In The Matter Of:

STARWYCK v.
ARC FREEDOM SQUARE

DR. PERRY STARER
May 20, 2014

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IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT
IN AND FOR PINELLAS COUNTY, STATE OF FLORIDA
CIVIL DIVISION
THE ESTATE OF STEPHEN L. STARWYCK,
by and through SIOBHAN CHICOINE,
Personal Representative,
Plaintiff,
Case No:
-against- 12-12070-CI-11
ARC FREEDOM SQUARE, LLC; ARC
MANAGEMENT, LLC; AMERICAN
RETIREMENT CORPORATION; BROOKDALE
SENIOR LIVING, INC. and
HERSHEL CAYWOOD, JR. (as to FREEDOM
SQUARE REHABILITATION AND NURSING
SERVICES),
Defendants.

IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT
IN AND FOR PINELLAS COUNTY, STATE OF FLORIDA
CIVIL DIVISION
THE ESTATE OF STEPHEN L. STARWYCK,
by and through SIOBHAN CHICOINE,
Personal Representative,
Plaintiff,
Case No:
-against- 12-12073-CI-8
ARC FREEDOM SQUARE, LLC; ARC
MANAGEMENT, LLC; AMERICAN
RETIREMENT CORPORATION; BROOKDALE
SENIOR LIVING, INC.; and SHELLY
CRADDOCK (as to THE INN AT FREEDOM
SQUARE),
Defendants.

IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT
IN AND FOR PINELLAS COUNTY, STATE OF FLORIDA
CIVIL DIVISION
ARC FREEDOM SQUARE, LLC d/b/a
THE INN AT FREEDOM SQUARE,
Plaintiff,
vs. Case No.:
12-8526CO
SIOBHAN CHICOINE,as Personal Division 054
Representative of, THE ESTATE
OF STEPHEN L. STARWYCK,
Defendants.

(Consolidated with Case Numbers: 12-12070-CI-11;
12-12073-CI-8 and 12-8526CO)

DEPOSITION of PERRY J. STARER, M.D.,
held at the offices of Fink & Carney Reporting and
Video Services, 39 West 37th Street, New York, New
York 10018, on Tuesday, May 20, 2014, commencing at
8:22 a.m., before Jean Wilm, a Registered
Professional Reporter, Certified LiveNote Reporter
and Notary Public within and for the State of New
York.

APPEARANCES:
WILKES & McHUGH, P.A.
Attorneys for Plaintiff
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Tampa, Florida 33609
BY: DONNA K. HAYNES, Esq.

QUINTAIROS, PRIETO, WOOD & BOYER, P.A.
Attorneys for Defendants
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Tampa, Florida 33607
BY: SHEILA K. NICHOLSON, Esq.

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PERRY J. STARER, M.D.,
called as a witness, having been first
duly sworn/affirmed by Jean Wilm, a
Notary Public within and for the State
of New York, was examined and testified
as follows:

EXAMINATION

BY MS. NICHOLSON:

Q: Good morning. Can you state your name?

A: Good morning. Perry Starer.

Q: It's my understanding you have been retained by the plaintiff in this matter to provide opinions?

A: That is correct.

Q: Are your opinions final?

MS. HANES: Form.

A: Well, my opinions are final as far as the material that I have been presented with to date. If I receive additional material, there may be additional opinions.

Q: What, if any, materials do you think you may be missing?

A: At this time, I don't know of any

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additional material that I'm missing, but sometimes there are additional depositions which are taken, so if there were, I would like to see those.

Q: It's my understanding you have given depositions before.

A: That's correct.

Q: Approximately how many?

A: I would have to estimate. It would be around 75 or 80.

Q: How about trials; have you testified at trial before?

A: Yes, I have.

Q: Approximately how many?

A: I'd say approximately 14 or 15.

Q: Have you testified at arbitrations before?

A: No, I don't believe I have.

Q: Of the approximate 70 to 80 depositions, how many of those would have been for the plaintiff?

A: I think they were all for the plaintiff.

Q: Of the 14 to 15 trials, how many would have been as an expert for the plaintiff?

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A: All of them.

Q: Other than the opinions that you've given in the affidavit that we will spend sometime with, do you have any other opinions?

A: I believe my opinions are fairly well summarized in the affidavit. I might have additional opinions that would support those opinions. That is to say, there might be evidence in the records which would support the opinions in the affidavit which were not actually included in the affidavit, as to say, the evidence for the opinions.

Q: What additional bases would there be for the dehydration opinion?

MS. HANES: Form.

A: Well, in order to answer that accurately, I would now have to look at the affidavit and then look at my notes and then see what's not there.

Q: Just off the top of your head, you can't tell me what the difference would be?

A: No. I just want to be fair and let you know that there might be items that are contained in my notes which were not included in the

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affidavit.

Q: It's my understanding looking through the affidavit that essentially you have two opinions: One regarding dehydration and one regarding pressure ulcers?

MS. HANES: Form.

A: That is correct.

Q: Other than dehydration and pressure ulcers, do you have any other, what I will call, broad category opinions?

MS. HANES: Form.

A: Well, if we are categorizing it as that, I would also include suffering and death.

Q: Anything else?

A: Well, also I would, if we are looking for broad categories, a failure to have a structured approach to ensure the well-being of a resident. In this case the resident being Mr. Starwyck.

Q: Anything else?

A: I think those are oddly the broad categories for which I will be offering opinions.

MS. NICHOLSON: What I would like to do is go ahead and go through the notice of deposition duces tecum. I appreciate

everybody rescheduling based on some unusual flight problems last week.

We will attach a notice of your deposition duces tecum — it's actually the third amended notice — as Exhibit 1.

(Third Amended Notice of Taking Deposition Duces Tecum was marked as Deposition Exhibit 1 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Were you provided a copy of the duces tecum?

A: I believe I was. I was provided with multiple copies, so I'm trying to locate the most recent one.

I have the one which says we are meeting at 8 a.m. on May 20th.

Q: The one for this morning, you don't have?

A: This is the one for this morning. 8 a.m. May 20th.

Q: Yes, today is May 20th. I'm going to go through the duces tecum that was attached because it had several items

to bring with you today and then we will identify what is in front of you and what you brought with you to the deposition today.

Paragraph 1 asked for a current copy of your resume or curriculum vitae. From what I can tell, the affidavit was executed April 26, 2014 and there is a CV attached to that.

Would that be your latest updated CV?

A: I have not updated it since then, so it should be.

Q: As an academic appointment for Mt. Sinai School of Medicine, what courses do you teach?

A: There is no set courses with that kind of teaching. It is on-site training in a hospital as care is delivered to the patients.

Q: Would the term "clinical education" be appropriate to use for that?

A: That would be fair.

Q: Then hospital appointments, the City Hospital at Elmhurst, what do you do for them?

A: So it's all taking — to make it as clear as possible, I have a faculty appointment at the medical school and I am an attending physician

in the hospital and that's both occurring simultaneously, so while I'm caring for patients in the hospital, I am teaching students and house officers in the same setting.

Q: Do you have what some physicians call a private practice?

A: I do now, yes. It's a recent addition.

Q: When did you start that?

A: I started it with an office in November, but it's been a gradual development, so even though I started November, there weren't that many patients.

Q: November 2013?

A: That is correct.

Q: What is the name of the practice?

A: Elmhurst Medical Providers.

Q: Is that an LLC? Incorporated? What type of business entity is it?

A: I really don't know. It's structured so that I'm an employee.

Q: Is the hospital — because of the Accountable Care Act and all of the things that are going on, many physicians are joining hospitals as a

practice. Is that what this is?

A: No. If anything, it's the opposite. I'm making an effort to leave the hospital.

Q: Are you currently seeing any residents at an assisted living facility or a nursing home?

A: No. I am not currently entering such facilities in order to deliver care within the facilities.

Q: Have you ever delivered care in an assisted living facility?

A: I have had patients who have been in assisted living facilities but when I delivered care to them, it would be in a hospital or office setting, not in their apartments.

Q: Have you cared for residents in a nursing home?

A: I have.

Q: Would that have been in the nursing home or would the patients have been brought to your clinic or at the hospital?

A: Well, it's both. I also did work in a nursing home. More than one, actually.

Q: When was the last time you cared for a resident, actually going to the nursing home and

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caring for the resident?
A: Actually providing care within the facility probably would have been around 1999.
Q: Have you ever been a medical director of a nursing home?
A: I have.
Q: When was the last time you were a medical director of a nursing home?
A: Once again, similar time, was in the late 1990s.
Q: Do you recall the name of the nursing home?
A: It didn't have a name. It was a skilled nursing facility within the Elmhurst Hospital. It occupied two floors, but we were certified, we were licensed as a skilled nursing facility.
Q: Was the unit known as a transitional care unit?
A: No. We didn't have such terminology at the time. It was actually a real skilled nursing facility.
Q: Under your publications, would any of the publications that you've listed in the CV relate

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to any of the issues in this matter?
A: I believe some of them might.
Q: Which ones?
A: I'm going to exclude the ones that do address urinary function even though Mr. Starwyck had problems with urinary retention. I don't think we are speaking about that today.
So then I would say that the articles that relate would be number 12 which is entitled "Medical Care of the Elderly in the Nursing Home," and number 19, "Care of the Nursing Home Patient."
Q: Any others?
A: That's all.
Q: Under textbook chapter, would any of those relate?
A: There may be an indirect relationship with number two, history and physical examination because it's a very general article, so it may touch upon some of the areas, but it's not going to specifically relate to the case of Mr. Starwyck.
Q: Under other publications, would any of them be related?
A: Probably not.
Q: Under abstracts?

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A: The answer is the same.
Q: Paragraph 2 on the notice of duces tecum asks for any of the texts, periodicals, or articles that you have authored or edited.
Did you bring of those with you today?
A: No, I have not.
Q: Number 3 asks for your time records, diary bills related to this matter.
Have you any invoices regarding this matter?
A: No, not at this point.
Q: How much time at this point have you spent on this matter?
A: I think it's about maybe 20 hours, I think. That's everything from the beginning.
Q: When were you retained?
If you have transmittal letters or correspondence, go ahead and pull those out.
A: I believe I was first retained around February of this year, 2014.
Q: Do you have it?
A: Oh, you want to see them?
Q: Yes. I'm going to go ahead and attach them.

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A: (Handing.)
MS. NICHOLSON: Donna, do you need to see them? (Handing.)
We will attach the three transmittal letters as Defendant Exhibit 2.
(Three transmittal letters was marked as Deposition Exhibit 2 for identification, as of this date.)
BY MS. NICHOLSON:
Q: Usually the transmittal letters come with the records. My assumption right now is that they came on a CD. Am I correct?
A: Yes, I have the CDs.
Q: Do you know which CD goes with this particular transmittal letter?
A: There should be dates on them and then some other identifying information.
Q: February 6th, would that correlate with the February 6th transmittal letter?
A: Yes, it does.
MS. NICHOLSON: We will attach a copy of that as Exhibit 3.
(CD, "Initial Medical Records 2/6/14" was marked as Deposition Exhibit 3

for identification, as of this date.)

BY MS. NICHOLSON:

Q: May 9th, there are two transmittal letters for May 9th. Based on what I'm seeing, it looks like that CD would go with that one and this one would go with this one.

I would ask you if that is right?

A: That is correct.

MS. NICHOLSON: We will attach the CD labeled "Additional Medical Records, May 9th, 2014" as Defendant Exhibit 4, and it correlates to the transmittal letter that has four medical records: Bay Pines VA, Gentiva Home Health, Dr. Roesler, and Dr. Wilmot.

(CD "Additional Med. Recs 5/9/2014" was marked as Deposition Exhibit 4 for identification, as of this date.)

MS. NICHOLSON: We will attach the CD also dated May 9, 2014 that correlates to the transmittal letter with 31 items on it.

(CD "Depos, Discovery, Licensure, Surveys, Regs, Photos & Notes" was marked

as Deposition Exhibit 5 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Based upon the affidavit that you filed in this matter, did any of the additional documents you received May 9th, 2014 by either transmittal letter, did any of those records change any of your opinions?

A: I did receive those records after signing the affidavit and the additional records did not alter my opinion.

Q: Did any of the additional materials add any bases to your opinions?

A: Yes, I believe they did.

Q: Which ones?

MS. HANES: Do you need to see the letters?

THE WITNESS: Yes, I would need to see them.

A: Thank you (Perusing document.) As a whole, they did add to the bases of my opinion. The ones I can specifically direct you to would be the records of Morton Plant Hospital, Northside Hospital, and then there are

other records of Largo Medical Center, which I didn't have. Those also added to the bases of my opinions. Also listed on here is the hospice records, so that added to my opinion. In addition, the records of Bay Pines VA. That was on the second transmittal there.

Oh, wait. I'm sorry. I was reading off of the first one. So that wasn't new stuff.

Q: Okay.

A: Let me start again. The first I actually had.

Adding to my opinions would be the Bay Pines VA, the survey reports, and the depositions, and I would say specifically the depositions of Bernardita Baldarian and Patricia Kennedy.

Q: Anything else?

A: That's all I recall at this time.

Q: Of the 20 hours, how many of those hours would have been after the receipt of the additional materials, May 9, 2014?

A: Oh, I didn't break it down like that, so I would be — I would have to guess, if you would want me to.

Q: If you could at least estimate.

A: Being that after I received the additional materials, I was not only viewing those materials, I was beginning to prepare for the deposition, so I would say half of those hours, if not a little more.

Q: Paragraph 4 asks for your entire file and obviously you have some additional records in front of you. If I could take a look at them and see what I need to attach versus what I don't.

A: Yes. This is everything that I had put together, so I will give it to you as I have it as a packet. It's somewhat organized.

(Discussion off the record.)

BY MS. NICHOLSON:

Q: In the materials that you brought, there is a curriculum vitae versus just spending the time going through and doing a comparison, I am just going to go ahead and attach it as an exhibit.

Is that okay?

A: Fair enough.

MS. NICHOLSON: We will attach it as 6.

(Curriculum Vitae was marked as Deposition Exhibit 6 for identification,

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as of this date.)

BY MS. NICHOLSON:

Q: That looks like your original executed affidavit?

A: That's correct.

Q: I think I have kept this together and I will let you tell me if I have or haven't. It's called "Nutrition Tips."

A: You have correctly kept it together.

MS. NICHOLSON: We will attach that as Exhibit 7. If you need any of this during the depo, absolutely, you are free to use it.

(Document entitled "Nutrition Tips" was marked as Deposition Exhibit 7 for identification, as of this date.)

BY MS. NICHOLSON:

Q: What is the "Nutrition Tips"?

A: Let me just — I will give it right back to you in a minute.

(Perusing document.) I obtained this off of the Internet when I was reviewing the case, I found that there is a facility called — there is an entity called Brookdale and Brookdale was

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responsible for the care of the individuals at Freedom Square, so I went to their website to learn a little more about them.

Within the website they had information for the public and this was a series which was being written by Dr. O'Neil. I believe it's Dr. Kevin O'Neil.

So I started reading what he was writing and he had a section on nutrition and he was responding to questions that people were sending in. So I just printed out the entire question-and-answer portion from the website.

Q: Did that form the basis of any of your opinions?

A: It just supports my opinions, that's all.

Q: Again, if you need this during the depo, just let me know.

Next — and I have tried to keep these together, also. The top of the document says "Management Team."

A: That's true. Is there a question?

Q: Have I kept the documents, the three of them together?

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A: Well, they came from the same place, but "Skilled Nursing Answers" is separate from "Management Team."

Q: Was that also information you took off the Brookdale website?

A: This and the prior form, which was called "Nutrition Tips," all came from the Brookdale website, that's right.

Q: The "Skilled Nursing Answers," did that document add to the bases of any of your opinions?

A: Just, it supports my opinions.

MS. NICHOLSON: We will attach the documents, there are two pages, called "Management Team" as Exhibit 8, and the document called "Skilled Nursing Answers" as Exhibit 9.

(Document entitled "Management Team" was marked as Deposition Exhibit 8 for identification, as of this date.)

(Document entitled "Skilled Nursing Answers" was marked as Deposition Exhibit 9 for identification, as of this date.)

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BY MS. NICHOLSON:

Q: Next is what appears to be an article from Geriatric Nephrology Curriculum entitled "Chapter 18: Acute Kidney Injury In the Elderly."

Have I kept that together?

A: Yes, you have.

MS. NICHOLSON: We will attach that as Exhibit 10.

(Document entitled "Chapter 18: Acute Kidney Injury in the Elderly" was marked as Deposition Exhibit 10 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Do you consider this article or chapter authoritative?

A: As I look through it, it is a reasonable article which I would rely on in my practice.

Q: Next is a document called "AHCA Draft" and there is an exhibit list on it numbered 2, were there any other documents that went with that?

A: No. I just printed this one out and in isolation.

MS. NICHOLSON: We will attach it as

Exhibit 11.

(Document entitled "Health Care Licensing Application" was marked as Deposition Exhibit 11 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Next are two documents: One has the title at the top "Isovolemic" — I'm sure I'm not saying that right — "Isovolemic Hypernatremia" and the other is at the very top "Symptoms."

Do these two documents go together?

A: No, they don't come from the same place. They go together as far as theme, but they are not from the same place.

Q: The "Isovolemic Hypernatremia," where did that document come from?

A: Now, this one, I don't remember exactly. What I did was, while reviewing the case, I was thinking about the science and I was reading off of the Internet, but I forget — for this one, I forget where it was from and I just cut-and-paste this part out. It was a table. At this point, I can't tell you exactly which website it was from.

MS. NICHOLSON: We will attach it as

Exhibit 12.

(Document bearing "Isovolemic hypernatremia:" was marked as Deposition Exhibit 12 for identification, as of this date.)

BY MS. NICHOLSON:

Q: The document titled "Symptoms"?

A: This one I remember a little better. Once again, it was just a fraction of what was written, but I believe it came from the Mayo Clinic's website and it was a section on dehydration and I think this was also echoed in an article in The New York Times on dehydration because somehow it was linked. But I believe the original source was MayoClinic.com or something like that.

Q: As we sit here today, do you have a specific reference?

A: No, I would really have to sit down again and duplicate the online search, but it would probably come right back, the same sites.

MS. NICHOLSON: We will attach that as Exhibit 13

(Document entitled "Symptoms" was marked as Deposition Exhibit 13 for

identification, as of this date.)

BY MS. NICHOLSON:

Q: Next appear to be Florida Administrative Codes.

A: Yes, that's what they are.

Q: Would that have come from the materials from plaintiff's counsel?

A: I think this was on one of the disks and I had just printed it out.

MS. NICHOLSON: We will attach these two pages as Exhibit 14.

(Document entitled "58A-5.0181 Admission Procedures, Appropriateness of Placement and Continued Residency Criteria" was marked as Deposition Exhibit 14 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Next are multiple pages of handwritten notes. Are these your handwritten notes on the matter?

A: Yes, they are.

Q: Any idea when these were created?

A: These were created between February 2014 and last night.

MS. NICHOLSON: We will attach them as composite 15.

(Handwritten notes was marked as Deposition Exhibit 15 for identification, as of this date.)

Q: I'm going to leave these here because I will assume you may want to refer to them and obviously you can have any of this you may need.

Paragraph 5 of the duces tecum asks for you to bring a list of all the cases in which you have either testified at deposition or trial.

I have gone through the materials. Obviously there is no list there.

Do you maintain a list?

A: I didn't bring this because I don't have a list for the past ten years. I have a smaller list.

Q: So you do have a list of cases that would be inclusive within the last ten years?

A: It wouldn't be going back ten years. It would be only going back maybe three or four years.

Q: I'm going to ask you to get that to the court reporter.

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A: Actually, I can get it for you right now. I didn't have it in the file because I didn't think it complied, but I did bring along a list of the ten — three years. Let me just make sure this is it. Yes, this is it.

MS. NICHOLSON: We will attach that as Exhibit 16.

(List of cases was marked as Deposition Exhibit 16 for identification, as of this date.)

BY MS. NICHOLSON:

Q: The next paragraph asks for a current fee schedule.

A: I don't have it written down, but I can transmit it to you verbally.

Q: Okay.

A: $200 an hour for review of records or other information, consultation, examination, preparing of my opinions.

Q: Do you charge any other fees?

A: Well, $200 an hour for time testifying.

Q: Depositions, trial testimony?

A: Yes, yes.

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Q: So $200 per hour is just inclusive of everything?

A: Yes.

Q: Paragraph 7 asks for any documents that would reflect the number of times that you have been retained by this particular plaintiff or the Wilkes & McHugh law firm and I think there is an objection filed to that.

MS. HANES: I did. I filed an objection to number 7 and number 11.

Q: Just so if I need to take this further with a judge, do you maintain any type of a record that would identify the number of times you have been retained by the Wilkes & McHugh law firm?

A: I have not created such a record. All I may have are letters that they sent me, but I don't save them after a case is resolved.

Q: Have you been retained by the Wilkes & McHugh law firm before?

A: Yes, I have.

Q: Do you have any idea how many times?

A: I would have to estimate.

Q: And the estimate would be?

A: Maybe ten or fifteen times.

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Q: Number 8 asks for a copy of the courses and seminars that you have attended in the last five years and when I went through the curriculum vitae, those are not listed on there.

Do you have any such list?

A: I don't keep a record of courses or seminars that I have attended.

Q: Number 9 asks for copies of any transcripts that you have of other prior depositions or trial testimony.

Do you have any?

A: I don't think I've ever received — I don't know if I have ever received trial testimony depositions and as far as transcripts of other depositions, when I don't need them, I discard them, so I don't think I have any at this time.

Q: Paragraph 10 asks for any prior affidavits that you have executed as a legal consultant.

Do you have any?

A: No, I don't think I have.

Q: I want to talk a little bit about renal disease.

When a patient has renal disease, is

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there a classification to it?

MS. HANES: Form.

A: Well, there are classes of renal disease, yes. May I have the article just in case? Just give me the whole packet and I will sort it out.

There are classifications as far as the chronicity of it, so you can classify renal disease as acute renal disease or chronic renal disease. Sometimes they might say acute renal injury.

There may also be classifications which would address the cause of the renal disease. That is to say, is it renal, prerenal, or postrenal.

There may also be classifications which would address the etiology of the renal disease by describing it as diabetic nephropathy or hypertensive nephropathy.

Q: And the article that you are looking at and referring to is Exhibit 10.

A: And I was not actually reading from the article but I just had it here in case you decided to discuss the article.

Q: The word "renal," when folks are

talking about renal disease, for the layperson, is that the kidneys?

A: We are speaking about the kidneys.

Q: If someone has renal disease, what is the prognosis? What is going to happen with regards to the renal disease?

MS. HANES: Form.

A: It's a very general prediction. In some cases, they may recover. In some cases, they might lose kidney function. However, they may still thrive.

I guess to be more specific, there are two kidneys, so somebody might have disease in one kidney, but they will still do well because of the second kidney.

To try and be as complete in my answer as possible, even with damage to the kidneys, which is not reversible and which may seriously impair the kidney's function, people have survived by being treated with dialysis.

Q: Is there any objective finding that indicates when a patient with renal disease would need to start dialysis?

A: There is always discussions as to when

somebody wants to go onto dialysis and it might be based on the glomerular filtration rate, which is a measure of the kidney's ability to filter out toxins from the blood. Because, as you know, the kidney is an organ which extracts waste material from the body which then comes out in urine.

But I just want to make sure everybody understands, it's not going to be based on just some number. It's going to be based upon quality of life and what a person chooses to do. So not everybody is going to want to go onto dialysis. It is a treatment which some might find very burdensome.

So there is a constellation of variables which would determine whether the doctor and the patient choose to use dialysis as a treatment modality.

Q: If a patient has kidney disease that has progressed to the point where they need dialysis but between that patient and the physician, a decision is made not to do the dialysis, is the renal disease going to get better or is it going to get worse?

A: If the kidneys have advanced to a point where dialysis is considered, then there is a

very likely possibility that the patient may not do well. Even if the kidney disease does not advance, they may not be able to thrive because it would be my understanding dialysis was recommended due to the need to have an additional way to filter toxins out of the body.

Q: Do you know how many years on average it would take someone diagnosed with chronic renal disease to make it to the point to where the kidneys would completely fail?

MS. HANES: Form.

A: I don't think I could say on average. Chronic kidney disease just indicates that there is a problem with the kidneys which is not going away. It's not reversible.

So I would look at each patient's individual trajectory to see how they are doing over time and then you can get a better prediction as to what the future may hold.

Q: In that projectory, what would you be looking for?

A: Well, in the trajectory which would allow me to make a prediction, I would look at variables such as the blood urea nitrogen and the

creatinine level. If I see that they are stable, then I would say that this patient is having a slow decline or no decline in kidney function. If I see that the numbers are not stable, then it indicates that the decline may be more rapid.

Q: When you are talking about stable, just talking about the BUN — which is the blood urea nitrogen, correct?

A: That is true.

Q: It is my understanding that, as with lab values, there is what is considered to be the normal range.

A: There is that reference range which is considered to be normal that most people would be within that range.

Q: When you are talking about you would look to see whether or not — one of the factors would be whether or not the BUN is stable or not stable, what would you use to define whether or not it's stable?

A: What I use is the patient's own baseline. So I look at the reference range to see how the patient compares to the general population, but most importantly, in making a prediction about

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future trends, I look at what the patient's own number was in comparison to what it currently is. I look at what it previously was.

Q: Then if the number that you've identified is the patient's own number, what type of fluctuation would you then define that it's stable or it's not stable?

A: Well, you can allow it to fluctuate by, you know, two or three or four, but you also want to see what the patient's condition was at the time.

And to be more precise in that answer, if there is an increase in the blood urea nitrogen, I want to see what else was happening with the patient at that time.

If the patient became acutely ill and there is a sudden change in the blood urea nitrogen level, a change being an elevation, I want to see if following the acute illness, the blood urea nitrogen returns to the patient's baseline. You have to factor that in also.

If it's elevated and remains elevated that indicates one thing. If it's elevated temporarily and then returns back to the baseline,

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that means something else.

Q: If it elevates and returns back to its baseline, what does that mean?

A: All right. If the baseline was abnormal — we are talking in general, but let's say the blood urea nitrogen baseline when we first start the analysis is above the reference range, then we can say that the patient has some renal disease and if it stays above the baseline at about that level, then we say this is chronic. If it suddenly jumps up and then returns to the baseline, we say that was an acute elevation, there was an acute insult to the kidney, so that is an acute chronic injury to the kidney on top of the chronic disease.

Q: What can cause that?

A: That's when we start getting into these categories of renal, prerenal, and postrenal. So within those categories, there are explanations.

Q: Are there any other causes other than renal, prerenal, and postrenal?

A: Well, these are categories, so within those categories, there are causes. By using that way of explaining it, it becomes more understandable for people. If you say renal, prerenal, or

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postrenal, it's a classification system that makes it easier to determine what the diagnosis is. But those are not actually the causes. Those are the categories which the causes go into.

Q: What are some of the causes?

A: All right. So if you have renal — acute kidney injury, one of the causes could be a medication effect. It means that there is something happening to the kidney itself, and that's why you have a problem with the function, but it could be reversed. The same thing could happen if there is say an inflammatory process affecting the kidney. So that is renal.

Prerenal means something is happening before the blood gets to the kidney, that there is a problem which is reducing fluid — I'm talking very simply — reducing fluid from flowing to the kidney. So the kidney has less blood profusion and that can happen in dehydration. It also would be that phrase hypovolemic we were talking about before. So if the kidneys don't receive enough profusion, the kidneys don't function well.

So with the renal problems we talked about, such as medicine causing a problem, if you

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take away the medicine, it may reverse. If it is prerenal and there is a decrease in volume, hypovolemia, decrease in perfusion, if we restore that, it can return to previous kidney function. That is why it is called acute.

Postrenal is a problem which occurs beyond the kidney and that would be an obstruction to urine flowing out of the body. So if somebody goes into urinary retention, which occurs after the kidney, then to say it simply, the urine backs up and there is decreased flow and then the kidneys suffer in that way.

But if you relieve the obstruction in postrenal acute kidney injury, then the kidney can return to normal function.

Q: Are there other causes for the prerenal?

A: Well, dehydration is the general category, so there can be different reasons for that. That would be anything which might lead to a loss of fluid, such as vomiting or bleeding or poor oral intake or the use of a diuretic, anything which dries the person out.

There is also a possibility that there

can be a problem if the heart fails and stops pumping the blood. Generally, it's anything which would keep blood flow from reducing — from — anything that would keep blood flow going to the kidney in a manner which it had done previously.

Q: What is syncope?

A: Syncope is fainting. It's loss of consciousness.

Q: My understanding is there can be a multitude of causes for syncope.

Would you agree with that?

A: I do.

Q: How do you treat it?

A: It's very general, but the general answer is, if somebody is having syncope, the first thing you do is make sure they don't hit the floor and injure themselves.

If you are speaking about preventing the next episode of syncope, then you would be able to treat it if you determine what the cause of it is.

But a fainting person has to be put in a protected setting so they don't injure themselves.

Q: Alzheimer's disease, would you agree

that it's a terminal disease?

A: No, not necessarily.

Q: Is Alzheimer's going to progress?

A: That's my understanding. That is how it is defined currently.

Q: If someone does not succumb to another disease process and the Alzheimer's progresses to its end stage, will they lose the ability to swallow?

MS. HANES: Form.

A: I think it is our current understanding that if somebody has no other conditions which may lead to their death and they live long enough and the disease is relentless enough to progress to the end stage, one thing which can happen is they will not take in food.

I can't say with certainty, and I don't know if it's understood, whether they are losing the ability to swallow or if they are losing the ability to eat unrelated to the swallowing process.

Q: Describing a patient like you just did, someone that, for lack of a better way of describing it, survives the other processes that may

or may not be going on with them, if they progress to the point of end-stage Alzheimer's, are they going to lose the ability to intake food and water or food and fluid?

MS. HANES: Form.

A: I can't say it's going to happen in every patient. There are staging mechanisms where they will describe someone as being end-stage dementia, but the aspect of not eating I don't think is that well defined and it may be something which is still remediable in that a patient with dementia is not eating because they are not understanding why they are being fed or they are not motivated to eat or they have lost the memory of how to eat, but there are opportunities within that to maintain nutrition.

Q: When you say "eating," does that include food and fluid?

A: Yes, yes.

Q: And when you say "nutrition," is that including food and fluid?

A: Well, I say "nutrition." I probably would make that more specific as far as calories and protein and I would leave fluid in a separate

category with the understanding that, for the most part, it's all coming in through the mouth.

Q: You said there are ways to remediate that situation where someone, if they progress to the end stage and wouldn't intake the food or the fluid, is one of the remediations a PEG tube, a feeding tube?

A: That would probably be a treatment one would put in reserve, if they ever use it at all.

Q: What would be the other ways to remediate?

A: Here I am approaching this with the idea that each person is an individual and the disease may manifest itself slightly different in each individual.

So after making a determination that the patient is alert, then we don't have to worry about the patient who, in the absence of alertness, can't process food without choking because you are not awake. We can then examine the entity which is called apraxia, and that means that the patient is unable to coordinate the muscles in a way to accomplish the task.

That's why I did want to separate that

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from dysphasia, which is a problem with swallowing.
Apraxia would be somebody who has the ability to move their muscles. They may even have the understanding that something needs to be done but can't accomplish the tasks; like tying their shoes.
The same thing with eating, if there is apraxia, the patient may not be able to coordinate the movements of the lips and the tongue in order to swallow.
However, the opportunity arises to work with that patient by sitting with them, slowly feeding them and, modeling for them how eating is accomplished.
So, yes, there are opportunities to assist the patient with dementia when they eat.
Q: My question was really for a patient at end-stage Alzheimer's disease.
A: Well, let me then do my best to make sure we are talking about the same thing.
When I think of a patient who is end-stage Alzheimer's disease, it is a patient who is laying in a bed, not moving, not talking, and not recognizing who other people are or who they are.

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It really is the end stage.
In that case, it could be very difficult to feed them and in that case, someone might elect to use a tube to provide nutrition.
Q: The feeding tube would also supply the fluids if it was used?
A: It can be provided through a feeding tube. There are also intravenous tubes which may accomplish that as well.
Q: Going back to the chronic kidney disease and the projectory for prediction, you also talked about creatinine?
A: I did.
Q: Really, my question is very similar to the BUN. Does the creatinine, are you looking for it to be stable or not stable also?
A: All right. These are numbers and in simple terms, they are measuring material in the blood which is not being cleared by the kidney. So as the numbers go up, you suspect that the kidney is not functioning as well.
It's the same process. Looking at the numbers and seeing what the numbers do. That's how I would use the numbers when evaluating a patient,

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is to look at trends and to correlate it with the patient's clinical condition.
Q: What is the fluctuation in the creatinine number that you would consider stable versus not stable?
A: Here it would be, and this is rough, within one, because it's a smaller number, usually measured one point something. So there may be fluctuations to a tenth.
Q: Anemia is, my understanding, the lack of red blood cells floating around in the body?
A: I would say maybe more general that there is a problem with the red blood cells. There may also be a problem with the size of the red blood cell. It may be a problem with the concentration of the red blood cell.
Simply, there is not enough good red blood cells to carry out the functions that the body needs.
Q: Causes of anemia can be some disease processes?
A: Yes, of course. It could be problems with the production of the blood cells. There could be problems that lead to the destruction of the

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blood cells.
Q: It could also be caused by bleeding?
A: And that would be loss of blood.
Q: Is that a yes?
A: Yes.
MS. HANES: Whenever you get to a breaking point.
MS. NICHOLSON: Yes, we can, right now.
(Whereupon, a recess was taken from 9:34 a.m. to 9:40 a.m.)
PERRY J. STARER, M.D., called as a witness, having been previously sworn/affirmed, was examined and testified further:
BY MS. NICHOLSON:
Q: Sodium is also a lab measurement, correct?
A: That's true.
Q: And we will actually see sodium on a lab report as a big "N" little "a" with a positive sign, correct?
A: That's correct.
Q: What can cause the sodium to elevate?

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A: When looking at the sodium level, there has to be an understanding that it's just a measurement of the proportion of the sodium, so the sodium can go up if there is extra sodium in the body, but also the sodium measurement can be elevated if there is less fluid in the body, since it is a proportion.

I'm tying to think of something simple which we may have all seen, the experiments they used to show us where you start pouring salt into a glass of water, it dissolves and after a certain point, you start to see the salt again. Obviously the more water in the cup, the more salt you can put in it. So it is a ratio of the salt to the body fluid. The sodium being the salt.

Q: Are there any other causes besides loss of fluid that can elevate the sodium level?

A: Yes. It could be the addition of sodium. So if somebody is treating the patient with an intravenous line and there's sodium in the fluid, that can happen.

There are also possibilities that the patient is taking sodium tablets. People I think may take that because they think it is the thing to

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take in hot weather.

There are also endocrinological diseases, like Cushing's syndrome — Mr. Starwyck didn't have that — which might disrupt the sodium balance. These are things that can occur without there being a loss — without a situation which we may describe as dehydration.

Q: Other than extra sodium in the blood and less fluid, are there any other medical conditions that can cause an elevated sodium?

A: I guess a medical condition, there might be something which is called diabetes insipidus, which is not the same as diabetes mellitus, and diabetes insipidus is a situation where the kidney — again, I'm going to simplify it — is not holding onto fluid.

The kidney is an organ which filters toxins but also helps us maintain fluid balance. So while it's doing its work, it is supposed to hold onto a certain amount of fluid, but if that gets disrupted and it starts letting too much fluid get out of the body, then the fluid level will be out of balance to the sodium level and you may have an elevation of sodium without there being a situation

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where the actual volume has decreased significantly.

Q: Any other conditions that you can think of that can cause an elevated sodium without there being extra sodium in the fluid or loss of fluid?

A: I mean, there are other syndromes. I just can't think of them right now.

Q: We are going to talk a lot about hydration.

When we talk about hydration going forward, is it fair to say that there is a difference between the offering of hydration versus the intaking of hydration?

A: If you are differentiating between leading a horse to water and then having the horse drink, yes, there is a difference. You can offer somebody something but that is not the same as having that person take the offer.

Q: A nursing home resident, can you force a resident to drink their fluids?

A: I think there are certain circumstances where you can administer fluids even if the patient does not volitionally take the fluids on their own.

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Q: Would that be through intravenous fluids?

A: It can be intravenous. It may even be through a tube. If there is a situation where it has been determined that this is essential for the patient's well-being and the patient is not in a condition in which they can actually participate in their treatment plan, and there has been a discussion as to what to do, and the decision has been made to administer the fluids, then yes, it can occur.

Q: When you say "tube," you are referring to a feeding tube?

A: It depends on the sentence but since they are both tubes that go into the gastrointestinal tract and tubes that go into the circulatory system, I guess I should then specify which tube I'm talking about.

In order to provide fluids, it can be done either through a tube in the gastrointestinal tract or a tube in the circulatory system.

Q: Absent doing some type of a tube to get fluids into a nursing home resident, if the nursing home resident is, for whatever reason,

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refusing, not taking in, not interested in fluids, can the staff of a nursing home force the resident to drink?

A: See, I think that is jumping too far ahead because then we are saying we are forcing all of our babies to drink.

If we categorize something as refusal — and I'm trying to respond to the question as best I can. If we categorize something as refusal, we are basically making the determination that the patient has taken in all the information, processed the information, and has made a willful judgment to decline fluids even though they understand the consequences of it.

I don't think that applies in cases like Mr. Starwyck's. I think by categorizing it as refusal, we are jumping too far ahead and we have to determine why he stopped eating. Is it the apraxia which I have spoken about? Is it the dysphasia, which you have spoken about? Is it a dry mouth which makes it hard for him to take in processes? Is it lack of understanding on his part? Is it fear of environment? Is it depression? Is it a medication effect?

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Until you go down that list, you have not done your due diligence in the care of this patient. You have not customized the care of this individual and you don't have the right to jump to the tube.

If you focus the discussion just on terms like "refusal" and "force," you are not providing care as determined by the standard of care in the realm of the provision of proper nutrition and dehydration.

Q: And I wasn't asking about Mr. Starwyck. I am asking in general of the nursing home resident.

A: Right. It applies to nursing home residents and it certainly does apply to Mr. Starwyck.

Q: If staff puts a fluid up to the resident's mouth and pours the fluid into the resident's mouth and the resident will not, for whatever reason, swallow that fluid, is there any way for the staff to force that fluid into that resident's body?

A: There are ways to do it. I don't think that actually occurred here with Mr. Starwyck.

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But yes, there are still ways to provide what is basic and essential for the patient's survival.

Q: How would the staff do that if they are putting the liquid in the mouth and the resident would not, for whatever reason, swallow it?

A: What can be done here — and we are talking hypothetical of patients in general, because I don't remember any of this happening with Mr. Starwyck — you would determine what is his current condition? What is his state of mind? What is the environment? Is he in a room which is too hot, too cold, too strange? Is he sleepy? Does he need to urinate? Should we come back later? Should we put something in the fluid to make it more palatable? Should we put it in a container which makes it easier for him to ingest it? It could be a bottle, a baby bottle. It could be a straw. Should we have a change in the feeder? Maybe he doesn't relate well to whoever just came into the room. Should we take time? Should we drink with him?

You go down the list and you try and you customize the care to the need of the individual. You do not walk away.

If the fluid is going into his mouth

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and he is spitting it back at you, that is different than if he is choking. That is different than if it is coming out of his nose. But you have to do your due diligence to help the patient.

If you have done this, which I don't recall seeing any of this occurring with Mr. Starwyck, then you call the physician saying, we've got a problem here and we need to notify the physician. This is a change in his status or her status. This hasn't happened before and if it continues, it will be detrimental to his health or her health and we need to consider other modalities.

It could be a tube into the gastrointestinal tract. It could be an intravenous line. It could be a trip to the hospital to accomplish that.

But if a patient stops doing what they did before, you have to figure out what went wrong and you really have to try because if you don't, the patient is harmed.

Q: So ultimately if that is happening, your expectation would be that the staff communicates that information to the physician?

MS. HANES: Form.

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A: I said if you get all the way down the line. My expectation is that the staff does something and part of that something might be contacting the physician, but to do nothing at all to document that the patient is not eating or drinking and then just walk away, that is not enough.

Q: In doing something, if the staff contacts the physician, would you still consider that to be egregious conduct?

MS. HANES: Form.

A: I don't really understand that. If they did something and contacted the physician — I don't understand what you are saying.

Q: If the patient is intaking less fluid and the staff is unable to get the fluid in the patient, is it egregious conduct for the staff to contact the physician and report that?

A: No. In that moment when they contacted the physician and they delivered an understandable report, that is good conduct.

Q: Looking at your affidavit, it is my interpretation obviously and I just want to make sure whether I'm right or wrong, that the opinions

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are regarding the nursing home.

A: This is correct.

Q: Do you have any opinions regarding the assisted living facility?

A: I didn't offer any in my affidavit and unless asked a question about the assisted living facility, I wasn't expecting to offer any right now.

Q: Do you expect to offer any opinions about the assisted living facility at trial?

A: I don't know what's going to happen at trial. If I'm asked a question, I will have to answer it. I don't know what is going to be asked of me at trial.

Q: As we sit here today, do you have any opinions about the assisted living facility?

A: I don't have in my mind any opinions about the assisted living facility. I would only be able to respond to any questions about the assisted living facility.

Q: I don't want to beat a dead horse. Obviously this is my only opportunity to get your opinions that you plan to offer at trial and the bases for those opinions.

So this is my one opportunity to know

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whether or not you are going to offer any opinions about the assisted living facility at trial and it's my understanding based on your testimony now that you have not developed or plan to offer any opinions about the assisted living facility?

A: Right. I have not proactively developed any opinions. I just want to be clear that somebody might ask me a question at which point in that moment, I might have an opinion or I might say I cannot answer the question, but I can't anticipate what may be asked of me.

Q: But as we sit here today, you have no opinions about the assisted living facility to provide to me?

A: I mean, I might have opinions, favorable or unfavorable, but I was not thinking about the assisted living facility today. I thought we were going to focus on the skilled nursing home component.

Q: Just to make sure my question is answered: As we sit here today, you are not going to be offering any opinions about the assisted living facility?

A: Well, so far I haven't. Once again, I

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don't know if somebody is going to ask me something today.

Q: You have not developed any?

A: I guess to be clear, as I look at it, I do develop thoughts about it. I just have not communicated it in a affidavit. If you ask me about the assisted living facility, I may or may not respond depending on what the question is. I don't know. I don't know what I will be asked.

Q: You understand that I am here to get your understanding about the affidavit but also to get your trial opinions?

A: I do understand that.

Q: As we sit here today, have you developed any opinions that you plan to offer at trial about the assisted living facility?

A: If I would answer it that way, I would say I'm not planning to offer any opinions. I might be surprised by being asked, but I was not planning to offer an opinion.

Q: My question is really: Have you developed any opinions about the assisted living facility that you plan to offer at trial?

A: I think it would be impossible to look

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at the records and not develop opinions as you are looking at the records, but I did not put them into any tangible format, and I may not even have that in the front of my mind right now, but you might ask me something as simple as, do you think the facility was located in a reasonable part of the building, and I would say, yeah, I did think about it and it was kind of nice that it was on the second floor. That's sort of an opinion.

Q: I'm going to do it this way. Can you give me any opinions about the assisted living facility?

A: Right now, without prompting, I really have no opinions in my mind to offer. That's why I say, I'm not planning to.

Q: If you change your mind and decide to offer any opinions about the assisted living facility, I'm going to ask that you let Ms. Hanes know so she can let me know and so that obviously I can reopen the deposition and get your opinions and bases.

A: Absolutely.

Q: Otherwise, it's my understanding that you are not offering any opinions about the assisted

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living facility.

What I was going to try to do is separate nomenclature so that we kind of stay on the same thing, but now if I say "Freedom Square," I'm talking about the skilled nursing facility.

Fair enough?

A: Fair enough.

Q: I'd like to turn now to your affidavit.

Did you draft this affidavit?

A: I didn't actually type it out. I did provide the opinions that are in the affidavit.

Q: Who typed it up?

A: Actually, I don't know who typed it out. I just was on the telephone communicating my opinions and then it was put into this format for me.

Q: Who were you on the phone with?

A: Ms. Donna Hanes and I think another person. I think it was Peggy Tyre. I'm not sure now.

Q: So if I'm understanding correctly, and obviously correct me if my understanding is wrong, you were providing your opinions over the phone to

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individuals at the Wilkes & McHugh law firm, they then draft up the affidavit and send it to you for review?

A: They send it to me after it's been formatted like this and then I look at it and if I agree that it represents my views, I have it signed.

Q: How many revisions did you offer to the draft that you received?

A: I don't think there were any revisions.

Q: When you execute the affidavit, what is your understanding of the execution of it? When you sign it, what does that mean?

A: It says that these are my opinions.

Q: Are you swearing to those opinions?

A: I am swearing. I guess that's the phrase they use, that yes, this is truthful.

Q: You would agree that the expectation is that the affidavit is truthful?

A: Yes, of course. This puts it in a formal document.

Q: You would agree with me in the affidavit you would not want to mislead the facts?

A: I agree.

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Q: Do you have the affidavit in front of you?

A: I do.

Q: Paragraph 1 of your affidavit, my understanding of paragraph 1 is, it offers no opinions with regard to Freedom Square?

A: That is correct.

Q: Paragraph 2 does not offer any opinions about Freedom Square?

A: That is true.

Q: Paragraph 3 does not offer any opinions about Freedom Square?

A: That is true.

Q: In paragraph 3, it says that you are board certified in internal medicine and geriatric medicine.

It's my understanding that there is no board certification in geriatric medicine.

A: Well, I don't know what you mean by that. I thought there was.

Q: It's my understanding there is a certification that you can get within the internal medicine category so you can be board certified in internal medicine with the certificate in geriatric

medicine. Is my understanding inaccurate?
A: I don't know. We might both be right because this has been changing over the years and when I look at my profile at the American Board of Internal Medicine, I thought that it was being listed as a certification being provided by the American Board of Internal Medicine. So I call it board certified in both. I thought that's how it was treated.
I think it's just a nuance of terminology because the process is similar for obtaining the certification in internal medicine and in geriatrics.
Q: Paragraph 4 offers no opinions about Freedom Square?
A: That is correct.
Q: Paragraph 5 offers no opinions about Freedom Square?
A: That is correct.
Q: Paragraph 6 offers no opinions about Freedom Square?
A: That is also correct.
Q: Paragraph 7, if I'm understanding correctly, the opinion is that Freedom Square did

not develop a care plan for fluid imbalances or dehydration?
A: That is true.
Q: Looking at the first sentence of paragraph 7, you would agree with me that Mr. Starwyck's residency at the assisted living facility had four interim hospitalizations?
A: While at the Inn of Freedom Square, he did go to the hospital multiple times. I don't know if each time resulted in an admission or just an emergency room evaluation and treatment. I would have to check.
Q: With regard to syncope, you are not saying that Freedom Square caused Mr. Starwyck to have syncope?
A: Now, we are speaking about the Inn at Freedom Square?
Q: The nursing home, Freedom Square. All of my questions are really going to be about the nursing home.
A: My understanding was that the syncopal episodes was occurring while he was at the assisted living facility, so I'm not going to make the statement that Freedom Square is causing his

syncope.
Q: The next sentence, "He suffered from chronic kidney disease."
Do you know how long he had been suffering from chronic kidney disease?
A: Based on the material that I have, and this does apply to what we were discussing before about laboratory values, I could see that he had some kidney disease in 2008 and that appeared to continue over the years subsequent to that. So I would say at least since 2008.
Q: Were you able to determine what was causing the kidney disease?
A: Well, I'm basing this on the medical records that were provided to me and I don't recall seeing as to what the treating physicians were attributing it to. They were just saying that he had chronic renal disease.
Q: Going on to the next page, the sentence that starts with "However ..."?
A: Page 3?
Q: Yes, sir.
A: Yes, yes.
Q: I just want to make sure that the

affidavit is clear.
The actual documentation for the discharge plan was based on Mr. Starwyck's goals?
A: I don't see where that is in the affidavit.
Q: It's actually the first beginning sentence on page 3 at the top where it starts "however ..."?
A: Oh, there is a second "however." I'm sorry.
Q: That's okay.
A: Well, I would say that this is a combined goal. I mean, it's the goal for Mr. Starwyck. He has a known history of dementia, so I don't think that he walked into the meeting and said, "This is my goal, everyone. Now, please implement a plan."
I believe this is actually coming more from the staff than from a patient who has known dementia.
MS. NICHOLSON: I will show you what we will mark as composite Exhibit 17, the social services assessment.
(Document bearing Bates stamp 000714

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and 000715 was marked as Deposition Exhibit 17 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Do you have it?

A: Yes, I do.

Q: I highlighted on page 1 and on page 2 of that exhibit where it says the resident's goal, correct?

MS. HANES: Form.

A: Resident stated goals.

Q: What is the resident's stated goals?

A: To return to Clare Bridge Place if able.

Q: On page 2, what does it say?

A: "Resident's overall discharge goal: To return to CBP at the Inn if able."

Q: Instead of in your affidavit where it says "when able," it's actually documented "if able," would you agree?

A: It's true it does say "if" here as opposed to "when." I don't think that is a significant difference though as far as what I was trying to communicate.

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MS. HANES: Do you have an unhighlighted version?

MS. NICHOLSON: Not with me.

MS. HANES: I'm just going to object to it being highlighted, but that's fine.

BY MS. NICHOLSON:

Q: You would agree that you sat here and saw me highlight it, correct?

A: Actually, I wasn't looking up so I don't know.

Q: I'm skipping the next sentence, but going to the following sentence that starts "The nursing home staff appreciated ...," do you see that?

A: Yes.

Q: In that sentence when you say that "The nursing home staff appreciated," what do you mean by that?

A: They were aware of it.

Q: Does that mean they assessed it?

A: I think the nursing home staff was aware of him having an indwelling urinary catheter. They recognized, based on their experience and knowledge, that the urinary catheter presents a risk

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of infection and they then communicated that by developing a care plan.

Q: Did that meet the standard of care?

A: Yes.

MS. HANES: Form.

Q: The next sentence on the interim care plan to encourage fluids, the intervention to encourage fluids, can that also address dehydration?

A: Yes.

Q: The next sentence is talking about the care plan with regards to hydration?

MS. HANES: Form.

A: It's discussing a care plan to address his fluid needs and hydration, yes.

Q: The infection in the nutritional care plan, did you find interventions on those care plans to address fluids?

A: I do see that the care plan for the infection addresses fluids, because it is important to maintain hydration in order to prevent infection, and I don't recall seeing a similar discussion of fluid in the nutritional care plan.

Q: Did you find the fluid discussion in the dietary documentation?

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A: I saw a nutritional risk review which was dated September 30th, 2011 that Mr. Starwyck was considered to be at risk for dehydration and that they calculated what his hydration needs were so that would be consistent with the standard of care, that component.

Q: When you say "consistent with the standard of care," does that mean meets the standard of care?

MS. HANES: Form.

A: That's what — it's a similar phrase, but to be accurate, the dietician needs to recognize whether or not a resident is at risk of dehydration and communicate that, and the dietician or nutritionist needs to determine how much fluid the resident does require on a daily basis and then communicate that to the other caregivers.

Q: For Mr. Starwyck did you see that was done?

A: Yes. There was a calculation that he required 2,149 milliliters of fluid a day.

Q: Did you also see on the same document the plan of how to meet that fluid requirement?

A: I don't recall exactly what the plan

was.

MS. NICHOLSON: We will attach the document that is titled at the top "Nutritional Risk Review" Bates-stamped 709 and 710 as Exhibit 18.

(Document that is titled at the top "Nutritional Risk Review" Bates-stamped 709 and 710 was marked as Deposition Exhibit 18 for identification, as of this date.)

BY MS. NICHOLSON:

Q: Once you have an opportunity to look at that, just let me know.

A: Yes, I have looked at it.

Q: Do you see about midpage where it talks about the plan for the hydration?

A: If we are focusing on the same area, I do see on the second page that there are modalities described as hydration cart and orange juice which is fortified with vitamin C.

Q: Is that a plan for fluids?

A: I think 4 to 6 ounces of orange juice once a day is not going to meet the 2 liters, but it certainly can make a small dent.

As far as what a hydration cart is, I'm imagining that something rolls around periodically with fluids on it and patients are invited to partake of the fluids. So, yes, it is part of a plan to provide fluids.

Q: Did you also see the Resource?

A: This is Resource, which is a tradename for a nutritional supplement, and it is a little can or box and it may provide some additional fluids as well. I don't think it was specified specifically for the provision of the fluids but it certainly is a contributor.

Q: You would use those fluid numbers to calculate whether or not the fluid requirement for Mr. Starwyck is being met or not, correct?

A: Well, I would use the dietician's determination of what he needs, which is 2 liters, more than 2 liters, but as far as phrases like hydration cart, it doesn't really tell you how much he is taking.

Q: My question was: Would you use these items to determine whether or not the fluid requirements were being met?

MS. HANES: Form.

A: I can only use a few of the items. The 4 to 6 ounces of orange juice once a day. We know that he is getting that. Whatever is in the Resource, if he takes it. Offering it is different from actual ingestion.

Q: There would also be fluids on his meal trays?

A: There should be. It's not included in the plan by the dietician.

Q: But the meal plan is included, correct, under the nutritional care plan?

MS. HANES: Form.

A: Yes, it's just not calculated out. It's not a rigorous discussion of how much fluid is being provided.

Q: Do you know whether or not based on this plan you could calculate what the fluids were?

A: I can't. As I'm sitting here with a can of Coca-Cola in front of me and I see that it's 12 fluid ounces, that is actually more than the one cup of orange juice, and 12 fluid ounces is 355 milliliters, so it's going to be a lot of cans of Coca-Cola to meet the 2 liters a day if I was to try and hydrate myself with Coca-Cola. That does

give me an opportunity to figure it out. That form does not because the numbers are not there. You need the numbers. You need to know.

Q: Do you know if the staff knows what the numbers are based upon their protocols?

MS. HANES: Form.

A: Well, based upon the records that I saw, if the staff knows the numbers, they are keeping it a secret because it's not documented anywhere that I saw how much is being provided and how much is being ingested. I think that is why they lost track and he became dehydrated.

Q: So you found no records that would document the nutrition that Mr. Starwyck is intaking daily?

MS. HANES: Objection. Form.

A: Actually, you just changed to a different category. Yes, there is a document where they, in general, document the nutrition, but that is different from the fluids, and I think that the proof of that is, they do have a separate document for intake and output, which they did very sporadically, but it does demonstrate that it can be done, they know how to do it, they have a process

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for doing it, but they failed to do it on a consistent basis and as a result, they failed to meet the standard of care and Mr. Starwyck suffered.

Q: The sporadic document that you are talking about, is it titled at the top "ADL Flow Sheet"?

A: No, it is not. It is titled at the top "Intake and Output."

Q: Do you have it with you?

A: I have notes on it and I can direct you to where it is on the disk.

Q: Go ahead.

A: Okay. Well, it would be in section 19 of the Freedom Square records that I was provided. I'm presuming you have the same.

MS. HANES: I don't have a disk drive on my computer.

THE WITNESS: It's in here.

A: But I did write very complete notes on what I found on this document.

MS. HANES: If I can get back on the Internet, I can probably still pull it up. I got bumped out.

Q: Is this the document that you are

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referring to?

A: No. The document I'm referring to actually had the volume of the fluids that he took in and the volume of the fluids that he urinated out measured in milliliters. This document does not contain that information.

Q: Was there any order by the physician to do intake and output?

A: I don't recall seeing an order by the physician, but it did seem to occur in the absence of that order.

Q: If a physician had wanted intake and output detail, could the physician have ordered it?

A: Of course, the physician could have ordered it.

Q: Does the standard of care require that interventions be repeated more than once on a care plan?

A: I'm not sure what you are saying. You mean duplication of an intervention?

Q: Yes, sir.

A: On the same care plan?

Q: On multiple care plans.

A: I think the standard of care requires

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that a goal is planned for by creating a process to achieve that goal and putting something on one care plan and then saying it applies to the other care plan may make sense, you know, as we are sitting here at the table, but makes it difficult to translate it into action because the staff may not understand that there is a separate goal that needs to be achieved.

I think the standard of care requires that you create a structure within your facility so care plans can be properly carried out.

Q: So if I'm understanding the opinion regarding the care plan, the opinion is there's no document that is titled on it "Care Plan for Hydration"?

A: It's a little more than that. You see, they fail to follow their own process. They have a clinical area assessment for dehydration and fluid maintenance where they clearly indicated Mr. Starwyck's risks for becoming dehydrated and they even stated on this document that they were going to create a care plan for dehydration and fluid maintenance and, yet, no such care plan ever was created. There is no document,

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plus there is no implementation of the care plan in the absence of a document.

Q: You would agree with me that the nutrition document, Exhibit 18, as we talked about earlier, has Resource as a plan?

MS. HANES: Form.

A: It's in there.

Q: I believe the date is October 5th next to it where it says "Resource."

A: It says "Resource," yes, and then there's October 5th is written on the side.

Q: Would you agree with me that indicates that on October 5th additional fluids were indicated by the dietician as a plan to meet fluid intake?

MS. HANES: Objection. Form.

A: Actually, looking at this form in its entirety, I might have to disagree with you.

Q: Might have to?

A: All right. I will. If you look at the handwritings, you see there are two people completing this document. One is signing it and writing a narrative on September 30, 2011, and that is the handwriting we

see first.

The Resource is then written in by the next person who is listed as an RD, registered dietician, and that corresponds, the handwriting seems to correspond with the October 6th and the narrative.

The reason the dietician is making an entry at that time based upon the handwriting and the dating would say that the albumin is decreased, and they are addressing that. And my understanding would be by the timing of this, the signatures, that the Resource is being provided not for a hydration problem, which doesn't seen to be recognized at that point, but by a nutritional problem, which is separate.

So, yes, this is a reasonable response to a nutritional deficit, but it is not a specific response for a fluid deficit.

Q: But the Resource is also going to address fluid?

A: It can, but it's not going to take you up to the over 2 liters a day.

Q: It, by itself, will not, correct?

A: Exactly. So we agree. You have to

have a comprehensive plan where you are going to fill in all the gaps. You can't build a house with one brick.

Q: You would agree with me that on September 30th when the dietary manager did her assessment, the fluid intake was calculated?

A: The desired fluid intake.

Q: The goal intake?

A: Right. The dietician, I don't think, is addressing what the patient is actually taking in. The dietician is setting the minimum that the patient should be taking in.

Q: You would agree with me on October 5th the registered dietician adds the Resource to the plan?

MS. HANES: Form.

A: That's my understanding of how the form was filled out, correct.

Q: And got physician's orders for the implementation of that plan?

A: It is my understanding that the dietician makes a recommendation to the physician and the physician gives the order and the staff carries out the order.

Q: My question is: Did the dietician carry out that plan?

MS. HANES: Objection. Form.

A: The dietician makes a recommendation. It's then going to be the nurses who carry out the plan.

Q: The dietician got an order from the physician to carry out that plan?

A: I think the way it would work and somebody can correct me if I am wrong, the dietician does the assessment, makes a recommendation. The physician then assesses that and gives an order and it's the nurses who are going to deliver the products to the patient or the resident. It's not the dietician who is carrying around the nutritional supplements. So to be accurate, the nurses are carrying out the order.

Q: Did you find evidence in the record that this plan was carried out?

A: Yeah, I did not specifically check to see if it was carried out. At this time, I have no criticism that says it wasn't carried out unless evidence is presented to me that the Resource was not provided.

Q: When you reviewed, you didn't look for evidence of whether or not this part of the plan was carried out?

A: I didn't look for it because I did not expect that they would fail at that level, so, no, I did not look for it.

Q: Did you find evidence that there was additional assessment the next day with regards to fluids?

A: By whom?

Q: I'm just asking if you found any.

A: Oh, you mean — so that would be October 5th or October 6th?

Q: October 6th.

MS. HANES: Are you saying the day after October 6th, which would be the 7th?

MS. NICHOLSON: October 6th.

MS. HANES: Okay. Sorry.

MS. NICHOLSON: That's all right.

A: There are portions of the records which can be utilized to assess fluids. I don't know if they were specifically utilized on October 6th. I don't remember seeing something

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which was an entry on October 6th that addressed fluids. I know on October 7th is when they did the clinical area assessment for dehydration and fluid maintenance.

Q: I'm going to show you what is titled at the top "Nutrition Diagnoses Statement" by the registered dietician.

MS. HANES: Can I have back the registered dietician's thing?

MS. NICHOLSON: (Handing.)

A: Okay. I see it.

Q: You would agree with me that the plan is to add the nutrient-dense liquid?

A: It is already in place according to this, which is consistent with what we just discussed.

Q: You would agree with me what we just discussed was to address liquid?

A: No, no. It says "nutrient dense." If it was really to address liquid, it probably would be more diluted. The way this is written and looking at the entire sheet where they say above it, and you highlighted that, "altered nutrition," and then seeing that it says

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"nutrient-dense liquids," they wanted to give a liquid form of nutrients. That would be my understanding of this form.

Nowhere here does it say that the patient is having a fluid problem and, in fact, at the bottom of this, there is a section where the dietician could have checked off at risk of inadequate fluid intake and did not check that off.

MS. HANES: I just want to correct something on the record. I think you said something about it being the next day. Both of these forms are dated 10/6/11.

MS. NICHOLSON: Next to the Resource, it says 10/5.

Q: You would agree with me that this is a plan that I understand you are saying is addressing the caloric intake but it also addresses fluid?

MS. HANES: Form.

A: To put it slightly different, I will agree with you that indirectly it will address fluid but I cannot agree that was the intent of the individual who signed that form at the time.

Q: Later in the month, did you find evidence where the Resource was increased from once

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a day to twice a day?

A: It might have happened. I don't recall specifically when that occurred.

MS. NICHOLSON: I don't think I said on the record that I would attach the "Nutrition Diagnoses Statement" as Exhibit 19.

(Document entitled "Nutrition Diagnosis Statement" was marked as Deposition Exhibit 19 for identification, as of this date.)

MS. NICHOLSON: Next, I will attach physician orders from October 27th as Exhibit 20.

(Physician orders from October 27, 2011 was marked as Deposition Exhibit 20 for identification, as of this date.)

BY MS. NICHOLSON:

Q: You would agree with me, October 27th, the Resource was increased to twice a day?

MS. HANES: What was the date?

MS. NICHOLSON: October 27th.

A: Yes. According to this, physician's

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order on October 7, 2011, Resource was increased to 3 ounces twice a day, which is still in total less than one-half of this can of Coca-Cola which I'm holding.

Q: That wasn't the sole source of fluid, correct?

A: No. I'm just saying it's one of few areas we can actually see what is being given. It's a fraction of what the patient would require during the course of the day.

Q: You would agree with me that's a plan to increase not just nutrition but also fluid?

A: Well, I guess the phrase would be, it's a drop in the bucket.

Q: So is that a yes or no?

MS. HANES: Form. He answered it.

A: It wasn't the intent from what I determined and it's a very small step.

Q: Paragraph 8, if I'm understanding the overall opinion of paragraph 8, it's that you are using the BUN and the creatinine level to opine he had severe dehydration on November 10, 2011.

A: I would say that's part of it. I'm using other indicators as well.

Q: What other indicators?
A: His clinical condition, and we are talking about November 10th, 2011 when he was admitted to Largo Medical Center, at which time they found him to be hypotensive, so he has become so dehydrated that he is having difficulty keeping the pressure of blood in the body at a normal level.
In addition, I'm combining that with the other variable in lab which was the sodium and he has hypernatremia. So he has a very elevated blood urea nitrogen, an elevated creatinine, an elevated sodium level. His body is having difficulty keeping the blood pressure up. And the physicians who examined him at that time also arrived at the conclusion that he is severely volume depleted.
Q: Looking at the history and physical that was attached to your affidavit, Exhibit B to your affidavit — it's actually Exhibit C to your affidavit — you would agree with me it doesn't say severe dehydration but rather says significant?
A: That's true.
Q: You would agree with me under the impression dehydration is not a diagnosis?

A: I don't have it in front of me, but I remember they wrote acute renal failure. They may not have included it in the impression but, they certainly did include it in their findings in the other section.
Q: Was there any other condition going on that is discussed in his history and physical that could account for these lab values other than dehydration?
A: My reading of the history and physical, the dehydration was the most likely explanation for his condition at that time.
Q: Did he also require blood transfusions?
A: Yeah, I don't recall seeing that as being the major thrust of the treatment plan. When I look at the discharge summary, I don't remember seeing that, that was a major component. They kept coming back to the renal failure secondary to the dehydration.
Q: Did you see in the history and physical where it talked about dilutional impact from the intravenous fluids?
A: I actually have to see that again to

comment on it. I don't have that in front of me.
MS. HANES: I have a copy, Doctor.
I have the discharge summary as well.
A: Yes, okay. Now I can explain this and I want to thank you for allowing me to review this again.
Here's my understanding as to what had taken place. He arrives at the facility severely dehydrated or significantly dehydrated. Either way, it's as bad as it can get. He is given intravenous fluids.
They were really concerned. So, in fact, as they write it here in their plan, they gave him aggressive intravenous fluids.
On top of his other problems, because he required the intravenous fluids, there is a dilutional effect. This is what we were speaking about before when you were talking about anemia. If you are putting in fluid, which is really a form of water, to keep his blood pressure up because of the dehydration, it takes up a larger component in the circulatory system and it dilutes it.
So if you measure the hemoglobin or

hematocrit measurements of blood, you will see that you diluted it and the number may go down. I guess the way to understand it, if you had a glass of tomato juice and you started pouring in clear water, you are going do dilute the tomato juice. Well, they diluted him because they had to rescue him from the dehydration. So that's what they are talking about.
Then to sustain him, they had to give him one unit of packed red blood cells, but I don't really see in the records that I have reviewed that any source of bleeding had been identified during his course there.
Q: You would agree with me that it actually says that they are going to give him another unit of red blood cells?
A: Well, if they gave him a second unit, that's reasonable.
Q: It also says he's got blood loss anemia?
A: It says, in addition to blood loss anemia, there is a dilutional impact.
When I saw the case summed up in the discharge summary, I don't see that there is

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anything that says that he might have been bleeding significantly. There is a mention that there was hematuria, so there might have been some blood in the urinary system.

Once again, this doesn't explain his hypovolemia and renal failure as well as dehydration does.

If, for some reason, in some speculative scenario that he actually had been bleeding at Freedom Square to the extent that he became volume depleted, well, that was something which was missed also at Freedom Square, but that is not actually what happened here. He became dehydrated from lack of fluids.

Q: You would agree with me that the discharge summary from that admission, as an admitting diagnosis dehydration was also not listed?

A: What they are doing in the discharge summary is, they are listing acute renal failure which is explained by the dehydration. The dehydration then gets explained in other parts of the records. But they are not offering a new and unexpected explanation of the acute renal failure. The way this is written and the way it is to be

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understood is that the acute renal failure, which they do list, is secondary to the dehydration.

Q: But there is nowhere in the record where it says that?

A: Well, it says that in many places in the records.

Q: Did you also see in the record where he was diagnosed with acute tubular necroses?

A: Yes, I did.

Q: Can acute tubular necroses cause renal failure?

A: It can, of course, but it can also be caused by an acute drop in fluid, which is the explanation that is most likely in this particular case.

Q: Did you also see in the diagnoses at the end where they had found a urinary bladder mass?

A: I did see that. They did indicate that there was a bladder mass, correct.

Q: With fluid resuscitation, you would expect the numbers on the labs to go down, the BUN, the creatinine, the sodium?

A: In general, I would expect the numbers to go down unless such damage had been done to the

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kidneys that it is now beyond rescue.

Q: At the end of page 3, you talk about the rapid physical deterioration of Mr. Starwyck. What time frame are you referring to? It's the very last sentence on that page.

A: I do see that. The time frame is really in November of 2011.

Q: Does it start on any particular day?

A: Well, we certainly can say that it's starting on November 10, 2011 when he is brought to the hospital in a very poor clinical state. It may have been a prelude for a few days while he was at Freedom Square, but it's clearly recognized when he is at the hospital.

Q: Did you see in the records on November 8th where the staff at Freedom Square are trying to get fluids into Mr. Starwyck?

A: I don't recall seeing a record which specifically addresses that. I do see that there was a note on November 8, 2011, at 6:30 p.m. in the daily skilled nurses notes saying that he had no urine output on that particular day and that he is taking oral fluids in very small amounts. So there

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is a recognition that something's happening. I don't know if that's the entry you are referring to.

Q: You didn't see on the same record fluids offered and accepted and then later in the day fluids encouraged?

A: Well, that's not — that's a very conservative approach to somebody who has stopped urinating. So yes, it's a nice thing to do, but he is really starting to demonstrate some real problems with the whole system of maintaining adequate body fluid.

MS. NICHOLSON: We will attach the nursing note from November 8th with those entries as Exhibit 21.

(Nursing note from 11/8/11 was marked as Deposition Exhibit 21 for identification, as of this date.)

MS. HANES: Do you need a stretch break?

(Discussion off the record.)

A: I do have that in front of me now.

Q: Do you see those entries?

A: I am looking at what you highlighted and it says — you highlighted "taking in very small

amounts" and you highlighted "fluids encouraged."
Q: Did you see also on that day where there was communication with the physician regarding the output?
A: Right. I think the communication from my memory here was concerning the functioning of the urinary catheter when I looked at it, yes.
Q: And the staff were communicating with the physician about what was going on at that point in time with Mr. Starwyck?
A: Just from what I saw documented, I think they were talking about the catheter and the output. I don't remember seeing that they were communicating about his fluid intake or any of his oral intake.
Q: But you would agree there is communication going on with the physician on November 8, 2011?
A: There is some communication on that date.
Q: Did you also see in the records where the physician communicated to the staff, according to the records, that the wife wanted Mr. Starwyck treated as much as possible at the facility?

A: There may have been entries like that. That's not inconsistent with the views of many family members.
Q: Did you see the next day where the staff is continuing to monitor the fluids?
A: There might have been a statement saying monitor PO intake, but I don't recall seeing any actual measurement of the oral intake.
Q: Do you recall seeing documentation fluid intake encouraged but poor?
A: Well, I do recall statements like that and that's what I was being critical of, is the lack of precision in such a statement.
Q: Did you also see that the staff was communicating Mr. Starwyck's condition to the physician on November 9, 2011?
A: There were communications with the physician, but I don't recall seeing a specific communication concerning Mr. Starwyck's fluid status.
MS. NICHOLSON: We will attach the nursing note from November 9, 2011 as Exhibit 22.
(Nursing Note dated 11/9/11 was

marked as Deposition Exhibit 22 for identification, as of this date.)
A: I do see this.
Q: What is a BMP?
A: That would be basic metabolic profile.
Q: Why would a physician order that?
A: To check — actually, I don't know why this physician actually ordered it, but there are certain things in there such as sodium, BUN, creatinine. There is also potassium, chloride, and maybe glucose, but — what is a little confusing to me is the dating on this. Is that supposed to be a nine or an eight? It looks like November 8th. I'm guessing it's actually supposed to be November 9th at 4 o'clock. This is the day before.
I cannot tell you with certainty what was ordered and what is actually being discussed because if it is as late as November 9th and they are saying that they are calling the doctor to notify about the last basic metabolic profile, the last metabolic profile was obtained on October 18, 2011. The next one will be obtained on November 10, 2011, the day after. They are discussing that they

are faxing the metabolic basic profile to the doctor's office in the morning, which would be on the morning of November 10, 2011.
It's a little confusing. I can't tell you exactly what is happening here. The dates would indicate that they are sending the results of a previous basic metabolic profile, which is about three weeks old, or they are anticipating there will be results the next day. That's about as much as I can dissect this.
Q: You didn't find any other records that would give more clarity?
A: The only clarity I have is in the chemistry results themselves. As I'm saying, the next one that is obtained is the 10th when the BUN has approximately doubled. Possibly what happened is on that date, they did communicate with the doctor, the doctor said get a BUN, and then the next day, it came back elevated and they sent the patient to the hospital. I'm not even certain that's how it played out.
Q: You would agree with me that if the staff is communicating to the physician Mr. Starwyck not intaking fluids well, that a BMP order would be

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appropriate?
A: I would say that it would be appropriate and that is how we would expect it to occur but, once again, going back to that note, the communication seems to be taking place through faxes and phone calls but not a direct conversation.
MS. NICHOLSON: I'm going to hand you additional nursing notes from November 9, 2011 and we will attach that as Exhibit 23.
(Nursing note dated 11/9/11 was marked as Deposition Exhibit 23 for identification, as of this date.)
A: This note now explains more and is later in the day.
Q: You would agree with me that based on that note the staff is communicating with the physician about Mr. Starwyck's hydration?
A: That, I cannot agree with. It seems they are very much focused on his catheter, on some blood which may have been coming out of his penis. The way it is written and the context with which it is in suggests that this is the thrust of the conversations. I don't have a document from the

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doctor. But I am going on what this is and it would seem that the order, which is now being obtained on November 9th to do a basic metabolic profile, is being combined with an urinalysis. So I think the thrust of this evaluation is on the drainage from the urinary catheter, the function of the urinary catheter, and in combination with that, they would also be able to assess fluid status because it's going to be included within this battery of tests which they are ordering.
Q: Did you also see that the physician had been to see Mr. Starwyck at the facility on November 2nd, 2011?
A: I don't remember in that note seeing it but yeah, I know the physician had seen the patient prior to that.
Q: Then did you see on November 10th where the staff continued to talk about encouraging fluids on Mr. Starwyck?
A: Yeah, that phrase has been repeated.
Q: And then, ultimately, the staff is talking to the physician and Mr. Starwyck is transferred to the hospital?
MS. HANES: Form.

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A: That is true, but I don't know what the conversations with the physician are.
Q: You would agree with me those last three days the staff is not ignoring Mr. Starwyck?
A: I'm not saying that they are ignoring Mr. Starwyck. I'm saying they don't have a structured approach to provide the customized care that he needs.
Q: So with regards to the rapid physical decline, is the time frame the last date that he is there in November or the entire month of November?
MS. HANES: Form. Asked and answered.
A: Well, it's most of the month being the last days that he is there is actually the beginning of the month.
Yes, you can see evidence of some changes in his function in those last few days at Freedom Square, and this is a prelude to the abrupt decline he then has subsequently.
Q: The remainder of the opinion in paragraph 8 says that this significantly contributed to his death.
You would agree with me that the death

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certificate says that his cause of death was dementia of Alzheimer's type?
A: I do.
Q: Do you disagree with the cause of death based on the death certificate?
A: I do not disagree that he has Alzheimer's disease and it may have been a factor in there, but I would say that the death certificate is incomplete.
Q: You would agree with me that Mr. Starwyck received a feeding tube while he was at the hospital on November 16, 2011?
A: True. I don't know exactly the date that was put in, but it was during that admission.
Q: The feeding tube would provide hydration and nutrition?
A: That would be the intent.
Q: You would agree with me that prior to being transferred to hospice on December 6, 2011, the feeding tube was withdrawn?
A: I think there was a decision to withdraw the treatments. I don't know if it was done in the hospital or in the hospice, but I know it was done.

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Q: What are the other causes of death that you believe the death certificate failed to list?

A: Well, it doesn't lay out the sequence, because the final event would be something along the lines of cardiac arrest or pulmonary comprise or cardiopulmonary arrest. So that part is missing.

But it doesn't include his renal disease, which certainly is mentioned at the hospice. I think that needed to be in there because that had a great impact on his physical function.

Q: Anything else?

A: Well, aside from cardiopulmonary arrest and acute renal failure superimposed on chronic kidney disease, I don't think there would be much else that one would put in there.

If they wanted to be complete, they might put in, you know, a second part that he also had high blood pressure but the death certificate is not comprehensively filled out. It only has one thing.

Q: While he was at the hospital, it was recommended that he undergo dialysis, correct?

A: This is true.

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Q: And the decision was made for Mr. Starwyck not to undergo dialysis?

A: I guess a discussion had been held and they had arrived at a decision not to dialyze him. So that is why I would have to include renal disease as a contributing factor to his death.

Q: Just trying to get percentagewise, death is a hundred percent and you are listing Alzheimer's, renal disease, hypertension as contributing causes to that death.

What percent would you attribute to the Alzheimer's disease?

A: Now, you know that can't be done. A hundred percent, I don't know even know what you meant when you said death is a hundred percent. A contribution is a contribution. I wouldn't do it by percentages. Instead, I would give you a sequence knowing that these factors all contribute and but for certain factors, the death would not have occurred.

So, yes, Mr. Starwyck had Alzheimer's disease. It was not being described as end stage when he entered Freedom Square and it is unlikely that it advanced to end stage while he was at

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Freedom Square. However, there is a likelihood that his dementia impacted upon his interactions with the staff. So there might have been some difficulties with oral intake. Therefore, I would say because of his dementia, there was a risk that he was going to become dehydrated and he did.

Because of the dehydration and the preexisting chronic kidney disease, he already had partial kidney function. And that combination led to renal failure requiring dialysis. In the absence of the dialysis, he could not survive and, therefore, he died.

So the Alzheimer's disease is not the main contributor. It's in there. But for the dehydration, he would not have died the way he did and when he did.

Q: So back to my original question: Are you able to give a percent as to what each disease contributed in your opinion?

MS. HANES: Asked and answered. He said no.

A: I said I cannot do it. I don't know how that actually is relevant because that is not how it works. You discuss what is the tipping

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point. It's not a percentage. It's what pushed him over the edge, and it was the dehydration.

Q: Acute tubular necroses, in your opinion, cannot lead to what we see with Mr. Starwyck on November 10, 2011?

A: No, I'm not saying that. This is why I brought you the article. Because it does explain this and when you have the prerenal acute kidney injury, which we talked about before, and you have decreased perfusion, it can progress to acute tubular necrosis. That is what is in there.

That's what leads to the renal failure. You are not giving enough fluid to the kidney and the kidney fails in the way that it does not become reversible.

Q: Anemia cannot account for acute tubular necrosis?

A: Well, there's a possibility. It would have to be more significant. What I would say here, if you look at the whole story, being that he was known to be anemic in the past, he was already in a condition where an additional stress would be harmful, but it's not the anemia that tipped him over; it's not Alzheimer's disease that tipped him

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over; it's not the chronic kidney disease. It's the added insult of the dehydration which then combined with the preexisting problems which led to an abrupt change in his clinical status which was to his detriment.

MS. NICHOLSON: We will attach as Exhibit 24 a copy of your affidavit.

(Affidavit was marked as Deposition Exhibit 24 for identification, as of this date.)

MS. HANES: What was 23? Is that the death certificate?

MS. NICHOLSON: The additional nursing note from November 9.

MS. HANES: Off the record.

(Discussion off the record.)

BY MS. NICHOLSON:

Q: Before I leave the hydration opinion, other than what we have discussed, are there any other bases with regards to the opinions that you have regarding Mr. Starwyck's hydration?

A: Just to be complete, and I will try and do it quickly, going back to what we were talking about with his baseline, having looked at

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previous records going back to 2008, you could see that he had an elevated BUN in the past. However, it maintained a level which was consistent. There were times when he was admitted for dehydration. The BUN went up, but then it would go back to his prior level. So that informed my opinion that he did have a chronic kidney disease but it was stable.

I also was basing my opinion on the meal and fluid detail reports which, although it did not indicate specifically fluids, it did indicate a combination of food and fluid and there were times that there were no entries at all when it was part of their care plan for nutrition to monitor his fluid intake at each meal, so they were not complying with their own care plan for nutrition.

We never actually pulled up that intake and output form, but it is noted in my handwritten notes.

Q: Anything else?

A: No, I think that's it.

Q: You would agree with me that meals have a component of hydration in them?

MS. HANES: Form. Asked and answered.

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A: Yes, there should be some fluids served with the meal and some of the foods themselves have a fluid content.

Q: That's what my question was. The food itself has a fluid content?

A: That's true. I just want to say it's variable, but yes, it's true.

Q: With regard to the stable kidney disease that is based upon the definitions that you had given me at the beginning of the deposition?

A: Yes, and it's based on the definition of chronic kidney disease and also the definition of stability which is something is not changing.

Q: Anything else with regards to hydration?

A: The only other thing I think we should speak about very quickly is that when the nutritionist did assess Mr. Starwyck, there was no notation that he had any difficulty swallowing, there was no aspiration, there was no choking.

So that would go back to, I think, the discussion we had before about why somebody might stop eating and what you have to look for. So there wasn't any recognition that at that time that this

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was a man who had problems swallowing.

Q: You would agree with me later in the month of October he is diagnosed with a swallowing problem?

A: I'm not recalling where that diagnosis was documented.

Q: Do you recall the speech therapist working with Mr. Starwyck on dysphasia?

A: I think by my recollection, the speech therapist may have been working with him on speech and not so much on swallowing.

Q: Would you rely on the records for whether or not speech therapy was working with him on swallowing?

A: I would have to look at the records and certainly I would rely on that, on what the speech therapist was delivering therapy for.

Q: Any other opinions or basis with regards to hydration?

A: No, I think we covered it.

Q: Moving to pressure ulcers, which is the remainder of your affidavit, I believe, if I'm understanding your affidavit correctly, it's the opinion that two of the right foot wounds that

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Mr. Starwyck is identified as having once — strike the "once." During the time that he is at Largo Medical Center after he has left Freedom Square, it's your opinion that those wounds are present while he was at Freedom Square and they were never identified, assessed, care planned, or treated?

MS. HANES: Form.

A: It is my opinion that there are three wounds on the right foot which are identified at Largo Medical Center which are not identified at Freedom Square and they were not care planned or — they were not care planned for and were not treated according to such a care plan.

Q: I want to separate out the wound on the top of the foot.

A: Okay.

Q: And see if I can get agreement with you regarding the top of the foot.

A: Okay.

Q: Would you agree with me that while at Freedom Square, the wound on the top of the foot is called a callous?

A: I would agree with you that on November 5, 2011, at Freedom Square they identify a

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callous on the interior area of the right foot which I'm understanding to be the top of the foot.

Q: You would agree with me that the physician was notified?

A: They documented that they notified the physician, so that's what I'm understanding.

Q: And that would meet the standard of care?

A: Indeed.

Q: You would agree with me that there was a treatment order for that wound?

A: There was an indication that there would be treatment as ordered.

Q: My question is really specific: Would you agree with me that there is an order to treat that wound?

A: I don't recall the specific order. I know that the physician was notified and may have delivered an order, but I do not remember what the order actually was.

(Physician order dated November 6th was marked as Deposition Exhibit 25 for identification, as of this date.)

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BY MS. NICHOLSON:

Q: We will attach as Exhibit 25 the physician's order from November 6th.

A: And, yes, there is an order on November 6th, the next day, to treat the top of the right foot.

Q: Would you agree with me that that treatment was implemented?

A: It's my presumption that it was implemented. I didn't actually check to see it if it was implemented. I'm not expecting that it was not implemented.

Q: If there is documentation that the treatment was implemented, would that meet the standard of care?

A: Yes, it meets the standard of care to carry out the physician's order.

Q: Did you also see documentation where the staff believed that was caused by his shoes and asked the wife to bring in a different pair of shoes?

A: I do see documentation which would indicate that there was a concern that the shoe was somehow pressing or abrading the skin and the wife

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of Mr. Starwyck was requested to bring in a different kind of footwear which would be described as soft.

Q: And that would meet the standard of care?

MS. HANES: Form.

A: It is an attempt to meet the standard of care. Yes, it's reasonable.

Q: Now, I think we can agree that the other two wounds on the right foot, you found no documentation in the Freedom Square records where any additional wounds were identified on the right foot?

A: This is true.

Q: I think the remainder of the affidavit with regards to the right foot wounds is that it's your opinion those were present while he was at Freedom Square but were not identified, documented, assessed, or treated?

A: That is the most likely explanation.

Q: When is the first time that the additional two wounds to the right foot are identified when Mr. Starwyck is at Largo Medical Center?

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A: The first time that they are identified at Largo Medical Center is on the day of the entry into Largo Medical Center, which is November 10, 2011.

Q: Do you recall what time?

A: I don't recall seeing a time entry on that particular form.

Q: You would agree with me that the history and physical completed in the emergency room at Largo Medical Center stated that the skin was normal color, no rash, warm, dry, intact, normal turgor?

A: I believe that is what it said.

Q: So you would agree with me that this document in the emergency room is not identifying these two additional wounds to the right foot?

MS. HANES: Form.

A: It's not identifying any wounds on the right foot.

Q: I'm specifically asking about the two additional wounds that you say are at Freedom Square and not identified at Freedom Square?

A: Well, that's true. Included in that are the additional two wounds.

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Q: There is nothing on the HPI-general adult that documented there's these two additional wounds on his right foot?

A: This is true.

MS. NICHOLSON: We will attach that as Exhibit 26.

(Document HPI-General Adult was marked as Deposition Exhibit 26 for identification, as of this date.)

BY MS. NICHOLSON:

Q: You would agree with me that the history and physical completed by a different physician on November 10, 2011 did not identify these two additional wounds?

A: I'm not sure which one you are referring to.

MS. NICHOLSON: We will attach it as Exhibit 27.

(Largo Medical Center History and Physical was marked as Deposition Exhibit 27 for identification, as of this date.)

A: Now, I agree that it doesn't say anything about the skin one way or the other. I am also noting that this note was written on

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November 11, 2011. That is actually the day after the wound ulcer evaluation, but yes, I agree with you.

Q: You would agree with me that it's dated for the admission November 10th?

A: It lists the admission date, which I think is just a bit of historical information, but on the last page is the date that it is actually written and that would be November 11, 2011. 11/11/11.

Q: Would you agree with me the first time that there is any mention of the two additional right foot wounds is at 8:28 p.m., November 10, 2011?

A: I can't agree with you yet without seeing the document that you are referring to.

MS. NICHOLSON: We will attach it as Exhibit 28.

(Document was marked as Deposition Exhibit 28 for identification, as of this date.)

A: I agree with you that it is timed and dated as you indicated and this might be the first time it is documented in the records which falls

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between the two previous notes that we had just discussed.

Q: You would agree with me Mr. Starwyck got to Largo Medical Center around about 2 p.m.?

A: I don't know the exact time, but I would not be surprised if he had.

MS. NICHOLSON: We will attach as composite 29 two additional emergency room records from military time 1452 and military time 1515.

(Two emergency room records was marked as Deposition Exhibit 29 for identification, as of this date.)

Q: You would agree with me there is no documentation in either one of these notes regarding these two additional foot wounds?

MS. HANES: I'm going to object to the form of that question.

A: What was the question again? I agree with you that it is timed for 2:52 p.m. on November 10, 2011 and these forms that you presented me with, there is no documentation of foot wounds.

Q: And page 2 is at 3:15 p.m.?

A: It's hard to read, but it does seem to

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be that way.
I don't see that there actually is a section in here to document the foot wounds.
Q: The integumentary assessment —
A: Okay. All it indicates here is that they are saying the assessment was not done. That's my understanding. It's written, it says "integumentary assessment" and then the word "no" pops up.
Q: Above that it says physical findings for those various categories?
A: It does, but you have to understand, if you look at the whole thing, it says neurologic assessment, no; musculoskeletal assessment, no. I don't know if that means he has no muscles and no nerves.
This is their own document. It's computerized. I don't know if that tells you that it's normal.
He didn't have a neurologic status that was normal at that time. I think it just means that the assessment was not done.
Q: Are there any other opinions or bases with regards to pressure ulcers?

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A: The opinion is basically the same in that we saw another area that the staff failed to customize the care to Mr. Starwyck and additional evidence for that is that while he was still at Freedom Square and had a lesion identified on his right foot as late as November 6, 2011, following that, they documented that he had no skin abnormalities on November 7, 2011; November 8, 2011; November 9, 2011, and November 10, 2011.
So there is no documentation of the wound that they did identify and then it's identified again when he goes to Largo Medical Center.
Q: When you say there is no documentation of the wound they identified, we went through documentation with regards to that wound, correct?
A: This is true, but this is not a case where they forgot to document. It's a case where on their own preprinted form, which is called the "Daily Skilled Nurses Notes," they actually indicate there are no skin abnormalities on those four days. So, yeah, they documented it and then they started documenting following November 6th that he had no skin abnormalities.

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Q: And the treatment that was given for the wound on the top of the foot was a treatment that was supposed to stay in place for five days?
A: I don't remember if it was actually for five days, but there was an application of some treatment that was to be provided and the invitation to the wife to bring in some soft footwear.
Q: I want to be clear for the record, identifying that the staff felt it was the shoes that had caused the callous to the top of the right foot and asking the wife to bring in a different pair of shoes was not customized care?
A: It's customized care in a proportional way, because part of it is being done.
But now knowing that his foot is subject to injury and needs to heal, there should have also been an effort not just to change the footwear but to keep the foot from having prolonged contact with other surfaces or materials which may cause skin breakdown and interfere with healing.
So there also should have been a customization to elevate the foot off of the bed when he was laying in the bed and I didn't see any evidence that that occurred.

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Q: Again, based on what you saw with regards to the callous on the top of the foot, are you saying that the staff ignored that condition.
A: I'm not saying they ignored, as I sort of indicated before. It's just that they did not have a systemic and comprehensive approach to his needs.
Q: Any other opinion or bases for the pressure ulcers?
A: No, I think we covered them.
Q: Any other opinions that you plan to offer at trial that we have not covered?
A: I think we have covered the opinions. I did want to point out that I did bring some of the additional materials. Some of the materials I reviewed were surveys, I don't think we discussed that. If you want, I'll very quickly tell you what surveys I looked at.
Q: They will be on the disk, right?
A: They will be on the disk, so I looked at the surveys and there were some deficiencies that were found after his time there. I don't know if we will be commenting on that at trial, but they were in my notes and on my disks.

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In addition, I also looked at the website of the, I guess we would call the corporate parent of the facility where they would support some of the opinions that I had addressing the care of a resident in the skilled nursing facility and addressing the importance of hydration.

Aside from that, I think we covered all my opinions.

Q: With regards to Mr. Starwyck, do you have any specific opinion with regards to what you looked at on Brookdale's website that we have not already discussed?

A: I am unclipping the exhibits. With regard to Mr. Starwyck, I would say there is a section in Dr. O'Neil's web page where he indicates that it is very important to keep up an adequate fluid intake, especially in the warm weather, which I think may apply to Mr. Starwyck and the environment that he was in.

And then also on the website, Brookdale Senior Living, it indicates that nursing homes provide customized care to residents that need assistance with daily living and makes the promise that their staff will work to create the ideal level

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of care that your loved one requires.

I do see that is their mission statement, that is their promise, and in the case of Mr. Starwyck, they failed to deliver that.

Q: Your opinion is based upon, your opinion that they failed to do that, is based upon what we already talked about today?

A: Indeed.

Q: Anything else?

A: I think that's it.

MS. NICHOLSON: Okay.

(Discussion off the record.)

EXAMINATION

BY MS. HANES:

Q: Just to clear up some things, Dr. Starer, showing you Defendant Exhibit 25, that indicates that they were aware he had a wound on the top of his foot on November 6, 2011, correct?

A: That is true.

Q: I think your criticism after that is that on the nurses' notes where they check off whether there is abnormalities, they stopped checking that off, correct?

A: Yes.

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Q: Or they don't check it off?

A: Well, they indicate that there is no abnormalities.

Q: It is your opinion, Dr. Starer, that the two additional wounds to the foot that were found at the hospital started at Freedom Square, correct?

A: Yes.

Q: And defendant showed you several documents from the hospital where she kept asking you, Dr. Starer, did they document the two additional wounds on Defendant Exhibit 26, did they document the two additional wounds on Defendant Exhibit 27, did they document the two additional wounds on Defendant Exhibit 28.

Wouldn't it be fair, Doctor, that they don't document any of these three foot wounds on these exhibits that you were shown by defense?

A: That's true.

Q: Including the one that they did recognize at Freedom Square on November 6th, correct?

A: That is correct.

Q: So they missed all three of them on

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those documents where the form didn't call for that or they didn't do the assessment, correct?

A: That is true.

Q: However, they do on the day of admission, in the document that is attached to your affidavit, recognize that he has the one wound that Freedom Square did document and the two additional ones, right?

A: Yes.

Q: Ms. Nicholson showed you some scant nurses' notes towards the end of Mr. Starwyck's residency where the staff indicated that they encouraged fluid or he took fluids in small amounts, correct?

MS. NICHOLSON: Objection. Form.

A: Yes, I was shown such documents.

Q: Is there anywhere in the record sufficient documentation of the amount of fluids that Mr. Starwyck was provided?

A: No.

Q: Nowhere do they document that he was given the amount of fluids recommended by the registered dietician, correct?

A: Just to be clear, there is that one

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intake and output form where I think about four times they documented, but in the rest of the record, I could not find anything that consistently documented that.

Q: Ms. Nicholson asked you some questions about, that insinuated that the staff was pouring fluids in the mouth of Mr. Starwyck and he wasn't swallowing the fluid.

There is no charting that you saw that states that the staff was pouring fluids into his mouth and he wasn't swallowing?

A: I haven't found any entries that would characterize their actions in such a manner.

Q: Is there any evidence that you found in the chart that Mr. Starwyck's physician was called and told that the staff was pouring fluids into his mouth and he refused to swallow?

A: I don't recall seeing any entry like that.

Q: With respect to the Defense Exhibit Number 17, the official services assessment, Ms. Nicholson asked you if it was actually Mr. Starwyck's goal to return to Clare Bridge if able. I want to show you one place that she didn't

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check off where it says "discharge to." This is the box filled out by the facility.

What did the facility check off?

A: Previous living arrangement.

Q: And his previous living arrangement was the assisted living facility?

A: That's my understanding.

Q: So apparently it was the facility's plan as well as that he be released there?

A: They both may have had that plan.

Q: With respect to the nutritional risk assessment, Defendant Exhibit 18, Ms. Nicholson asked you several times about the registered dietician's plan to address his hydration.

I just wanted to be clear. Where it indicates hydration cart 4 to 6-ounces of orange juice and the Resource, above that does it say it's a plan or does it indicate that it's the registered dietician's recommendation?

A: It says it's recommendations of the dietician. That's what it says.

Q: This isn't an indication that he is even going to receive that amount, correct?

A: Well, the dietician can make a

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recommendation and the staff has to carry it out if they choose to do so.

Q: Ms. Nicholson asked you about whether the physician ever ordered intake and output be recorded.

You would agree with me, Dr. Starer, there doesn't have to be a physician's order to record and monitor a resident's intake and output?

A: I would agree with that.

Q: With respect to Defendant Exhibits numbers 21, 22, and 23, these were some nursing notes that you were shown, Dr. Starer?

A: Yes.

Q: I think defense was asking you about information being communicated to the physician. She highlighted some notes about fluid being offered and then she highlighted some notes about the MD being contacted about certain things. Is there any indication on these nurses' notes on Exhibits 21, 22 and 23 that the physician was ever told that Mr. Starwyck was not taking in adequate fluids?

A: No.

Q: And I think it was your understanding that the communication with the physician had more

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to do with his catheter?

A: That's how I was interpreting the dialogue.

Q: Based on the fact that a urinalysis and culture and sensitivity were also ordered?

A: Yes.

Q: Did anything that you were shown by Ms. Nicholson today during this deposition illustrate to you that Mr. Starwyck was being offered the required fluids that he needed?

A: Although I was shown material that said he was being offered fluids, I did not see anything which specifically indicated that he was being offered fluids in the volume which he required.

Q: Then would you agree with me you certainly were not shown anything that would indicate that Mr. Starwyck was getting the amount of fluid he required on a daily basis?

A: No, I did not see that.

Q: Would anything you've seen today, Dr. Starer change any of the opinions that you hold and that you place in your affidavit?

A: No. My opinions remain the same.

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Q: And the couple of nurses' notes where the staff documents that PO fluids were offered and accepted or he was taking in small amounts of PO fluids, do you consider that documentation to be documentation of the staff monitoring his fluid intake?

A: No. It's not the type of monitoring that he would have required.

Q: With respect to the cause of Mr. Starwyck's death and the impetus being the dehydration, I just wanted to make sure that all of your opinions are on the record with respect to that?

A: Yes. The dehydration was the major factor which led to the abrupt decline in his renal function which was a significant contributing factor to his death.

Q: And the dehydration was caused by not receiving sufficient fluid?

A: That's correct.

Q: And this was an acute event with Mr. Starwyck?

A: It was an acute event, it occurred in a short period of time, and it led to his demise.

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Q: Would you agree that this was not something that was expected to occur as a result of the preexisting kidney condition that he had?

A: I saw no indications in the records that anybody had thought at that time that his preexisting kidney condition was going to lead to his death in that manner and in that time course.

Q: With respect to the fact that the staff never documented the two additional wounds to his feet at Freedom Square and did not continue to document the presence of the wound to the top of the foot, Dr. Starer, is that an indication of the pattern by Freedom Square of being indifferent to the needs of Mr. Starwyck?

MS. NICHOLSON: Objection. Form.

A: Well, it does reflect indifference to his needs and then in combination with the failure to meet the standard of care for hydration, it demonstrates a pattern.

Q: If he has a bandage covering a wound to his foot, you wouldn't expect the staff to document that he has no abnormalities because they can't see it under the bandage, would you?

MS. HANES: Objection. Form.

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A: No, they could document that he has a wound under the bandage. They are not going to remove it at that particular time, but you can't just keep saying that there's nothing going on.

MS. HANES: I don't have any other questions. Thank you.

MS. NICHOLSON: Just a couple of quick follow-ups.

EXAMINATION BY
BY MS. NICHOLSON:

Q: Just so the record is clear, you found no documentation that there are these two additional wounds while Starwyck was at Freedom Square?

A: That's true. I did not find those at Freedom Square.

Q: When you were talking about you found — Ms. Hanes was asking you about the monitoring of fluids, I just want to make sure that, again, the record is clear.

You would agree with me the staff is monitoring with their documentation. If I'm understanding your opinion correctly, it's that you are of the opinion they were not monitoring as Mr. Starwyck required?

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MS. HANES: Form. Mischaracterizes his testimony.

A: No. I'm saying they are writing the word "monitoring." It's like saying monitoring blood pressure, and then nobody actually measures the blood pressure or writes it down. There is no place that I could find that shows how much volume he was taking in and that is essential in order to implement a treatment plan.

Q: With regards to Exhibits 21, 22, and 23, do you know what the conversation was between the staff and Mr. Starwyck's physician?

A: The conversation is not documented.

Q: You would agree with me there is documentation, there is a conversation?

A: I don't know if he even says there is a conversation at times. I think sometimes it just says a fax was sent.

Q: If the document says that there's a phone call with the physician, would you agree with me that that is some type of conversation going on with the physician?

A: Not necessarily. I think one time they actually documented that there was a phone call

and they left a message. It wasn't a conversation. It was a delivery of a message.

Q: A BMP test, does that test a catheter problem?

A: It would test the consequences of a catheter problem.

Q: It will also test a hydration problem?

A: It will test multiple things. You could use it for more than one evaluation.

MS. NICHOLSON: Okay.

MS. HANES: Just a couple of more questions, Doctor.

EXAMINATION

BY MS. HANES:

Q: The fact that the two wounds, the wound to the right outer heel and to the right ankle not being documented at Freedom Square, you finding no documentation, isn't that kind of the point, Doctor, that they weren't recognizing it and documenting at the nursing home?

MS. NICHOLSON: Objection. Form.

A: My point is that if something exists, you have to see it and document it and communicate it to others.

Q: And it's your opinions that those wounds formed while he was at Freedom Square, correct?

MS. NICHOLSON: Objection. Form.

A: That's the most likely explanation of how they occurred.

Q: And some of the bases for that would be, Doctor, that when he goes to the hospital on the date of admission, they document the condition and the presence of those wounds, correct?

MS. NICHOLSON: Objection. Form.

A: That's true and then location. To have three separate wounds on a foot suddenly appear in a new facility is not as likely as having the wound form in the previous facility.

MS. HANES: Thank you. I don't have anything else.

MS. NICHOLSON: Nothing. I would assume you will read.

THE WITNESS: Yes.

(Whereupon, at 12:06 p.m. the deposition was concluded.)

CAPTION

The Deposition of PERRY J. STARER, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

The Deponent will read and sign the transcript of said deposition.

CERTIFICATE

STATE OF_____:

COUNTY/CITY OF_____:

Before me, this day, personally appeared PERRY J. STARER, M.D., who, being duly sworn, states that the foregoing transcript of said deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

PERRY J. STARER, M.D.

SUBSCRIBED and SWORN to before me this_____ day of _____ ____, 2014, in the jurisdiction aforesaid.

My Commission Expires Notary Public

DEPOSITION ERRATA SHEET

RE:

CASE CAPTION: THE ESTATE OF STEPHEN L. STARWYCK, et al.

vs.

ARC FREEDOM SQUARE, LLC; et al.

DEPONENT: PERRY J. STARER, M.D.

DEPOSITION DATE: MAY 20, 2014

To the Reporter:

I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request for the following changes be entered upon the record for the reasons indicated.

I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

SIGNATURE:_____ DATE:_____

PERRY J. STARER, M.D.

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CERTIFICATE

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, Jean Wilm, a Shorthand (Stenotype) Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Deposition, of the witness, PERRY J. STARER, M.D., taken at the time and place aforesaid, is a true and correct transcription of said deposition.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of May, 2014.

JEAN WILM, RPR, CMRS