:00am. Ms. Calvert reported that CPR was in progress when she went to Mr. Kendrick's room to offer him lunch.

- The ventilator unit is a high-traffic area, with staff moving about frequently. No staff noted any unauthorized visitors to have been in the area, and Mr. Kendrick and his roommates are not able to inflict harm due to their physical debilitation. No reason to suspect any ill will by others was identified during the investigation to have contributed in this event.

- Mr. Kendrick's death and related review were discussed at the 7/18/13 weekly QA/Risk Management meeting. AHC Medical Director, Dr. Mark Albey, confirmed that the ventilator functions should be reviewed, recommended they be checked, and directed use of the machine that had been used for Mr. Kendrick be discontinued pending inspection by the equipment provider, Alliance. This was done.

- Initial review from Alliance indicated that Mr. Kendrick's equipment sounded at 8:20 am (which was the time Mr. Mills was changing Mr. Kendrick's inner cannula,) and had not sounded again until the time the code was initiated. This report of when the vent alarm sounded correlates with information in AHC reports and records of when circumstances presented that would have triggered the alarm. The complete written report from Alliance is pending at the time of this documentation.

Summation

Mr. Kendrick's preference to have the sheet pulled over his head inhibited view of the trach/ventilator insertion site. Although there are ways for the trach to accidentally dislodge, per the design of the equipment in use, a fail-safe alarm is to sound when ventilation is interrupted, and is a reasonable expectation and safety measure. The circumstances that prevented sounding of the alarm were unusual, outside normal parameters of expectation, and could not have been reasonably anticipated.

Also, Mr. Kendrick's known ability to use his call light and voice to summon assistance in an emergency situation and his failure to do so is perplexing, and supports the theory that an incapacitating event had occurred which prevented him from alerting staff prior to his discovery and immediate initiation of life-sustaining efforts.

Although only speculation is available in the absence of post mortem examination, possible contributing events could have included seizure activity, cardiac event, or other unexpected medical occurrence related to Mr. Kendrick's fragile medical condition.

It appears that the circumstances surrounding Mr. Kendrick's demise were not reasonably avoidable, and no related neglect was determined to have contributed to the situation or his death.

The investigation failed to produce evidence of any maltreatment associated with Mr. Kendrick's unfortunate demise, and staff who had worked with him expressed sadness regarding his passing.

Secondary issues identified during the investigation are being forwarded to nursing administration for follow up, preventive corrective actions are underway, and policy revisions are pending.

Maltreatment is unsubstantiated in this case.

Arkansas
State Claims Commission
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BEFORE THE CLAIMS COMMISSION OF THE STATE OF ARKANSAS

LANELLE KENDRICK,
As Special Administrator of the Estate Of KENNY KENDRICK, Deceased, And on Behalf of the Wrongful Death Beneficiaries of KENNY KENDRICK

CLAIMANT

vs.

CLAIM #14-0154-CC

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES

RESPONDENT

MOTION FOR SUMMARY JUDGMENT ON WRONGFUL DEATH CLAIM

Respondent Department of Human Services ("DHS"), for its Motion for Summary Judgment on Wrongful Death Claim, states as follows.

1. There is no genuine issue of material fact on Claimant's claim that Respondent negligently caused the death of Kenny Kendrick, and accordingly Respondent is entitled to summary judgment as to same..

2. The grounds for this motion are more particularly set forth in a brief in support filed herewith.

Department of Human Services
Office of Policy and Legal Services
P. O. Box 1437, S260
Little Rock, AR 72203
501-320-6306
Fax: 501-682-1390

By: _____
Brooks C. White, Ark. Bar No. 2000093
Attorney for DHS

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CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of February, 2016, I served a copy of the foregoing on the following via hand delivery:

Jeff R. Priebe
James, Carter, & Coulter PLC
500 Broadway, Suite 400
Little Rock, Arkansas 72211
jpriebe@jamescarterlaw.com

I further certify that I served a copy of the foregoing on the following via email:

Robert H. "Bob" Edwards
The Edwards Firm
711 West Third Street
Little Rock, Arkansas 72201
bob@bobedwardslaw.com

Brooks C. White

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $?

Claim No. 14-0154-CC

Attorneys

Lanelle Kendrick for the Estate of Kenny Kendrick — **Claimant**

Robert Edwards, Attorney
Jeff Priebe, Attorney — **Claimant**

AR DHS/Behavioral Health Sys. — **Respondent**
State of Arkansas

Brooks White, Attorney — **Respondent**

Date Filed August 15, 2013

Type of Claim Wrongful Death, Failure to Follow Procedure, Negligence, Pain & Suffering, Mental Anguish

FINDING OF FACTS

The Claims Commission hereby unanimously denies the Respondent's "Motion for Summary Judgment." Therefore, this claim will proceed to hearing as scheduled.

IT IS SO ORDERED.

(See Back of Opinion Form)

CONCLUSION

The Claims Commission hereby unanimously denies the Respondent's "Motion for Summary Judgment." Therefore, this claim will proceed to hearing as scheduled.

Date of Hearing March 10, 2016

Date of Disposition March 10, 2016

Chairman

Commissioner

Commissioner

***Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33 of 1997 and as found in Arkansas Code Annotated §19-10-211*

Arkansas
State Claims Commission
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK,
As Special Administrator of the Estate
Of KENNY KENDRICK, Deceased,
And on Behalf of the Wrongful Death
Beneficiaries of KENNY KENDRICK **CLAIMANT**

vs. **CLAIM #14-0154-CC**

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

OBJECTION TO AND MOTION TO STRIKE CLAIMANT'S DEPOSITION "SUMMARIES"

Respondent Department of Human Services ("DHS"), for its Objection to and Motion to Strike Claimant's Deposition Summaries, states as follows:

1. Claimant filed a single document entitled "Claimant's Deposition Summaries."

2. The "summaries" in the document are not summaries at all, but instead are bulleted lists of cherry-picked citations which Claimant believes are favorable to her case. Claimant ignores all testimony which is unfavorable to her case.

3. Furthermore, and more problematically, many of the bulleted items either outright misstate or only partially state what the deponent said in the cited testimony (i.e., "half-truth"), creating an inaccurate and misleading impression of the actual testimony.

4. For these reasons, Claimant's "Summaries" are objectionable should be stricken, and the basis for this motion is more fully set forth in a Brief in Support filed simultaneously herewith.

Department of Human Services
Office of Policy and Legal Services
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501-320-6306
Fax: 501-682-1390

By: _____
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Attorney for DHS

CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of March, 2016, I served a copy of the foregoing on the following via hand delivery:

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I further certify that I served a copy of the foregoing on the following via email:

Robert H. "Bob" Edwards
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_____
Brooks White

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Arkansas
State Claims Commission
MAR 09 2016
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK,
As Special Administrator of the Estate
Of KENNY KENDRICK, Deceased,
And on Behalf of the Wrongful Death
Beneficiaries of KENNY KENDRICK **CLAIMANT**

vs. **CLAIM #14-0154-CC**

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

OBJECTION TO AND MOTION TO STRIKE ARGUMENTATIVE EXHIBITS

Respondent Department of Human Services ("DHS"), for its Objection to and Motion to Strike Argumentative Exhibits, states as follows:

1. Rule 4.7 of the Arkansas State Claims Commission Rules and Regulations expressly states that exhibits should not be argumentative.

2. In violation of Rule 4.7, Claimant has submitted various exhibits, specifically Claimant's Exhibits 2-15, which contain selective highlights of portions of the Exhibit which Claimant believes is favorable to her case, and/or contain box text comments with arrows drawn to certain portions of the document. The text in the box comments is not supported by citation to any testimony given in this case.

3. Accordingly, these exhibits should be stricken, and in any event, the Commission should not consider or give any regard to any of Claimant's highlighting or commenting on these Exhibits.

WHEREFORE, Respondent requests that the exhibits be stricken, and for all other relief to which it may be entitled.

Department of Human Services
Office of Policy and Legal Services
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Fax: 501-682-1390

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Attorney for DHS

CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of March, 2016, I served a copy of the foregoing on the following via email:

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STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $? **Claim No.** 14-0154-CC

Attorneys

Lanelle Kendrick for the Estate of Kenny Kendrick — **Claimant** — Robert Edwards, Attorney; Jeff Priebe, Attorney — **Claimant**

AR DHS/Behavioral Health Svs. — **Respondent** — Brooks White, Attorney — **Respondent**

State of Arkansas

Date Filed August 15, 2013 **Type of Claim** Wrongful Death, Failure to Follow Procedure, Negligence, Pain & Suffering, Mental Anguish

FINDING OF FACTS

The Claims Commission denies the Respondent's "Motion to Strike." It is the policy of the Claims Commission to accept any and all materials received on claims filed with the Claims Commission.

IT IS SO ORDERED.

(See Back of Opinion Form)

CONCLUSION

The Claims Commission denies the Respondent's "Motion to Strike."

Date of Hearing March 10, 2016

Date of Disposition March 10, 2016

D. Moore — **Chairman**

Commissioner

Bill Lamb — **Commissioner**

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**Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

LANELLE KENDRICK, AS SPECIAL ADMINISTRATOR
OF THE ESTATE OF KENNY KENDRICK, DECEASED
AND ON BEHALF OF THE WRONGFUL DEATH
BENEFICIARIES OF KENNY KENDRICK — CLAIMANT

v. — No. 14-0154-CC

STATE OF ARKANSAS,
DEPARTMENT OF HUMAN SERVICES — RESPONDENT

CLAIMANT'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant, Lanelle Kendrick, as Special Administrator of the Estate of Kenny Kendrick, and on behalf of the wrongful death beneficiaries of Kenny Kendrick, submits the following Findings of Fact and Conclusions of Law:

PROPOSED FINDINGS OF FACT

1. Kenny Kendrick lived almost 41 years of his life at home and had been taken care of by his mother, Lanelle, with the help of home health aides.

2. That when the Arkansas Health Center admitted Kenny as a resident, the Arkansas Health Center was aware that Kenny was totally dependent on the Arkansas Health Center for all aspects of his life including that he required a ventilator for oxygen.

3. Kenny Kendrick was entitled to receive his Arkansas Resident Rights including the right to receive adequate and appropriate healthcare and the right to be treated courteously, fairly and with the fullest measure of dignity.

4. The policies of the Arkansas Health Center were mandatory and were required to be followed by the staff.

5. The Arkansas Health Center was to provide patients such as Kenny Kendrick with "exceptional nursing home care" pursuant to its mission statement.

6. The policy of the Arkansas Health Center required nurses to check on patients such as Kenny Kendrick every hour.

7. The ventilator manual required the Arkansas Health Center to continuously monitor vent patients such as Kenny Kendrick.

8. That the Arkansas Health Center was required to follow physician orders for Kenny Kendrick.

9. The Arkansas Health Center was responsible for setting and maintaining the ventilator alarms for Kenny Kendrick.

10. The Arkansas Health Center was responsible for unlocking and locking the cannula tube on Kenny Kendrick.

11. That the Arkansas Health Center turned off Kenny Kendrick's low minute volume alarm without having a physician order.

12. The records of the Arkansas Health Center document that nurses actually laid eyes on Kenny Kendrick at 8:20 a.m. and again at 12:10 p.m. and that almost four hours went by without documentation of nurses laying eyes on Kenny Kendrick.

13. That on the morning of July 15, 2013, at 11:20 a.m., Kenny Kendrick's alarm sounded.

14. When the Arkansas Health Center staff asked him what was wrong he said one word – "accident."

15. Despite hearing Kenny Kendrick say "accident" none of the staff at the Arkansas Health Center physically checked on him to see if there was a problem.

16. That at 12:10 p.m. (25 minutes after he said "accident") when staff went to check his blood sugar (that was ordered to take place at 11:00 a.m.); Kenny was found with his breathing tube out of his throat and was blue and cyanotic.

17. That when he was found around 12:10 p.m. he was cyanotic because he lacked oxygen because his tube was dislodged.

18. Kenny Kendrick had a pulse at the time he was found at 12:10 a.m.

19. Kenny Kendrick died, in whole or in part, because of a lack of oxygen.

20. Kenny Kendrick died as a result of his breathing tube not providing him with the oxygen that he needed to live.

21. That the event trace on Kenny's ventilator indicates that no alarms sounded on the ventilator from 6:52 a.m. until 12:44 p.m.

22. Kenny Kendrick did not remove his own breathing tube.

23. Kenny was forty-one years old when he died.

24. Kenny is survived by his mother, Lanelle Kendrick, who loved her son very much and still loves him to this day.

25. The Arkansas Health Center failed to follow physician's orders for Kenny Kendrick.

26. The Arkansas Health Center failed to check Kenny Kendrick's blood sugar as was ordered to be done at 11:00 a.m. on July 15, 2013.

27. The Arkansas Health Center failed to constantly monitor Kenny Kendrick.

28. The Arkansas Health Center failed to follow its policies in the care and treatment of Kenny Kendrick.

29. The Arkansas Health Center charted that it provided care and treatment to Kenny Kendrick after he died.

PROPOSED CONCLUSIONS OF LAW

1. The Arkansas Health Center failed to follow its own policies and procedures in providing care to Kenny Kendrick.

2. The Arkansas Health Center failed to follow the ventilator manufacturer policies and procedures in providing care to Kenny Kendrick.

3. The Arkansas Health Center failed to follow physician orders for Kenny Kendrick.

4. The Arkansas Health Center was solely responsible for the monitoring of Kenny Kendrick.

5. The Arkansas Health Center was solely responsible for ensuring that Kenny Kendrick's cannula tube did not become dislodged or removed.

6. The Arkansas Health Center failed to meet the standard of care related to Kenny Kendrick.

7. The Arkansas Health Center was negligent in the care of Kenny Kendrick.

8. That the Arkansas Health Center was medically negligent in the care of Kenny Kendrick.

9. The Arkansas Health Center failed to ensure that Kenny Kendrick received his Arkansas Resident Rights, specifically the right to receive adequate and appropriate healthcare and the right to be treated courteously, fairly and with the fullest measure of dignity

10. That as a result of these failures, the Arkansas Health Center was a proximate cause of the death of Kenny Kendrick.

11. As a result of the actions of the Arkansas Health Center, the Estate of Kenny Kendrick is entitled to compensation of $250,000.

12. As a result of the actions of the Arkansas Health Center, Lanelle Kendrick is entitled to compensation of $250,000.

13. That the Arkansas Department of Human Services is not entitled to be reimbursed for any monies that were paid by Medicaid for the care and treatment of Kenny Kendrick either during his life or at the Arkansas Health Center.

Respectfully submitted,

LANELLE KENDRICK, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF KENNY KENDRICK, DECEASED

By: _____

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

Arkansas
State Claims Commission
MAR 03 2016
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LANELLE KENDRICK,
As Special Administrator of the Estate
Of KENNY KENDRICK, Deceased,
And on Behalf of the Wrongful Death
Beneficiaries of KENNY KENDRICK **CLAIMANT**

vs. **CLAIM #14-0154-CC**

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The above-styled matter was heard on the 10th day of March, 2016. Based upon the documents, exhibits, testimony, and other documents and evidence submitted, the Commission finds and concludes as follows:

FINDINGS OF FACT

1. Kenny Kendrick was a 41-year old patient at Arkansas Health Center ("AHC") who had multiple chronic health problems, including Duchenne's muscular dystrophy, chronic congestive heart failure, diabetes, and morbid obesity.

2. Mr. Kendrick was diagnosed with muscular dystrophy at three weeks old, and had been given a life expectancy of 20 years.

3. Due to his muscular dystrophy, Mr. Kendrick was completely bedridden, and had been ventilator-dependent for sixteen years when he died on July 15, 2013.

4. Mr. Kendrick was admitted to AHC on June 18, 2013.

5. On July 15, 2013, at approximately 12:10 p.m., two AHC employees – LPN Tasha Lenard and CNA Tasha Marshall – went to check Mr. Kendrick's blood sugar.

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6. Mr. Kendrick had a preference of keeping a sheet over his head 90 percent of the time he was at AHC.

7. Upon arriving in his room, Ms. Lenard and Ms. Marshall made several attempts to speak to Mr. Kendrick, but he did not respond.

8. They then uncovered Mr. Kendrick's head and observed that the left side of his face was purple, and that he was pale and cyanotic.

9. They immediately notified Kay Moseley, the RN on duty, and Paul Mills, the respiratory therapist on duty.

10. When he entered the room, Mr. Mills pulled the sheet down past jaw level, and noticed that the inner cannula of Mr. Kendrick's trach tube had dislodged and was resting against his neck.

11. The tracheostomy tube used by Mr. Kendrick was prescribed as part of the Discharge Orders by the physician who treated Mr. Kendrick at St. Mary's Hospital in Russellville, Arkansas, immediately before he was admitted to AHC.

12. Resuscitation attempts were made at AHC until the ambulance came and transported Mr. Kendrick to Saline Memorial Hospital, where he was pronounced dead at 12:49 p.m.

13. Mr. Kendrick's family did not request that an autopsy be performed.

14. Mr. Kendrick had a foot-operated call light, and used it frequently to call the nurse's station.

15. He had made calls on his call light the morning of the day he died.

16. That morning, at approximately 11:45, he called the nurse's station, but then stated "accident."

17. Mr. Kendrick had accidentally hit his call light multiple times in the past and stated that it was an accident.

18. Ms. Moseley testified that she knew what Mr. Kendrick meant by "accident" because he had several times in the past hit his call light by accident and said the same thing.

19. When the inner cannula dislodges from the trach tube, an alarm called the low pressure alarm is supposed to sound on the ventilator due to the depressurization of the air line caused by the disconnection of the line from the patient.

20. However, in this case, the alarm did not sound.

21. It did not sound in this case because the inner cannula came to rest against Mr. Kendrick's chin immediately upon dislodgment, so that the ventilator's computer never detected any change in pressure in the line, and therefore the alarm was not triggered.

22. The ventilator had another alarm called the low minute volume alarm, which monitors the volume of air flowing through the ventilator circuit.

23. This alarm sounds when the measured volume of exhaled air back to the ventilator falls below a certain threshold.

24. This alarm was disabled on Mr. Kendrick's ventilator per physician's orders.

25. Per physician's orders, the cuff on Mr. Kendrick's trach tube was to remain deflated, and the low minute volume alarm was to be off, except when he was eating or taking medication.

26. When a trach patient's cuff is deflated, the patient's exhaled air does not go back to the ventilator, but instead goes out the patient's nose and/or mouth.

27. Accordingly, if the low minute volume alarm had been on while the cuff was deflated, then it would be constantly alarming, because the exhaled air would not be flowing

back to the ventilator and therefore the ventilator would not measure a volume of exhaled air above the threshold for triggering of the alarm.

28. There is no evidence that AHC negligently caused the death of Mr. Kendrick on July 15, 2013. Specifically, there is no evidence that Mr. Kendrick died because his trach tube dislodged, and the fact that Mr. Kendrick did not make a call to the nurse's station seeking help for a problem with his trach tube indicates that Mr. Kendrick had been rendered unconscious by an acute health event which caused his death. If Mr. Kendrick had been conscious at the time his trach tube dislodged, then it would be expected that he would make a call on his call light to the nurse's station seeking help. There is no evidence that Mr. Kendrick was unable to make a call to the nurse's station for any reason other than that he was not conscious at the time the trach tube dislodged.

29. In fact, Mr. Kendrick made a call on his call light at 11:45, approximately 25 minutes before he was found unresponsive, stating "accident." The Commission finds that this call was an accidental call made by Mr. Kendrick and not a call by Mr. Kendrick seeking help. First, Mr. Kendrick did not make any follow-up call after Mr. Moseley considered it an accidental call and did not respond. Had he been attempting to alert staff to a problem with his trach tube, he would have almost certainly made follow-up calls until staff responded. There is no reasonable explanation for failure of Mr. Kendrick to make any such follow-up calls, other than that the call was, indeed, as Ms. Moseley believed it was, an accidental call. Second, Mr. Kendrick did not suffer from any mental impairment, and would not likely have communicated a problem with his trach tube by simply stating "accident." Given these observations, and the testimony of Ms. Moseley that Mr. Kendrick had made multiple calls of this nature in the past

which were, in fact, accidental calls, the Commission finds that the 11:45 call stating "accident" was nothing more than an inadvertent call to the nurse's station by Mr. Kendrick.

30. The commission does not credit the opinion of Dr. Loren Lipson, plaintiff's medical expert witness, that Mr. Kendrick died as a result of the cannula dislodgment. Dr. Lipson's testimony reveals that his opinion is based on pure speculation and not on any specialized knowledge, training, or experience he has. Essentially, Dr. Lipson's reasoning is that Mr. Kendrick died of the cannula dislodgment because the cannula was found dislodged, and Mr. Kendrick would not have been able to breathe as a result of the dislodgment. This is not medical reasoning, and is no different than the same speculative reasoning as to Mr. Kendrick's cause of death which a layperson could engage in. The commission does find credible the testimony of Dr. Ed Hill, Respondent's medical expert witness, that Mr. Kendrick likely died of an acute health event related to his heart, which in turn caused the cannula dislodgment, rather than the cannula dislodgment causing death. Dr. Hill's testimony is bolstered by the testimony of Dr. Dennis Berner, Mr. Kendrick's primary care physician. Dr. Berner testified that Mr. Kendrick had a life expectancy of six to twelve months, and in so testifying, indicated that Mr. Kendrick's primary problem was his heart.

31. There is no evidence that AHC in any way breached the standard of care with regard to its care of Mr. Kendrick. Claimant asserts that AHC personnel should have "checked on" Mr. Kendrick by looking under his sheet and visually inspecting his trach tube at periodic intervals. However, the Commission finds that it was not unreasonable for AHC to rely upon at least two warning systems in place, which would have been expected to alert staff to any dislodgment of Mr. Kendrick's trach tube. First, as previously discussed, Mr. Kendrick had a call light which he could, and did, use to contact the nurse's station in the event he needed or

wanted something. As previously discussed, the fact that he did not utilize the call light indicates that he did not die of the dislodgment of the cannula. Second, the ventilator's low pressure alarm would have been expected to sound in the event of a dislodgment, but due to an unlikely occurrence in this case, did not sound because the cannula immediately lodged against Mr. Kendrick's neck, preventing depressurization of the line. It was Mr. Kendrick's personal and expressed preference to keep the sheet over his head almost all of the time while he was at AHC. Therefore, given these two warning systems in place, it would not have been reasonable to disturb Mr. Kendrick by looking under the sheet periodically to visually inspect his trach tube.

32. In any event, it would be speculative to conclude that any periodic visual inspection of Mr. Kendrick's trach tube in the manner urged by Claimant would have prevented any death by dislodgment of the trach tube, even if it were conceded solely for argument that Mr. Kendrick died from dislodgment of the trach tube. Indeed, Kelly Kidd, RN, one of Claimant's expert witnesses, conceded that it is unknown whether checking on Mr. Kendrick as she opined was required would have prevented Mr. Kendrick's death.

33. The Commission does not credit the testimony of Claimant's expert witnesses – Loren Lipson, MD, and Kelly Kidd, RN – that Respondent breached the standard of care with regard to Mr. Kendrick. Dr. Lipson and Ms. Kidd both opine that AHC personnel did not adequately check on Mr. Kendrick, but neither has cited any objective standards in support of their opinions that under the circumstances, AHC personnel were required to check on Mr. Kendrick in any manner other than what they did.

34. The Commission finds that there is no evidence that Mr. Kendrick suffered pneumonia during his stay at AHC which was caused by aspiration of food as a result of any negligence of the AHC staff. Dr. Lipson opines that the pneumonia diagnosed in June 2013 was

as a result of Mr. Kendrick's aspiration of food because the facility did not follow orders in keeping his trach tube inflated while eating. However, Dr. Lipson's opinion is purely speculative for multiple reasons, including that there is no evidence that Mr. Kendrick had aspirated any food which caused the pneumonia. Moreover, Dr. Hill credibly testified the x-ray taken which was the basis for the diagnosis of pneumonia was inconsistent with aspiration pneumonia, because there was no infiltrate noted in the places where infiltrate would be expected to be present in the event of an aspiration pneumonia.

35. Claimant has made various other miscellaneous allegations of negligence against Respondent related to Mr. Kendrick's residence at AHC, but Claimant has failed to meet its burden of proof to substantiate any of these allegations. These miscellaneous allegations relate to alleged failure to properly document certain care on certain days. However, there is no evidence to indicate that AHC committed any act of negligence causing injury to Mr. Kendrick with relation to any of the alleged documentation errors.

36. There is no evidence of any injury to Mr. Kendrick as a result of any negligent or other improper act or omission on the part of Respondent.

CONCLUSIONS OF LAW

1. Ark. Code Ann. §16-114-201 *et. seq.* applies to "actions for medical injury." An "action for medical injury" is defined as "all actions against a medical care provider, whether based in tort, contract, or otherwise, to recover damages on account of medical injury as defined in this section." Ark. Code Ann. §16-114-201(1).

2. "Medical injury", in turn, is defined as "any adverse consequences arising out of or sustained in the course of the professional services being rendered by a medical care provider

to a patient or resident, whether resulting from negligence, error, or omission in the performance of such services." Ark. Code Ann. §16-114-201(3).

3. In this case, Claimant alleges such adverse consequences arising out of professional services rendered by AHC, and accordingly this case falls within the governance of this statute.

4. Under Ark. Code Ann. §16-114-206(a)(3), in order to prevail in this action for medical injury, Claimant must prove "[by] means of expert testimony provided only by a qualified medical expert that as a proximate result [of the alleged breach of the standard of care], [Mr. Kendrick] suffered injuries that would not otherwise have occurred."

5. Further, Ark. Code Ann. §16-114-206(a)(3) provides that "Rule 702 of the Uniform Rules of Evidence shall govern the qualifications of expert witnesses." Under Rule 702, "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." "An important consideration in determining whether the testimony will aid the trier of fact is whether the situation is beyond the ability of the trier of fact to understand and draw its own conclusions. *Buford v. State*, 368 Ark. 87, 243 S.W.3d 300 (2006), *citing Utley v. State*, 308 Ark. 622, 826 S.W.2d 268 (1992).

6. For the reasons set forth above, Claimant has failed to prove with valid expert testimony, admissible under Rule 702, that Mr. Kendrick suffered any injuries that would not have otherwise occurred as a proximate result of any act or omission of AHC. First, as noted above, Dr. Lipson's opinion as to Mr. Kendrick's cause of death is purely speculative and is not based on any specialized knowledge, training, or experience he possesses. Second, as Ms. Kidd

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conceded, even if Respondent had checked on Mr. Kendrick as she opines that it was required to do, it is unknown whether any such checking would have prevented Mr. Kendrick's death.

7. Moreover, for the reasons set forth above, Claimant has failed to prove any actual breach of the standard of care by AHC.

8. Even if this case were treated as one for ordinary negligence rather than an action for medical injury under §16-114-201 *et. seq.*, the result would be the same. "The essential elements of a cause of action for negligence are that the plaintiff show a duty owed and a duty breached, and that the defendant's negligence was a proximate cause of the plaintiff's damages. *See, e.g., Pace v. Davis*, 2012 Ark.App. 93, 394 S.W.3d 859 (2012). Claimant has failed to prove any breach of duty on the part of AHC which in turn was the proximate cause of any injury to Mr. Kendrick.

9. Claimant also asserts a "cause of action" for violation of the Arkansas Protection of Long-Term Care Facility Residents Act, Ark. Code Ann. §20-10-1201 *et. seq.* However, Ark. Code Ann. §20-10-1209(a) provides that "any [injured resident] may bring a cause of action under §16-114-201 et. seq..." Subsection (d)(1) further provides that "[a] deprivation or infringement of rights under this subchapter does not itself create an additional cause of action." Accordingly, there is no separate cause of action available to Claimant for violation of this Act.

10. In any event, there is no evidence of any violation by Respondent of the Act which resulted in any injury to Mr. Kendrick.

11. For these reasons, the Commission finds and concludes that Claimant's claim is without merit, and is hereby denied and dismissed.

IT IS SO ORDERED.

CONCLUSION

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Upon consideration of all the facts, as stated above, the Claimant Commission hereby Unanimously disallows this claim, and hereby dismisses same.

Date of Hearing: March 10, 2016

Date of Disposition:_____

_____
Chairman

_____
Commissioner

_____
Commissioner

STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $? **Claim No.** 14-0154-CC

Lanelle Kendrick
Estate of Kenny Kendrick **Claimant**

vs.

Department of Human Services, Behavioral Health

Respondent

State of Arkansas August 15, 2013

Date Filed

Attorneys
Robert H. Edwards, Attorney
Jeff Priebe, Attorney **Claimant**

Brooks White, Legal Counsel **Respondent**

Type of Claim Failure to Follow Procedure, Wrongful Death, Negligence, Pain & Suffering, Mental Anguish

FINDING OF FACTS

The original claim was filed for failure to follow procedure, wrongful death, negligence, pain and suffering and mental anguish in the total amount of $320,000.00. The Estate of Kenny Kendrick is awarded $160,000.00 and Lanelle Kendrick is awarded $160,000.00 against the Arkansas Department of Human Services. Present at Hearing on March 10, 2016 was the Claimant, represented by Attorneys Robert Edwards Jeff Priebe, and the Respondent, represented by Brooks White, Attorney. The Claims Commission herby unanimously finds for the Claimant, Lanelle Kendrick. in the amount of $?????.

PROPOSED FINDINGS OF FACT

1. Kenny Kendrick lived almost 41 years of his life at home and had been taken care of by his mother, Lanelle, with the help of home health aides.

2. That when the Arkansas Health Center admitted Kenny as a resident, the Arkansas Health Center was aware that Kenny was totally dependent on the Arkansas Health Center for all aspects of his life including that he required a ventilator for oxygen.

3. Kenny Kendrick was entitled to receive his Arkansas Resident Rights including the right to receive adequate and appropriate healthcare and the right to be treated courteously, fairly and with the fullest measure of dignity.

4. The policies of the Arkansas Health Center were mandatory and were required to be followed by the staff.

(See Back of Opinion Form)

CONCLUSION

Upon considerable consideration of all the facts, as stated above, the Claims Commission hereby unanimously allows this claim in the total amount of $320,000.00 and The Estate of Kenny Kendrick is awarded $160,000.00 and Lanelle Kendrick is awarded $160,000.00 **will include the claim in a claims bill to be submitted to the appropriate session of the General Assembly, for subsequent approval and payment.**

Date of Hearing **March 10, 2016**

Date of Disposition **March 10, 2016**

Chairman

Commissioner

Commissioner

***Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33 of 1997 and as found in Arkansas Code Annotated §19-10-211.*

5. The Arkansas Health Center was to provide patients such as Kenny Kendrick with "exceptional nursing home care" pursuant to its mission statement.

6. The policy of the Arkansas Health Center required nurses to check on patients such as Kenny Kendrick every hour.

7. The ventilator manual required the Arkansas Health Center to continuously monitor vent patients such as Kenny Kendrick.

8. That the Arkansas Health Center was required to follow physician orders for Kenny Kendrick.

9. The Arkansas Health Center was responsible for setting and maintaining the ventilator alarms for Kenny Kendrick.

10. The Arkansas Health Center was responsible for unlocking and locking the cannula tube on Kenny Kendrick.

11. That the Arkansas Health Center turned off Kenny Kendrick's low minute volume alarm without having a physician order.

12. The records of the Arkansas Health Center document that nurses actually laid eyes on Kenny Kendrick at 8:20 a.m. and again at 12:10 p.m. and that almost four hours went by without documentation of nurses laying eyes on Kenny Kendrick.

13. That on the morning of July 15, 2013, at 11:45 a.m., Kenny Kendrick's alarm sounded.

14. When the Arkansas Health Center staff asked him what was wrong he said one word -- "accident."

15. The term "accident" only appeared in one entry in Kenny Kendrick's official Arkansas Health Center medical records and that entry was made after Kenny Kendrick had died.

16. Despite hearing Kenny Kendrick say "accident" none of the staff at the Arkansas Health Center physically checked on him to see if there was a problem.

17. That at 12:10 p.m. (25 minutes after he said "accident") when staff went to check his blood sugar (that was ordered to take place at 11:00 a.m.); Kenny was found with his breathing tube out of his throat and was blue and cyanotic.

18. That when he was found around 12:10 p.m. he was cyanotic because he lacked oxygen because his tube was dislodged.

19. Kenny Kendrick had a pulse at the time he was found at 12:10 a.m.

20. Kenny Kendrick died, in whole or in part, because of a lack of oxygen.

21. Kenny Kendrick died as a result of his breathing tube not providing him with the oxygen that he needed to live.

22. That the event trace on Kenny's ventilator indicates that no alarms sounded on the ventilator from 6:52 a.m. until 12:44 p.m.

23. Kenny Kendrick did not remove his own breathing tube.

24. Kenny was forty-one years old when he died.

25. Kenny is survived by his mother, Lanelle Kendrick, who loved her son very much and still loves him to this day.

26. The Arkansas Health Center failed to follow physician's orders for Kenny Kendrick.

27. The Arkansas Health Center failed to check Kenny Kendrick's blood sugar as was ordered to be done at 11:00 a.m. on July 15, 2013.

28. The Arkansas Health Center progress notes reflect that there were no entries made between 5:40 p.m. on July 14, 2013, and 12:13 p.m. on July 15, 2013.

29. The Arkansas Health Center failed to constantly monitor Kenny Kendrick.

30. The Arkansas Health Center failed to follow its policies in the care and treatment of Kenny Kendrick.

31. The Arkansas Health Center charted that it provided care and treatment to Kenny Kendrick after he died.

PROPOSED CONCLUSIONS OF LAW

1. The Arkansas Health Center failed to follow its own policies and procedures in providing care to Kenny Kendrick.

2. The Arkansas Health Center failed to follow the ventilator manufacturer policies and procedures in providing care to Kenny Kendrick.

3. The Arkansas Health Center failed to follow physician orders for Kenny Kendrick.

4. The Arkansas Health Center was solely responsible for the monitoring of Kenny Kendrick.

5. The Arkansas Health Center was solely responsible for ensuring that Kenny Kendrick's cannula tube did not become dislodged or removed.

6. The Arkansas Health Center failed to meet the standard of care related to Kenny Kendrick.

7. The Arkansas Health Center was negligent in the care of Kenny Kendrick.

8. That the Arkansas Health Center was medically negligent in the care of Kenny Kendrick.

9. The Arkansas Health Center failed to ensure that Kenny Kendrick received his Arkansas Resident Rights, specifically the right to receive adequate and appropriate healthcare and the right to be treated courteously, fairly and with the fullest measure of dignity.

10. That as a result of these failures, the Arkansas Health Center was a proximate cause of the death of Kenny Kendrick.

11. As a result of the actions of the Arkansas Health Center, the Estate of Kenny Kendrick is entitled to compensation of $160,000.

12. As a result of the actions of the Arkansas Health Center, Lanelle Kendrick is entitled to compensation of $160,000.

13. That the Arkansas Department of Human Services is not entitled to be reimbursed for any monies that were paid by Medicaid for the care and treatment of Kenny Kendrick either during his life or at the Arkansas Health Center.

IT IS SO ORDERED.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Arkansas
State Claims Commission
APR 18 2016
RECEIVED

April 18, 2016

Via hand delivery

Ms. Brenda Wade, Director
Arkansas Claims Commission
101 East Capitol Avenue
Little Rock, Arkansas 72201-3823

Re: *Estate of Kendrick v. DHS*, Claims Commission Case No. 14-0154-CC

Dear Brenda:

Respondent Department of Human Services (DHS) hereby appeals the decision of the Arkansas Claims Commission to the General Assembly pursuant to Arkansas Code Ann. §19-10-211. DHS respectfully requests that this matter be set for hearing before the Claims Review subcommittee.

The Claims Commission's decision that Arkansas Health Center (AHC) negligently caused the death of Mr. Kendrick is not supported by actual facts. The Commission adopted the Claimant's pre-hearing submission of proposed findings and conclusions verbatim, and Claimant's submission contains multiple assertions of fact which are not supported by any evidence of record. In fact, as will be explained below, Claimant's theory of how AHC caused Mr. Kendrick's death is not even physically possible.

Basic Facts

The basic facts are not in dispute: Mr. Kendrick, a ventilator-dependent patient, died on July 15, 2013 while a resident at AHC. That morning, at approximately 11:45, he made a call on his foot-operated call light. When nurse Kay Moseley answered, Mr. Kendrick stated one word: "accident." Ms. Moseley testified that she recognized this as Mr. Kendrick's accidentally hitting the call light with his foot, because he had done so many times in the past and said the same thing. At approximately 12:10, personnel went to check on Mr. Kendrick, who liked to keep a sheet over his head. When personnel pulled the sheet down, they discovered that he was blue-colored, and that his trach tube had dislodged. Mr. Kendrick was taken to the hospital, and died shortly thereafter. A ventilator alarm – the low pressure alarm - was supposed to sound on the ventilator when the trach tube dislodged to alert staff to any dislodgment, but it failed to do so. Another alarm on the ventilator – the low minute volume alarm – was disabled per physician's orders.

Mr. Kendrick Could Not Have Stated "Accident" If His Trach Tube Had Dislodged.

From these facts, Claimant theorizes that when Mr. Kendrick stated "accident", he was calling for help because his trach tube had dislodged, instead of it being an accidental call. Thus, argues Claimant, the facility personnel should have checked on Mr. Kendrick, and had they done so, they would have discovered him in time to keep him from dying.[1] This theory defies possibility because ***people, including Mr. Kendrick, cannot talk when they can't breathe, and Mr. Kendrick would not have been able to breathe if his trach tube had dislodged.*** Nevertheless, the Commission found for Claimant, at least implicitly finding that somehow Mr. Kendrick did something no human being has ever done, and talked without being able to breathe.

A Person With Normal Mental Function And Speaking Ability Like Mr. Kendrick Would Not Merely State "Accident" If He Was Trying to Inform Staff of a Dislodgment Of His Trach Tube.

Moreover, even if one looks past this impossibility, there is no reasonable explanation for why, if Mr. Kendrick made a call to the nurse's station to inform staff of his tube dislodging, he would merely state "accident." It is important to understand that Mr. Kendrick was not in any way mentally impaired and had normal cognitive function and speaking ability. Accordingly, Mr. Kendrick, had he realized his trach tube had dislodged, would have certainly said something like, "I need help, my trach tube has dislodged", instead of simply the word "accident." Yet, the Commission found that he did the latter.

Erroneous Findings of Fact

Following is a brief explanation of some of the most serious erroneous findings in the Commission's order:

Finding #11: That the Arkansas Health Center turned off Kenny Kendrick's low minute volume alarm without having a physician order.

This finding is simply false. There was a physician order which specifically stated that the low minute volume alarm was to be turned off, and Respondent made it clear in pre-hearing briefing that such an order existed by attaching the order after Claimant falsely asserted in its briefing that there was no such order.

Finding #13: That on the morning of July 15, 2013, at 11:45 a.m., Kenny Kendrick's alarm sounded.

[1] Claimant's case rests on an assumption that Mr. Kendrick died because the trach tube dislodged, which is an assumption unsupportable by the record or any competent medical testimony. Mr. Kendrick was terminally ill, with chronic congestive heart failure, diabetes, and morbid obesity in addition to his primary illness of Duchenne's muscular dystrophy. Indeed, the opinion of Dr. Ed Hill, one of Mr. Kendrick's actual treating physicians and a staff physician at AHC, opined that the trach tube dislodgement was a *result of* an acute health event, not the cause of Mr. Kendrick's demise. In harmony with Dr. Hill's opinion, Mr. Kendrick's primary care physician, Dr. Berner, testified that Mr. Kendrick's life expectancy was six to twelve months.

Again, this finding is false. No ventilator alarm sounded at 11:45. Mr. Kendrick *made a call on his call light* to the nurse's station at 11:45, and nurse Moseley answered the call. The call light is not an alarm.

Finding #18: That when he was found around 12:10 p.m., he was cyanotic because he lacked oxygen because his tube was dislodged.

This was indeed the opinion of Dr. Loren Lipson, Claimant's medical expert. However, as pointed out in Respondent's briefing, Dr. Lipson had no explanation whatsoever as to why, if Mr. Kendrick was conscious at the time his tube dislodged, he did not make a call to the nurse's station to inform the staff of the problem. Dr. Lipson did not even assert that the call stating "accident" was a call informing the staff of any problem. Indeed, Dr. Lipson candidly stated "I don't know" when asked why Mr. Kendrick made no call informing staff of dislodgment of his tube. The fact that he did not make a call indicates that Mr. Kendrick could not make a call because had been rendered unconscious as a result of some acute health event related to his grave condition.

These are only some of the most serious erroneous findings. There are others which are erroneous. Moreover, the remainder of the findings are red herrings which do not support a conclusion that AHC negligently caused the death of Mr. Kendrick in the manner Claimant asserted. Noticeably absent is any set of reasoned, logical findings which explain how the facility actually negligently caused Mr. Kendrick's death.

In Any Event, The Award of $320,000 Is Excessive

Finally, even if the Commission's conclusion as to liability is accepted, the award of $320,000 is excessive. While any death is a tragedy, Mr. Kendrick was in grave health, and his treating physician gave him a life expectancy of six to twelve months at the time of his death. Mr. Kendrick's grave health condition had progressed to the point where he was completely bedridden.

For these reasons, Respondent respectfully requests that the Committee reverse the decision of the Commission, and that even if liability is upheld, that the award of $320,000 be reduced.

Sincerely,

Brooks White

cc (via email): Jeff Priebe
Bob Edwards