IN RE: ARBITRATION PROCEEDINGS

BONNIE BERENS, by and through her next friend and guardian, DAVID BERENS,

Plaintiff,

vs.

CLERMONT ALF INVESTORS, LLC, d/b/a SUPERIOR RESIDENCES OF CLERMONT,

Defendant.

PLAINTIFF'S STATEMENT OF THE CASE

Background:

Mrs. Bonnie Berens was admitted to Superior Residences of Clermont (SRC) 6/13/06. Her past medical history included type 2 diabetes, Alzheimer's dementia and questionable paranoid/ bipolar disorder. She was 65 years old. It is undisputed that her husband, David Berens, was extremely attentive and remained actively involved in her daily care needs. Initially, he frequently took his wife home for overnight stays including bathing/ showering needs. He was aggressive, to a fault, according to SRC's management, in his involvement in her care and attendance to her needs. Mrs. Berens was ambulatory but had severe dementia and behavioral disorders which were controlled with medications.

Summary of Case:

A Resident Health Assessment for ALF was completed 6/12/06 by Dr. Borislav Vatev. Dr. Vatev noted that Bonnie **required assistance with all of her ADL needs and help with her medications**. She was independently ambulatory according to the admission assessment but had

severe dementia and behavioral issues which were controlled with medications. She would remain a resident of this ALF through 12/28/07 when she sustained a fall with right hip fracture.

According to the nurse's note authored by Melissa Hobson, who was later terminated by SRC, she **"fell asleep on her feet"** in the middle of the night in the tv room. Mrs. Berens required emergency transport to South Lake Hospital and underwent right hip hemiarthroplasty by orthopedic surgeon Dr. James Ray. Records indicate that **she was administered an anxiety medication, 1.0 mg of Ativan, and a sleeping pill, 8 mg of Rozerem, at 8:00 p.m. only hours before the fall**. She had also received doses of Ativan earlier in the day, 1 mg at 8:00 a.m. and .5 mg at 4:00 p.m.[1] SRC and South Lake Hospital records do not indicate that anyone was assisting, supervising or monitoring Mrs. Berens closely at the time she fell after midnight in the common area t.v. room. within sight of at least some of the staff on duty.

Indicia of Fall Risk Behavior:

- **Medications:**

According to Superior Residence of Clermont (SRC) records, Mrs. Berens was noted immediately upon her admission to SRC to be extremely active, "aimlessly" pacing most of the day and often during the night. She exhibited behaviors of wandering and exit seeking as well as combativeness associated with ADL care, refusals of care and occasional aggression toward other residents. As a result, a multi-disciplinary service plan was developed to address the problems with appropriate interventions. Her medications were initially managed by Dr. Vatel as well as Dr. Jean-Louis and included multiple psychotropic medications. Within days of her admission Ativan was added to be used on an as needed basis at bedtime in an attempt to reduce her night ambulation/ pacing. Mr. Berens also collaborated with the physician and SRC staff regarding his wife's medications. Shortly before the fall in December 2007, the time of the administration of Ativan was modified at the request of SRC staff, but Mrs. Berens continued to

[1] The SRC chart indicates that seven days earlier on 12/20/07, the staff had requested and apparently received authority to give the routinely administered 6:00 p.m. Ativan dose at 4:00 p.m. instead.

take several doses of prescribed Ativan daily. Known side effects of Ativan include the following:[2]

- Dizziness
- Weakness
- Unsteadiness
- Drowsiness
- Fatigue
- Vertigo
- Disorientation

Mrs. Berens was also prescribed Rozerem, a sleeping pill, at the time of the accident. The records indicate that, in fact, she had received a dose of Rozerem at 8:00 p.m. on the night of her fall. Rozerem is a sedative that is generally supposed to be taken 30 minutes before bedtime after which it is recommended that patients do nothing other than get ready for bed. Its fundamental purpose is to help patients sleep and its side effects include dizziness, drowsiness and fatigue.

- **Behavior**

As early as 7/25/06 Mrs. Berens demonstrated being at risk of falling due to her pacing behavior. On that date nurse noted 9:30 AM a **nurse noted she was leaning to one side while ambulating**. Yet, there is no indication in the record that this was reported to anyone or investigated, worked up, care planned, or evaluated in anyway by the nursing staff. Many staff members demonstrated an early ability to practice good nursing intervention and protect Mrs. Berens from her own risky behavior. In fact, the very next night, a **nurse observed Mrs. Berens again leaning to one side after pacing up and down the common areas during the early morning hours of the 10 PM – 6 AM shift**. The **nurse noted that Mrs. Berens was**

[2] Dr. Torres, Mrs. Berens' treating psychiatrist until September 2006, has testified that these are known side effects of Ativan and that the fundamental purpose of Rozerem is to put the patient to sleep. Likewise, the Physician's Desk Reference contains these side effects.

"obviously tired" and "walking slowly and leaning to R side". She still refused to stay in bed, but this nurse didn't give up. **She sat beside Mrs. Berens for a full hour until she fell asleep**. She practiced good nursing, and instead of just allowing Mrs. Berens to continue pacing to complete exhaustion, she intervened in an appropriate manner and got her to sleep. This is why Mr. Berens was paying thousands of dollars per month for Superior's help. He could not do this at home, and he expected the professionals at SRC to do it and assumed they were doing it when he wasn't there.

It is clear from the scant record-keeping alone that Mrs. Berens commonly paced to the point of exhaustion, particularly in the middle of the night. Once again on 8/3/06 a **nurse notes that at 6 AM she was up walking, "looking tired and confused."** Two days later on 8/5/06 she was again **observed late at night, at 11 PM, "wandering up and down the common area, leaning to one side while ambulating**." Once again, a competent nurse who kept copious notes of the event took Mrs. Berens to her room and **"sat with her until she went to sleep, about 15 minutes" and Mrs. Berens slept several hours**.

On 9/24/06 Mrs. Berens was noted to have jerking movements. In addition, her **legs buckled and she fell to her knees several times**. She was transferred to South Lake Hospital ED via 911 due to possible seizure activity, returning to SRC shortly after noon without new orders. Subsequent faxes to Dr. Torres 9/25/06 and 9/26/06 indicated the jerking and tremor activity had stopped and that the emergency room physician had told Mr. Berens that his wife was likely experiencing withdrawal symptoms of Depakote and Ativan. Seroquel dosing was increased again 9/28/06, 10/10/06 and 10/23/06 when nursing noted continued behavioral problems, constant pacing, anger and insomnia.

On 11/14/06 a nurse noted that Mrs. Berens had been **observed to have jerking movements and difficulty with ambulation**. She **further noted Mrs. Berens' legs "giving out with ambulation."** Yet another incidence of gait instability was documented 11/15/06 when Bonnie was **noted to have stood up from the dining table "and legs seemed to give out"**. Dr.

Jean-Louis was noted to have come to see Bonnie at SRC 11/17/06 for consultation regarding behavior management and medications.

Clear evidence of inadequate supervision by SRC staff is reflected in the 1/7/07 nurse's note when the Bonnie entered the common dining area at 10:45 a.m. with a powdery white substance around her mouth and nose. Despite watering eyes and dripping mucous from her nose, Superiors staff did not contact a Poison Control Center at any time and did not contact her husband David until 11:30 a.m. SRC's Director of Nursing was notified at 12:30 p.m. and at 1:30 p.m. the resident was transferred to South Lake Hospital for evaluation, returning to SRC at 4:30 p.m.

The hospital emergency room records discharge instructions were for allergic reactions. The emergency room physician also gave prescriptions for a 5-day course of Prednisone, PRN Benadryl and twice daily Tagamet. Additional nursing documentation from 1/7/07 indicated the staff had searched the memory care unit in an attempt to see what Mrs. Berens had ingested without success. They also gave her some milk and a banana, and later found as vomitus in the bathroom sink of room 309.

On 1/17/07 **a nurse noted that Mrs. Berens was walking into chairs and walls while holding her head down and not looking up**. This note was at 1:00 AM. Yet, there is no indication that this behavior was reported to anyone, followed up, or evaluated in any way by the nursing staff of SRC. The next day, 1/18/07, she was **again noted to be walking with her head down**. This record indicates a continuing increase in exhaustion or ambulation in a manner that increased her risk of falling. Yet, no evaluations were performed and nothing was reported to anyone, including the DON, the physician, or Mr. Berens.

Bibi Shabbeer, who still works for SRC and was a resident care assistant when Bonnie Berens was at SRC, has testified under oath about her memory of Mrs. Berens' behavior. She was one of the first witnesses deposed and volunteered the following:

Q: Do you have an independent memory as you sit here about what her ambulatory ability was, how well she could walk and transfer and move about?

A: As I can remember, she walked. **Sometimes she gets tired from pacing**, you know….

Q: Is there any more you can tell me about your memory of Mrs. Berens ability to walk and how she got about the facility during these two months or month or two that you were with her?

A: She walked sometimes, you know, with a little----well, you know, **sometimes a little stumble in her feet**, but she walks.

Q: Did you report the stumbling to the nurses when you saw it?

A: Everybody knows she walks. **When she gets tired, she kind of, you know, gets a little tired on her feet.** And that's when she would sit for a few minutes, you know.

Q: You saw that during the first month of two you were at ----

A: Yeah. She gets tired on her feet then, she will sit for a few minutes.

Q: Was it when she was tired is when she would stumble?

A: I wouldn't say stumble. Her feet get tired, a little weaker than---and she would sit.

The current director, Debra Woods, an LPN, was a floor nurse in Mrs. Berens' unit before she fell. She testified that she had observed how Mrs. Berens would behave when she got tired on her feet:

Q: How did you know she was getting tired?

A: **She would start leaning forward and kind of running. She would be walking and then she would start leaning forward and start----she would start to walk a little faster**.

Q: What else made her appear to be tiring to the point that she would go lay down on the couch other than what you've just told me?

A**: I think you could see it in her eyes that she was getting a little tired. And at that time, we'd usually try to redirect her to lay down on the bed or the couch.**

Q: I guess that's sort of where I was headed with this. When you saw these behaviors, as a trained nurse in the long term care setting, you know, here's a risk---

A: Absolutely.

Q:---I need to go redirect this patient so that she's not a danger to herself, correct?

A: Absolutely.

Q: So if you saw her getting tired on her feet, you knew that that's something that needed to be considered?

A: Right. And we did do that. A lot of times, it wouldn't work. She would get right back up. She would be really, really tired. You would assist her to bed. You'd think she was going to be asleep and five minutes later, she'd be up and pacing again. She did that consistently.

Q: Did you ever consult with Bonnie (Hook) about that behavior?

A: Yes.

Q: What did y'all talk about about how to deal with that? I take it that it had become a problem in your mind that was an increased risk to Mrs. Berens?----

Q: ----What we were talking about is the fact that when you see somebody like Mrs. Berens tiring on her feet that you know they need redirection or they might be a danger to themselves or might get so tired they just fall, right?

A: Right.

Q: And then we talked about Mrs. Berens and you said a lot of times that didn't work, and she'd be right back up five minutes later, and it just wouldn't work?

A: At that point, we would try to redirect her with an activity or some form of redirection to where she's not pacing.

Q: Is that something you and Bonnie talked about doing as a solution?

A: Right.

Q: What other solutions did you and Bonnie talk about?

A: We had activities during the day. At nighttime, the aides would sit with her, talk to her, give her a hug. We were consistently trying to redirect her with some form of activity if she didn't rest. But there was a lot of times she would just rest, too. You would lay her down, and she

would take a little nap and she would feel better. Or you would lay her down on the couch and she would sleep 20, 30 minutes, and she would have a little cat nap.

Q: **Have we talked about all the ways that you and Bonnie and the staff had decided to use to deal with her tiring on her feet?**

A: **Well, we used medication as a last resort.**

Mrs. Berens was on several medications, including "prn" medications the staff could provide "as needed." Among her prescribed daily medications was Ativan, a drug commonly used to treat anxiety which, according to the notes was administered several times daily, including at approximately 4 p.m. or 6 p.m. on the date of the fall in December 2007.[3] Common side-effects of Ativan include:[4]

- Dizziness
- Weakness
- Unsteadiness
- Drowsiness
- Fatigue
- Vertigo
- Disorientation

In addition, she was prescribed Rozerem. At 8:00 p.m. only hours before the fall, she had been administered Rozerem which is a sleeping aid. Its fundamental purpose is to assist patients to sleep. Side effects include dizziness, fatigue, and drowsiness.

- **Expected Nurse and Staff Interventions**

Even with these risky behaviors and the effects of medications, the records are clear, particularly toward the end of her stay but prior to the fall, that she was most often easily

[3] The medication administration records are unclear about the administration of medications on the date of the accident. The nature of the MARS entries for the date of the incident even call into question whether the MARS were kept contemporaneously with the administration of the medications.

[4] Mrs. Berens' treating psychiatrist until September 2006, has testified that these are known side effects of Ativan and that the fundamental purpose of Rozerem is to put the patient to sleep. Likewise, the Physician's Desk Reference contains these side effects.

redirected by caring and competent staff that were properly monitoring and supervising Mrs. Berens. On 7/16/07 the monthly nursing summary stated **the staff was able to "easily redirect"** Mrs. Berens. Again on 8/9/07 the nurse noted that while she could be aggressive with the staff at times, **she was "easily redirected**." Anjanette Vargas, a former employee and one of the nurses who cared for Mrs. Berens, testified that Mrs. Berens was **easily redirected** to bed if a nurse took the time to properly intervene. She also explained why she would intervene when Mrs. Berens was pacing late into the night:

Q: Tell me what you remember about that.

A: She would wake up and just walk around, like she did during the day, and just pace around, as she did during the day, until she got tired and then she would sit and sleep, or go back to her room and sleep.

Q: Okay. Did you ever redirect her to go back to bed?

A: Yes.

Q: Okay. And why did you do that?

A: Because it was the middle of the night, and she wouldn't be the only resident up, there would be other residents up. So our job is to redirect them and, **you know, keep them safe, put them back to bed, see if they would go to sleep**. **And most of the time she would**. **You would just sit with her for a couple of minutes and she would go right back to sleep**.

Q: Okay. And that's what I noticed in the chart, if you, your experience was, that if you redirected her and put her back to sleep, that she generally would comply?

A: Yes.

Q: And when you did that, would you have to sit with her for a little while -----

A: Yes.

Q: before she would ----

A: Yes.

Q: ----go to sleep?

A: Yes.

Q: And while she was in bed?

A: Yes Yes.

……

Q: Would you also redirect her to go back to bed in the middle of the night for her own safety?

A: Yeah.

Q: And what about her wandering around in the middle of the night like that was unsafe that would lead you to redirect her to go back to bed?

A: Like I said, she would sometimes go into other residents' rooms or into the kitchen areas or just different areas, so, we would just feel that that wasn't safe for her to do, so we would put her to bed. And she didn't sleep much.

Q: Okay.

A: So we would feel that, you know, she needed her rest.

Q: Right.

A: She lost a lot of weight in the time she was there, too.

Q: Would she get tired on her feet from all that pacing?

A: I would guess. I don't know if she did or didn't. She didn't appear to, but I would think if you would walk all day you would get tired.

Denise Stammis was the acting Assistant Director of Nursing at the time of Mrs. Berens' fall. She testified that the staff was trained to redirect residents like Mrs. Berens for their own safety. As to Mrs. Berens, she admitted she was unaware of Mrs. Berens knees buckling or her legs giving out or walking late at night and leaning to one side or walking late at night and looking tired. The former ADON further testified:

Q: I want you too assume for me that in the middle of the night, you know, Bonnie would walk, and on a particular occasion walk enough that she got tired on her feet, was leaning to one side,

and that this was a repetitive behavior----if that were true, okay, if the records bore out that that were true, that she would walk to the point of getting tired on her feet and leaning to one side, would you expect your staff to redirect her when they observed her in that condition?....

A: Yeah, I do. **They would have been, you know, if I had been the nurse on the floor, I would have said to whoever, "Could you maybe redirect Bonnie to her room? She's looking very exhausted. Let's see if we can't get her to lay down."**

…..

Q: **You wouldn't expect your staff to simply watch her fall asleep on her feet and fall, would you?**

A: **No.**

Q: Okay. **You would expect your staff to take action and intervene if they saw any resident falling asleep on their feet wouldn't you?**

A: **Yes.**

….

Q: And you, as the Assistant Director of Nursing back at this time supervised the nurses and resident care assistants who were charged with that responsibility, did you not?

A: Yes.

Q: Do you know why Mrs. Berens was there?....

A: Because her husband was awake 24 hours a day seven days a week because she wouldn't sleep.

Q: Okay.

A: So she got to be a handful at home.

Q: Okay.

A: So he brought her to us to watch her.

Q: Because he needed professional help?

A: Yes.

Q: And you were the professional help that he was paying-----

A: Yes.

Q: ---to supervise and monitor her---

A: Yes.

Q: Correct?

A: Yes.

The director of nursing, who was in transition to floor nurse at the time, was Bonnie Hook. She is now a surveyor of long term care facilities for the Agency for Health Care Administration. She also testified about what she would expect of her nurses in caring for Bonnie Berens, given the above behavioral history and admitted she was never told of much of this behavior.

Q: Did you perform fall risk assessments of each patient, including Bonnie Berens, periodically?

A: I did not.

Q: Who did you rely on to do that?

A: The charge nurses.

Q: And did you rely on the floor nurses to tell you and to record in the charts whether or not somebody was a fall risk?

A: Yes.

….

Q: Did anyone ever tell you that Mrs. Berens would fall asleep on her feet?

A: No.

Q: Anyone ever tell you she would get tired from pacing?

A: No.

…..

Q: Did anyone ever tell you that Mrs. Berens wandered in the middle of the night to the point of getting tired on her feet?

A: No.

….

Q: As director of nursing did you provide any guidance, training or orientation to the resident assistants, or the floor nurses, about how to deal with patients who paced late into the night and became a fall risk because of that behavior?

A: Yes, we did.

Q: What were your instructions and guidance in that regard?

A: That when a person with dementia is pacing, you know, that they should watch them, observe them, try to redirect them. If the patient became combative or frustrated with attempts at redirection, just back away and let them pace. And you know, you just kept working with dementia patients. And everyone was different so you had to do your redirection based on where the patient is at that point in time.

…

Q: Well, you wouldn't expect Melissa and the other staff members to just stand by and watch her fall asleep on her feet, would you?

A: No.

Q: I mean, you would expect them to closely watch her that evening and, if it looked like she was getting tired on her feet, to redirect her, wouldn't you?

A: Right.

…

Q: If you had been told that she had wandered to the point of becoming tired on her feet in the middle of the night, and that she would even lean to one side as she was pacing and become tired in the middle of the night, would you have considered her a fall risk at that point?

Q: Knowing everything else that you knew about Mrs. Berens?

A: Had---yes. If she would wander to that length and extent, yes.

…..

Q: Would you have told the staff any different things to do if you had known those facts?

A: Yes.

Q: About how to intervene, redirect, or otherwise engage in fall prevention measures for Mrs. Berens?

A: Yes.

Q: And what measures would you have suggested?

….

A: If she would have been unsteady on her feet rather than wandering around, we would probably have someone walk with her. We would have had somebody probably try to help her sit down and rest. They did try to do that. Probably had we noticed that she was unsteady on her feet, she may have been---we may have used a walker, you know, things for her. But she was never unsteady on her feet so those things weren't—

Q: At least you were never told that she was unsteady?

A: Right.

Q: You were never told that she would get tired on her feet, or that her knees would buckle, or anything that would suggest she had an unsteady gait or was at a fall risk?

A: Right.

….

Q: If, in fact, she was getting tired and the staff observed that behavior in the middle of the evening, like this evening, if , in fact, she was getting tired on her feet, she should have been redirected, shouldn't she?

A: If they observed her getting tired, yes.

Q: And they, in fact, ought to be on the lookout for her getting tired, if that was the behavior she exhibited in the past, correct?

A: Yes.

Q: At 12:00 midnight or 1:00 in the morning?

A: Correct.

Q: And we note from the nurses notes that I showed you earlier that a couple of nurses, in fact, successfully redirected her to bed, even if they had to sit there for an hour to do it, correct?

A: Correct.

….

Q: When it comes to having someone walk with her, would you expect the staff to use their good judgment to go over and walk with her, or stand next to her, if their observation was that she was becoming a fall risk to herself in the middle of the night, because she was getting tired on her feet?

A: If she saw that she was unsteady on her feet, yes, I would expect that they would go over there. Then they would report it to me so then we could start taking some more appropriate measures.

Q: So you wouldn't expect them to just stand by? You would expect them to use their good judgment and also report it to you?

A: Yes.

….

Q: And perhaps would one of those interventions even been offering to or suggesting to him (Mr. Berens) that he hire a sitter? I mean would you have gone to that extent?

A: Right. Yes, we would have. In fact, when he would go out of town, he would have a sitter come in.

Q: During the day?

A: Right.

Q: But nobody ever suggested to Mr. Berens that he needed a sitter in the middle of the night, at 1:00 in the morning?

A: No, because it was not necessary at that time.

- **No Care Plan**

There is no record of a written care plan at SRC or consideration to developing a written care plan at SRC which would provide for consistent and uniform interventions to minimize the risk of a fall injury to Mrs. Berens given her behavioral history and medication regiment. It simply isn't addressed in the SRC record in any professional manner. Predictably, Mrs. Berens ultimately fell and was severely injured.

SRC's Record of the Incident:

Nursing notes on Mrs. Berens' status were scant after September 2007 until the nursing note of 12/27/07. The nursing notes of 12/27/07 indicated she had been taken to South Lake Hospital via EMS when she **"fell asleep standing up and fell over"**. Although there was a nursing note 12/6/07 indicating her medications had been reordered by ARNP Rauch, the last substantive nursing note prior to this final fall occurred over a month earlier on November 15, 2007. This note was a "monthly summary" indicating she paced around most of the day and night. The medication administration records were unclear and confusing but she regularly received a dose of Ativan and Rozerem, a sleeping pill a few hours before the fall according to the physician orders. There have never been any corrections, amendments, late entries, or supplements to Nurse Hobson's note from the evening in question.

Written Policies and Procedures:

SRC's written policy on Interdisciplinary Notes provided as follows:

PURPOSE: To ensure that an interdisciplinary continuum of care is provided to all residents and that all responsible caregivers have a full and clear understanding of the residents' health status and specific needs of care.

POLICY ….These notes are used to offer a **detailed summary** of the issues experienced by a resident and the actions taken to assist him or her.

Moreover, SRC's written policy on Resident Rounds provides as follows:

PROCEDURE:

- The staff of the two shifts, 3:00 p.m.- 11:00 p.m. and 11:00 p.m.-7:00 a.m., will ensure that all residents are in their own rooms, and all room doors are unlocked at the change of shifts.
- The staff of the 11:00 p.m.-7:00 a.m. shift will conduct rounds every 2 hours throughout the night, attending to any resident's need, observing status changes, and reporting and documenting changes.

The SRC Shift Report policy also required a shift report of any important events, issues, or concerns that occurred during the assigned work period. There are no shift reports produced and pertaining to any incidents involving Bonnie Berens. There are no nurses' notes requesting that any of her risky behavior or her risk of falling be addressed, assessed, or discussed in any way. There is no written care plan addressing interventions to prevent Mrs. Berens from falling and hurting herself.

SRC's Resident Falls policy provided as follows:

PURPOSE: **Provide the maximum amount of safety awareness for residents, family and caregiver staff**.

POLICY: Minimize the frequency and the severity of falls in and around the residence.

PROCEDURE: **Advise the caregiver team regarding the findings that might contribute to a potential for falling**.

It is clear from a review of the SRC chart, particularly in view of the testimony, that SRC's staff were woefully inadequate in charting and advising the care team of concerns about Bonnie Berens' safety so that the care team could establish a known strategy for keeping her safe when she was pacing late at night after taking sleeping pills and Ativan. In addition, it is clear that these behaviors and the risks posed were not discussed with Mr. Berens so that he could consider measures that he could take to keep her safe.

The Incident:

The nurse on duty on the evening of 12/27/07 was Melissa Hobson. She was later terminated by Opal Doty, the executive director, and Bonnie Hook, the DON, allegedly for "cursing". There have never been any changes, corrections or additions to the nursing note made by Nurse Hobson on the very evening in question. Despite ample opportunity during the post-accident investigation by SRC's management staff as well as the Department of Children & Families, Nurse Hobson and SRC never changed, corrected, or added to this nursing note recorded within minutes of the accident itself. As mentioned previously, **her note says Mrs. Berens fell asleep on her feet and doesn't describe any interventions earlier that evening to prevent or minimize that risk**.

Contrary to the nurses' notes and testimony, former SRC Nurse Anjanette Vargas testified that she was **told by staff members that Mrs. Berens had "fallen several times one night and was sent to the hospital."** She also testified that **Nurse Hobson complained about having to work double shifts**. The nurse work schedules produced by SRC indicate that, indeed, **Nurse Hobson was working a double shift on 12/27/07.**

Sharon Campbell, still employed as a resident care assistant at SRC, now testifies was allegedly present when Mrs. Berens fell. She says she ***saw*** Mrs. Berens fall near the television in the common area. Sharon testified she was going from one resident's room to another. She says that Melissa Hobson and another resident care assistant were in the vicinity in the common area when she fell. At the time, Mrs. Berens was the only resident in the common area. She disagreed with Melissa's nursing note description that Mrs. Berens fell asleep on her feet but had no other explanation for the cause of the fall when she was deposed.

"Radica", an aide allegedly on duty at the time of the incident testified that she was specifically assigned to rooms 301 through 310, including Room 305, Bonnie Berens room. She also specifically testified she was assigned to Bonnie Berens on the evening of the incident, had

not attempted to get Bonnie back in bed that night or attempted to redirect Bonnie that night, and did not see the fall but heard Sharon yell that "Bonnie was on the floor".[5]

Records of South Lake Hospital emergency department indicate that Mr. Berens advised the hospital staff that she had **fallen asleep while sleep walking after being given Ativan and Rozerem**. As mentioned earlier, common side-effects of Ativan can include unsteadiness, fatigue, drowsiness, etc. She arrived at South Lake Hospital at 1:55 AM. In addition, Rozerem is a sleeping aid and its side effects include drowsiness, fatigue and dizziness.

SRC's written policy on Hospital Admission provides as follows:

PURPOSE: When a resident requires treatment at a hospital, staff members must ensure that the hospital receives the information necessary to provide proper care. The staff at the facility has the responsibility of ensuring that all pertinent information about the resident and the actions taken to receive treatment at the hospital are properly documented.

PROCEDURE: ….the Supervisor on duty must make certain that a copy of the Resident Information sheet should be located in front of the resident record/chart.

There is no indication in the hospital chart that all the proper information was relayed to them by SRC staff and supervisors on the evening of the fall. Nonetheless, the hospital chart reflects that Mr. Berens told the hospital employees on the evening of the fall the events described to him by SRC in the early morning hours of December 27, 2007, i.e. **that Mrs. Berens fell asleep on her feet while the staff were in a meeting in plain sight of her**. In short, despite a self-imposed obligation to do so, there is no indication that SRC communicated in any meaningful way with South Lake Hospital's emergency department regarding what happened, how it happened and why it happened. This conduct alone can be seen as an admission of negligence. Conduct, like statements, can be admissions, e.g. leaving the scene of an accident or, as here, not communicating details, likely harmful to the accountability of the facility, when

[5] Radica's testimony is quoted in more detail later in this summary. Note that Radica was terminated in February 2010 after some kind of altercation/exchange with a resident and does not appear to have been interviewed by the DCF or SRC management. Moreover, it does not appear that any reports, including the "occurrence" report by SRC or the DCF report identify her as the resident care assistant responsible for Bonnie Berens on the evening of the fall.

under a self imposed mandate to do so. Yet, now, SRC denies the fall occurred as documented by Melissa Hobson immediately after the fall on the night of the fall and as described to Mr. Berens that very evening.

Mr. Berens was deposed for a grueling 4 ½ hour deposition. Despite serious heart ailments and multiple heart attacks, he has stuck to the same story all along about what he was told when contacted the evening that this fall that occurred between Christmas and the New Year in 2007.

Q: …Now, according to your notes at one-thirty a.m. you received a call from Melissa, correct?

A: Yes sir.

Q: And Melissa was the nurse on duty at that time?

A: She was the R.N., sir, yeah. Not the nurse's aid, the R.N.

…..

Q: …What do you recall Melissa telling you?

A: **She said Bonnie has fallen. We quote, unquote, we were having a meeting; we looked over and saw her sleeping on her feet in front of the T.V.; we heard a loud clunk; we this and we that**. She was talking about having a meeting about twenty yards away from Bonnie, if that's where they were having it at the table. There should have been three nurses' aides on. I don't know. The nurse that came to the hospital where Bonnie's operation was going on, might have been one of them. And she said she called the ambulance and they were taking her to South Lake. And when we got there, they did an x-ray and noticed a broken hip. Dr. Ray was available. Within 24 hours, he did the operation.

…..

Q: So, the conference table was within twenty to thirty feet of the T.V.?

A: Yes.

…..

Q: Do you know where your wife fell?

A: Right in front of the T.V.

Mr. Berens also kept personal diary notes from the incident, in which he wrote, shortly after the incident and before retaining an attorney, that **Melissa, the R.N. on duty, called him at 1:30 a.m. and advised Bonnie was walking in her sleep and fell and that she had been earlier seen walking with her eyes closed and bouncing off of walls. He further wrote that she told him they looked over to see her standing in front of the T.V. with her eyes closed sleeping before they heard a loud clunk and she was down**.

Department of Children and Families Investigation:

The Florida Department of Children and Families performed an investigation at the request of Mr. Berens and pursuant to Chapter 415, Florida Statutes and its specific limitations, along with their budgetary limitations. This investigation was apparently begun in February 2008, well over a month after the incident. While the Florida Department of Children and Families investigator found no indicators of inadequate supervision, the investigator was clearly not aware of all of the facts uncovered in formal discovery in preparation for these arbitration proceedings and was not investigating the incident as a "civil" matter but under an entirely different statutory scheme.

Of course, this investigative report would not be admissible at any civil trial as it invades the province of the jury and would be subject to statutory privileges contained within Chapter 415, Fla. Stat. In addition, this civil action is not brought pursuant to §415.1111, Fla. Stat. which authorizes civil actions that arise from neglect as specified by Chapter 415, Fla. Stat. Rather, this action is brought pursuant to § 429.29, Fla. Stat. which arise from a violation of resident's rights granted by § 429.28, Fla. Stat. Section 429.29, Fla. Stat. specifically provides the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in § 429.28, Fla. Stat.:

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, **the claimant shall have the burden of proving, by a preponderance of the evidence, that:**

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, **a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances**.

(4) In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such **nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses**.

Accordingly, the standards and burden of proof are entirely different for a panel of arbitrators or a jury deciding a civil case on these facts. Perhaps most importantly, the version of the events as told to the DCF investigator are inconsistent with the original story told to Mr. Berens, with the history in the hospital records, with Nurse Hobson's nursing note and with SRC's own records, including their own "occurrence report".

. The DCF investigator wrote in the DCF report as follows, referring to SRC's "occurrence report" prepared by Melissa Hobson, RN and Sharon Campbell:

"Report states that the underlying incident occurred in the common area. States resident was standing next to TV in east hallway when *we heard* a 'thud' and observed resident on floor. Resident taken to South Lake Hospital…Husband notified of possible hip injury. Report states that resident was observed on floor and remained on floor while Melissa checked all extremities for movement and vitals. Resident could move all extremities without pain. Resident sat up without pain. Resident helped to standing position and when

she attempted to walk on her leg she said, 'OOOHH' and lifted her leg off the floor. Resident sat down in chair. 911 called as she was not weight bearing. Proactive steps were taken to prevent occurrence. Nurse sat resident in reclining chair. Resident put to bed at 12:05 a.m. Resident walks non-stop all day and night. Resident given snacks and drink during the night. Several attempts made to get resident back in bed but resident will not stay in bed."

The DCF investigator spoke to Bonnie Hook, the executive director/director of nursing of SRC. She told the investigator that Nurse Hobson and three care assistants, Sharon Campbell, Rose Trout, and "Radika" were having a "standup" meeting in the memory care unit when Mrs. Berens fell. Bonnie Hook did not tell the investigator that anyone actually **saw** the fall and what Bonnie Hook did say to the investigator implies the opposite, i.e. that the four staff members on duty were in a "meeting". Bonnie Hook has also testified in this case under oath. In her deposition testimony, she tells yet another story of what the staff told her. In her testimony, she says that she spoke to the "three" staff members who said they were all "in the vicinity" and "they saw" Mrs. Berens "grab onto the t.v. and then she went down."

Bonnie Hook is now a surveyor of long term care facilities for the Agency For Health Care Administration. She acknowledged in her deposition she would expect her nurses to tell the truth in the charts and that Nurse Hobson's nursing note tells an entirely different story than the staff told her and the story the staff told the DCF. **She also acknowledged that there are perfectly acceptable procedures to allow late entries or corrections in nursing notes. Yet, neither she nor Nurse Hobson made any notes in the chart correcting, amending, or supplementing Nurse Hobson's nursing note despite there being ample opportunity to do so**.

According to the report, the DCF investigator was then told by Melissa Hobson, RN, that Sharon Campbell was in "Room 307" when she **heard** a "thud" and asked Mrs. Berens if she

was okay and she said yes. The DCF report later indicates that Nurse Hobson told the investigator "Sharon and Rose" **saw** Mrs. Berens fall. Nurse Hobson's nurse note from the evening and even the "occurrence report" are both at odds with SRC's later and current contentions that the staff, e.g. Sharon Campbell, ***saw*** Mrs. Berens fall and that she did not fall asleep on her feet.

Sharon Campbell has now testified under oath that she was in the common area seven feet away from Mrs. Berens and **saw** her fall **while going from one resident room to another**.[6] The DCF report records interviews with both aides allegedly on duty. One told the investigator that she was attending a **"stand-up meeting"** and "witnessed" Mrs. Berens fall. She said she was awake, not sleepwalking, walked up to the tv, stopped suddenly, and put her hands forward as if to prevent herself from falling forward, lost her balance and then fell to the side and rolled over.

Of course, none of this is in the SRC chart, the nurse's notes, or even in the "occurrence report" prepared by Nurse Hobson. In fact, the opposite is stated in her nursing note, i.e. that Mrs. Berens fell asleep on her feet. This version is also inconsistent with everything that Mr. Berens was told, with his personal diary, and with the hospital records.

The other aide allegedly told the investigator that Mrs. Berens was not "bouncing off any walls", was walking slowly while the staff was in a "stand-up meeting", and that **she did NOT see Mrs. Berens fall. She heard a "bang"**. "Radica", an aide allegedly on duty at the time of the incident testified that she was specifically assigned to rooms 301 through 310, including Room 305, Bonnie Berens room. She also specifically testified she was assigned to Bonnie Berens on the evening of the incident, had not attempted to get Bonnie back in bed that night or attempted to redirect Bonnie that night, and did not witness the fall but heard Sharon yell that "Bonnie was on the floor":

[6] Just as in the case of "Radica", a resident care aide who has testified she was present, assigned to Bonnie Berens that evening, but did not see the fall because she was in another resident's room, the ADL flowsheet for December 2007 does not appear to bear either the initials or the signature of Sharon Campbell. Radica testified that her signature should be on the ADL flowsheet for December 2007 as she was assigned to Rooms 301-310 and to Bonnie Berens.

Q: Were you working when she fell?

A: Yes.

Q: Were you on duty on her hall?

A: Yes.

….

Q: And do you remember, as you sit here, whether you were assigned to Bonnie Berens the evening of the fall?

A: Yes.

Q: And you were?

A: Say it again.

Q: Were you assigned to provide care to Bonnie Berens on the evening of the fall?

A: Yes.

….

Q: I know you have to sign. My question is do you have a specific recollection of being assigned to provide ADL care to Mrs. Berens?

A: Right, right, yes.

…

Q: I thought I asked this earlier. But were you assigned to provide care to Bonnie Berens that night?

A: Yes. Yes, I do.

…

Q: Were you assigned certain rooms?

A: Yes.

Q: What rooms were you assigned in December ’07?

A: 301 to 310.

…

Q: Is 305 on that hall?

A: Right. Yes. Yeah, yeah.

…

Q: Do you remember whether or not you tried to get her to bed or any of that, that evening?

A: No. I did not try to get her to bed. When I walked in, we check all the rooms. She was sleeping.

Q: Do you know if anyone tried to get her back to bed that evening?

A: That I remember, no.

….

Q: Did you see the fall?

A: No.

Q: Where were you?

A: I was in a room.

…

Q: So would you – were you able to see Mrs. Berens from where you were?

A: No.

Q: Did you hear anything?

A: Yes.

Q: What did you hear?

A: I heard, Bonnie is on the floor. Bonnie is on the floor.

Q: Who did you hear say that?

A: Sharon, year.

Q: Did you hear anything else?

A: No.

Q: And what did you do after you heard that?

A: I run out of the room, and I run toward Bonnie. Ms. Sharon was there.

Q: Who else was there?

A: Sharon was there, and this lady, but she was training, Olga,. The two of them was there.

….

Q: What happened next?

A: The nurse, I remember – what is her name? Melissa.

Q: What happened?

A: I can't remember – I asked, you guys call 911? Sharon said yes. The nurse is calling. And then I looked. I saw her. She was calling 911.

…

Q. I understand that. But did Sharon tell you that evening that she was looking at Bonnie when she fell?

A: No, no.

Q: Did anyone tell you that evening that they were looking at Bonnie at the moment Bonnie fell?

A: No, no. I didn't hear anyone say – looking at Bonnie.

…

Q: I understand you didn't see Bonnie fall.

A: No, I did not.

Q: You saw her on the floor?

A: Yeah.

Q: But you didn't see Melissa anywhere in that area at that time, correct?

A: Not that I can remember, no.

…

So, nothing in Radica's testimony suggested that anyone *"saw"* Mrs. Berens fall that evening and the testimony establishes that despite being responsible for Mrs. Berens that

evening, she was not even in eyesight of Bonnie Berens at the time of the fall. Yet, Bonnie fell at the television, far from her room.

Strangely, despite the fact that Radica was assigned to Mrs. Berens at the very time of the fall, she was never interviewed by the Department of Children and Families, nor was she interviewed by SRC management:

Q: Were you interviewed by the Department of Children and Families?

A: No.

Q: Do you know why you weren't interviewed by the Department of Children and Families?

A: No, I don't..

Q: Did you – I mean did you tell your employers that you were there that evening?

A: Nobody asked me anything. Nobody.

…

Finally, Radica was not informed by any nurses of the medications that Bonnie was taking, the side effects of the medications, or provided any instructions about how to deal with her pacing behavior other than to "keep an eye on her."

Q: Did anyone from management at Superior ask you what you had seen and heard that evening after the fall?

A: I can't remember, no. I don't think nobody asked me anything, no.

…

Q: Did anyone tell you that the Department of Children and Families had come and interviewed everyone who was supposedly there that evening?

A: No.

…

Q: Do you know what kind of medication she was on each evening before you came on duty?

A: Not really, no.

Q: Did any of the nurses discuss with you when you came on duty what kind of medications she was on?

A: No.

…

Q: Did any of the nurses ever give you any special instructions for how to watch Mrs. Berens whenever she would get up and pace in the evenings?

A: Yes. They said we have to watch her, you know, because she up – when she's up, she's up. Most of the night, she got up and she walked. In your own knowledge, you're on the job, and you have to watch her.

Q: What instructions did they give you about her and watching her in the evenings when she would walk in the middle of the night?

A: Just keep an eye on her.

Q: did they give you any other information or instructions?

A: No. Not that I can remember, no.

Oddly, Radica's initials do not appear on the ADL flowsheets for the month of December 2007, despite that she was assigned specifically to Bonnie's care.

Nurse Hobson told the DCF investigator that Mrs. Berens was not sleep-walking, that she sat Mrs. Berens in a recliner with a blanket and doll to get her to go to sleep at 10:30 p.m., that she put her to bed at midnight, and that Sharon was in Room 307 when she **heard a "thud"**. Later Nurse Hobson told the DCF investigator that both Sharon and Rose **saw** Mrs. Berens fall. Nurse Hobsons's various statements to the DCF investigator are not only internally inconsistent; they are also inconsistent with the SRC chart and the SRC "occurrence report". Nurse Hobson wrote in her nursing note that Mrs. Berens fell asleep on her feet. If her version to the DCF investigator is the truth, why would she write in her own hand the opposite in her nurse's note, right after the incident happened?

The DCF report further reflected an interview with Mr. Berens who again retold his original and unwavering version of the evening's events. **He was called by Nurse Hobson and told that his wife fell and was walking in her sleep and standing in front of the t.v. with her eyes closed.**

The DCF investigative report states that the investigator was told that Mrs. Berens was supposed to be on Seroquel and Ativan but "all PRN meds were stopped because her husband did not want her to have it." This is both inaccurate and untrue. The medications administered to Mrs. Berens on the night in questions were not "PRN" medications. The records and physicians' orders are clear that Mrs. Berens was on both Ativan and Rozerem on the day and evening in question, per doctor's orders, and while Mr. Berens was involved months earlier in medication management during her residency, his involvement was immaterial to the night in question.

Perhaps most importantly, the DCF investigator did not interview other staff members and caregivers for a complete and full picture of Mrs. Berens behavioral history at SRC including behavior that, particularly in light of her medication regiment, placed her at definite risk of falling.[7] The sworn testimony of caregivers in depositions in this civil action indicate observations that foretold that this incident would indeed occur if SRC didn't develop a consistent care plan, uniformly instruct the nurses an residents on the care plan, and follow it.

The nurses and resident care assistants on duty on 12/27/07 did not take the time to redirect Mrs. Berens and sit with her for an hour, if necessary, to get her to sleep in the middle of the night, as several nurses did successfully in the past and recorded in SRC's own nurse's notes. **In her nursing note, Melissa Hobson records nothing but a brief summary consistent with her story to Mr. Berens in the 1:30 a.m. telephone call and records nothing about any attempts being made to redirect Bonnie on the evening in question or to have any resident care assistant or other staff sit or stand with her to prevent falls or injuries**.

[7] The DCF investigator did not even interview "Radica" who was the resident care assistant assigned to Bonnie Berens on the very evening of her fall.

Given Mrs. Berens' history and medication, SRC's staff should have stood next to Mrs. Berens, especially since she was the only resident awake in the common area, if necessary, until she was safe or at least attempted to get her back in bed. At a minimum, Mr. Berens should have been fully advised of this past behavior as it occurred and the risks posed by the night walking behavior and the medication regimen absent continuous and direct supervision in the late hours of the evening. None of this was discussed in detail with him; therefore, he was deprived of the opportunity to consider any alternatives to relying upon SRC staff for direct supervision in the memory care unit in the late evening hours to prevent a fall and a hip fracture that would statistically put Mrs. Berens at a well-known and significantly increased risk of dying within a year.

Staffing:

SRC destroyed the payroll records that would be necessary to actually prove whether SRC had complied with its own staffing policies and procedures on the night in question. Those payroll records are no longer available for review. The resident care assistants allegedly on duty at the time of the fall did not even sign the ADL flowsheets for the month of the fall.

Conclusion:

Bonnie Berens was admitted to Superior Residence of Clermont 6/13/06 for assistance with activities of daily living, supervision and accurate medication administration. The administrator and staff at Superior Residence of Clermont had a duty to perform ongoing assessments to justify ongoing retention of Bonnie Berens. Florida law as well as SRC's Resident Bill of Rights Policy gives every resident the right to live in a safe and decent living environment, free from abuse and neglect, and access to adequate and appropriate health care. SRC was being paid thousands of dollars per month to adequately supervise Mrs. Berens because

Mr. Berens could not do so at home. Immediately upon admission, SRC's records indicate she **required supervision with all activities of daily living**. She was private pay.

Mrs. Berens sustained at several near falls in September 2006 as well as difficulty with ambulation in November 2006 prior to her fall of 12/27/07 that resulted in a right hip fracture. She was also inadequately supervised in January 2007 when she ingested an unknown substance and required transfer for evaluation at South Lake Hospital. On many occasions she was seen getting tired on her feet, stumbling, and engaging in other behavior leaving her at risk for falling. None of this was reported to Mr. Berens or the care planning team or addressed in any care plans prior to the 12/27/07 fall. In addition, Bonnie Berens was known to be taking Ativan and Rozerem (sleeping pill) per doctor's orders and those medications have side effects consistent with the staff's observations, such as drowsiness, fatigue, unsteadiness, etc. Yet, there is no indication that any of these behaviors and the risk posed in conjuction with these medications were discussed with Mr. Berens or her physicians in any significant way, nor was this behavior addressed in any care plans or any uniform interventions emphasized to the staff as critical to keeping her safe.

Finally, she was inadequately supervised on the evening of her fall on 12/27/07 when she was allowed to fall asleep on her feet after being administered two separate medications that had drowsiness and fatigue as side effects and with caregivers in near proximity reportedly in a "standup meeting". **Despite later recantations, the records from the evening in question are clear that the staff watched her fall asleep on her feet and engaged in no nursing interventions to prevent the fall or minimize the risk on the evening in question after administering Ativan and Rozerem. Quite simply, their own records from the evening tell the truth, that they watched her fall asleep on her feet or collapse from exhaustion**.

While there were sporadic notes of combativeness and aggressiveness toward the staff and a few times toward other residents, during the last year or more, SRC's records indicated she was easily redirected and there were few, if any, mentions of aggressive behavior. SRC's

admission policy required every resident to be reassessed every six months or when a significant change in condition occurred to assure the resident was appropriate for continued residency. According to SRC's "Discharge Policy" a resident should be discharged when determined to be a potential danger to herself or others and efforts to control the behavior or environment have failed. SRC elected to keep her in its memory care unit despite the issues that arose, and now instead of accepting responsibility for a fall that was easily preventable if the staff on duty had intervened by redirection or sitting with her until she fell asleep, SRC apparently takes the position that she was so difficult of a patient that the fall was Mrs. Berens' own fault and unpreventable. If she was too much to handle with the available staff, they should have discussed discharge and transfer. They did not.

SRC's Managed Risk Agreement also provided a procedure to discuss with residents and their families the risks of certain behaviors and care plans so that residents and their families could identify risks that were acceptable and unacceptable and identify choices and the risks and consequences of choices in care, identify the benefits of choices and identify alternatives. Mrs. Berens' progressive fall risk behavior and known side effects of her prescriptions were never discussed with Mr. Berens, and he was never advised that she was getting tired on her feet from midnight pacing while on these medications and becoming more and more of a fall risk. He was never given an opportunity to act on his wife's behalf by making any intelligent choices about her late night care that might minimize the risk of a midnight fall and serious injury or death. Mr. Berens indisputably was extremely involved in her care and attentive to her every need, even to the point that SRC was critical of him for being too involved. If they had told him about this behavior and her medication side effects and the significant risk of her falling asleep on her feet, he would have assuredly spent whatever amount was necessary to keep her safe. Even the former resident care director/director of nursing testified that he had hired sitters in the past to be with her during the day when he was away and that he would have likely hired a sitter for evenings, if necessary, to keep her safe, had he known of the risky nighttime wandering.

Superior Residence of Clermont:

- **Failed to provide care and services appropriate to the needs of Mrs. Berens, including close supervision;**
- **Failed to offer personal supervision as appropriate for Mrs. Berens;**
- **Failed to properly and adequately inform Mr. Berens of late night behavior and conduct that increased the risk of falling and serious injury or death, so that he could make intelligent decisions on her care needs during the early morning hours to best protect her from fall injuries;**
- **Failed to provide accurate medication administration;**
- **Failed to develop appropriate resident service plans to address Mrs. Berens needs;**
- **Allowed Mrs. Berens to fall asleep on her feet despite the opportunity to redirect her, sit with her, or stand with her as a fall preventative on 12/27/07.**
- **Retained Mrs. Berens as a private pay resident when they were unable to meet her care needs OR failed to transfer Mrs. Berens for appropriate 24 hour supervised care when they were unable to meet her care needs.**

Damages:

As a result of the fall at SRC, Mrs. Berens was promptly diagnosed with a fractured hip. X-rays in the emergency department revealed a complete displaced intrascapular fracture of the right hip. The day after the fall, she underwent an uncemented hemiarthroplasty of the right hip under general anesthesia. She was discharged on 1/3/08 and resided at Health Central Park, a long term care facility until her family moved her to Wisconsin where she and Mr. Berens would reside near their children for support.

Mrs. Berens' medical expenses from the incident in question have been paid by a combination of Medicare and Blue Cross Blue Shield. Medicare's last asserted subrogation

amount was $ 52, 079.27, as of June 3, 2009 and no updates have been received since that date. Blue Cross Blue Shield last asserted a subrogation right of $ 4,279.33 as of April 22, 2009. Bills collected include the following:

Lake-Sumter EMS	$ 350.00
South Lake Hospital	$ 50,294.00

Mr. Berens also has had to privately pay nursing home care to the extent Medicare has not paid for post-acute care following the incident, as Mrs. Berens is now committed to long term care in the nursing home setting. At the time of this writing, the billing statements of all long term care are not in Plaintiff's possession, but the typical long term care monthly expense for such patients is $ 2,500 -3,000.

Since Mrs. Berens dementia had robbed her of her wits, she only had her mobility left when she entered SRC. SRC took that away from her on 12/27/07. She is now confined to a "merry walker" or wheelchair for ambulation. The pain and suffering and mental anguish sustained by Mrs. Berens and her husband are immeasurable, and Mr. Berens had hoped that Mrs. Berens would reside in an assisted living environment for years to come. The accident changed everything and caused Mr. Berens to lose tens of thousands of dollars before he had the opportunity to consult with Medicaid planning attorneys to manage the long term care of his wife and the stifling expenses of that care. Despite his extensive heart problems, he insists on personally telling his story to the arbitration panel.

Costs of Litigation:

On behalf of Mr. and Mrs. Berens, Colling Gilbert Wright & Carter has incurred expenses of litigating this case and preparing for arbitration. The total amount of those expenses to date is $ 9,929.60 and continuing. An itemization of these expenses will be made available at the arbitration proceedings.

Under Florida law, the Plaintiff is entitled to court costs in all actions to redress statutory rights. Under the common law, parties are free to contract out, by an arbitration provision or

otherwise, any common law remedy which might otherwise be available. However, any provisions in an arbitration agreement that attempts to interfere with a Plaintiff's right to receive attorney's fees and costs as provided for in a statute is unenforceable. See, American International Group vs. Siemens Building Technologies, Inc., 881 So. 2d 7 (Fla. 3rd DCA 2004). Any provision in an arbitration agreement which attempts to reduce statutory coverage by impairing a parties' ability to recover costs is an invalid attempt to reduce or impair a statutory cause of action. See, American Indemnity Company vs. Comeau, 419 So. 2d 670 (Fla. 5th DCA 1982).

While attorney's fees may only be awarded by agreement or statute, court costs are always recoverable pursuant to Florida Statute §57.041(1) Florida Statutes (2005) which provides:

"The party recovering judgment **shall** recover all his or her legal costs and charges which **shall** be included in the judgment…."

Thus, under Florida law, recovery of court costs is mandatory. See, Hendrix Tractor Company vs. Fernandez, 432 So. 2d 1315 (Fla. 1983); Bessey vs. Difilieppo, 951 So. 2d 992 (Fla. 1st DCA 2007). Under Florida law, parties may agree to arbitrate statutory claims so long as the agreement furnishes an adequate mechanism for vindicating the claimant's statutory rights. However, when an arbitration agreement contains provisions which defeat the remedial purpose of the statutes, that part of the agreement is not enforceable. An arbitration agreement which requires an employee to bear half the fees and costs associated with an arbitration of her discrimination action was unenforceable on the grounds that the agreement contravenes the employee's statutory right to seek a full award of fees and costs and defeated the remedial purpose of those statutes. See, Flyer Printing Company, Inc. vs. Hale, 805 So. 2d 829 (Fla. 2nd DCA 2001).

In Bland, Ex Rel Coker vs. Health Care and Retirement Corp. of America, 927 So. 2d 252 (Fla. 2nd DCA 2006), the Court found that there is nothing in Florida law which would restrict an arbitrator's ability to evaluate public policy considerations and determine whether to

enforce or refuse to enforce remedial limitations contained within arbitration agreements. See also, Romana vs. Manor Care, 861 So. 2d 59 (Fla. 4th DCA 2003) (Arbitration provision which limited non economic damages to $250,000 and excluded punitive damages was unenforceable as a matter of law because it defeated the remedial provisions of the statute protecting nursing home residents). Costs are mandatory under Florida Statute §57.041.

Chapter 429 is a remedial statute designed to protect the elderly and to preserve their ability to bring meaningful causes of action for violation of their statutory rights. Any provision in an arbitration agreement that limits damages or their ability to collect costs would violate public policy as it would significantly impair a resident's ability to bring a claim in arbitration.

Based upon the statutory requirements and case law, it is clear that the Plaintiff would be entitled to collect court costs in an arbitration proceeding regardless of the provisions of the agreement itself. An arbitration agreement can not restrict or limit statutory rights or claims.