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Litigation Strategies In Cases Against Assisted Care Facilities

A common trial theme for tort cases is “the Rules of the Road”. This trial theme emphasizes the fact that a Defendant had a specific duty to follow the “Rules” and for one reason or another, failed to do so, resulting in the Plaintiff’s injury. The decision to follow the “Rules” and how the “Rules” are to be followed, is wholly within the Defendant’s discretion. A Plaintiff’s attorney should concentrate on the Defendant’s failure to follow the very “Rules” that were intended to protect the health, safety and well-being of the injured claimant.

As a trial theme, “the Rules of the Road”, can be successfully used in many cases, including those involving injuries caused by operators of commercial motor vehicles (a professional truck driver has a duty to comply with the Federal Motor Carrier Safety Regulations in the safe operation of a semi-tractor); construction site injury (Occupational Safety and Health Administration rules are designed to protect worker safety by requiring fall protection at the jobsite); injured railroad workers (the Federal Railroad Administration has the responsibility for regulating operational practices and protecting consumers and railroad employees from injury); and, injuries to residents of assisted living facilities¹ (an impaired resident at an Intermediate Care Facility for the Mentally Retarded [hereinafter, ICF/MR] shall be properly supervised to prevent injury). The “Rules” in these cases are promulgated federally, typically adopted by the state and enforced locally.

An ICF/MR's primary business involves the residential treatment of impaired children and young adults. Such individuals represent the most vulnerable Indiana citizens. Parents and caregivers place their loved ones in residential facilities with the expectation that their children will be well cared for, supervised and will receive the benefits and expertise promised by the facility and its staff. Such trust is unequivocal as the facility operator stands in the shoes of a parent to its residents. For this service, the facility operator is compensated and required, at a minimum, to follow Indiana and Federal law. The federal laws applicable to ICF/MR’s are located at 42 CFR Part 431, 435, 440, 442 and 483. Indiana adopted, in whole, the federal ICF/MR laws and are incorporated into Indiana law pursuant to 431 IAC 1.1-3-1, et seq., as authorized by IC 12-11-1.1-1, et seq.

The purpose of the ICF/MR laws is to protect the health, safety and well being of residents in ICF/MR facilities. All such facilities are required by law to provide “a protected residential setting, ongoing evaluation, planning, 24 hour supervision,

¹An assisted living facility means a long term care facility, such as a group home, ICF/MR or comprehensive care unit (nursing home). The obvious distinctions between a group home and a nursing home include the home’s target audience, operational and regulatory authority, and the rendering of medical care to its residents. Group homes typically distribute medications, but do not render medical care to its residents. However, the principles described herein are applicable to all long term care facilities.

coordination and integration of health or rehabilitative services to help each individual function at his greatest ability”. 42 CFR Part 435.1009.

The ICF/MR laws include specific requirements concerning, in part, the facility operation, staffing, training, and resident protections, as well as client rights. The facility “must be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety and sanitation”. See, above and 42 CFR 483.420 (b).² A particular emphasis with respect to the ICF/MR is to ascertain certain “Conditions of Participation” (meaning rendering of services and care to a resident by the facility) and to determine whether the facility, and in turn, the resident, has been free from abuse³ or neglect⁴. The fundamental conditions of participation are Governing Body (compliance with the laws and “Rules”); Client Protections (i.e., client rights to be free from abuse and neglect); Facility Staffing (i.e., training, direct care staff); Active Treatment Services (i.e., ISP, IPP implementation); Client Behavior and Facility Practices (i.e., management of targeted behaviors); Health Care Services (i.e., medication distribution, dental services); Physical Environment (i.e., minimum standards for client bedrooms and living area); and, Dietetic Services (i.e., food and nutrition services).

² ICF/MR litigation requires the purchase of the “ICF/MR Survey”, a publication of the American Health Care Association. www.ahcapublications.org The “ICF/MR Survey” includes a complete copy of the regulations, forms, procedures, interpretive guidelines, guidance on immediate jeopardy and summary of surveyor training on abuse and neglect.

³ Abuse is “the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain, or mental anguish”.

⁴ Neglect is the “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness”.

The Indiana State Board of Health is the designated agency charged and empowered to not only license long term care facilities, but to conduct investigations and surveys⁵ of the same, including ICF/MR facilities. See, above and 42 CFR Part 431.610, et seq. Upon a complaint or facility self report of serious injury, assault or other reportable offense, the Indiana State Board of Health will assign certified, trained and qualified surveyors for the purpose of conducting an official investigation.⁶ Such investigation⁷ typically includes on site interviews with staff and facility residents; observation of residents and staff; on-site records audits; a review of resident records, as well as the records of other facility residents; a review of corporate protocols, procedures and policies; an inspection of the facility; and, anything else that may be important for the purpose of assessing whether the ICF/MR “Rules” were violated. The investigation⁸ is summarized in a written report. If present, the written report will document substantiated violations or findings of abuse, neglect or other statutory violation. Depending on the severity of the substantiated findings, a facility may be placed on “immediate jeopardy”, meaning that the resident or other facility residents health, safety and welfare are in imminent peril.⁹

When an investigation results in findings of substantiated violations, the facility will have an opportunity to refute, deny or accept the findings. The facility will file a “Plan of Corrective Action” which addresses the substantiated findings. The plan is

⁵ The principal focus of the survey is on the “outcome” of the facility’s implementation of ICF/MR active treatment services. The survey is divided into three stages. Fundamental Survey (analysis of Client Protections; Treatment Services; Client Behavior and Facility Practices; and, Other Care Services); Extended Survey (deficiencies found during Fundamental Survey; and, Full Survey (based on initial survey results or previous, systemic deficiencies).

⁶ <http://www.in.gov/isdh/>
Indiana State Department of Health, Division of Long Term Care, 2 North Meridian Street, 4B, Indianapolis, Indiana 46204. 317-233-7289. The Division of Long Term Care issues a weekly, monthly and yearly report, as well as bulletins, directly to care givers, discussing strategies, commentary and policy on such topics as elopement (wandering); resident falls; pressure sores (decubitus ulcers); supervision; proper use of restraints; employee hiring, training and retention; resident rights and expectations, etc. These materials may serve as an invaluable resource to show what an operations manager knew or should have known relative to the treatment and or prevention of resident injury.

⁷ In 2007, approximately 1,700 consumer complaints were filed and investigated by the Indiana State Board of Health. That year, approximately 5,000 surveys were conducted on long term care facilities in Indiana. Slightly more than 300 deficiencies were identified with immediate jeopardy in approximately 100 instances.

⁸ The investigation may be obtained directly from the Indiana State Board of Health. Counsel must request a complete copy of the investigation file, which includes the final written report, but may also include draft reports; photographs; handwritten notes; summaries of statements given to investigators by caregivers and residents; copies of protocols, standards and policies; investigative timeline including length of investigation (hourly); and, other relevant and potentially admissible evidence.

⁹ Immediate jeopardy is a “crisis situation” and is defined as a “situation in which a provider’s non compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident”.

subject to the approval of the Indiana State Board of Health. The failure to file a corrective plan, a rejected plan, or a plan that is otherwise not implemented, may result in sanctions or permanent closure of the facility.

ICF/MR laws establish a minimum standard of care. A minimum standard of care does not necessarily mean that the same is a reasonable standard of care for an individual resident or for the facility as a whole. Each resident must be considered individually and any action taken pertaining to an individual resident must be the least restrictive, for that particular resident, and as to the other residents and their rights as a whole. For example, a resident requiring an alarm on their bedroom window to prevent elopement, or to warn of impending elopement, is least restrictive as pertains to that resident. An alarm system on another residents' bedroom window, without history or threat of elopement, is restrictive as pertains to other residents' rights.

Indiana courts have a long and continuous history of recognizing negligence actions for statutory violations. City of Indianapolis v. Garman, 848 N.E.2d 1087, 1088 (Ind. 2006) (violation of statutory duty requiring operation of emergency vehicles with due regard for the safety of all persons); Patrick v. Miresso, 848 N.E.2d 1083, 1087 (Ind. 2006) (same); City of Gary v. Smith & Wesson Corp., 801 N.E.2d 1222, 1234-1235 (Ind. 2003) (violation of gun registration laws); Canfield v. Sandock, 563 N.E.2d 1279, 1283 (Ind. 1990) (violations of statutory duties of pedestrians); Clipp v. Weaver, 451 N.E.2d 1092, 1094 (Ind. 1983) (violation of statutory standard of care owed by boat operators); Cory v. Smith, 233 Ind. 452, 455, 120 N.E.2d 410, 411-412 (1954) (violation of statute prohibiting certain types of farm animals from running at large on the highway or on other people's property); Northern Indiana Transit, Inc. v. Burk, 288 Ind. 162, 172, 89 N.E.2d 905, 909 (1950) (violation of statute regulating standing or parking of vehicles); Indiana & Chicago Coal Co. v. Neal, 166 Ind. 458, 460, 77 N.E. 850, 850 (1906) (acknowledging "the general rule": "In every case where a statute enacts or prohibits a thing for the benefit of a person, he shall have a remedy upon the same statute for the thing enacted for his advantage, or for the recompense of the wrong done him contrary to said law.")¹⁰ The violation of a duty fixed or prescribed by statute is often described as negligence *per se*. New York Cent. R.R. Co. v. Glad, 242 Ind. 450, 457, 1979 N.E.2d 571, 574 (1962); Larkins v. Kohlmeyer, 229 Ind. 391, 398, 98 N.E.2d 896, 899 (1951); Prest-O-Lite Co. V. Skeel, 182 Ind. 593, 600, 106 N.E. 365, 368 (1914). As recently explained by the Court of Appeals, the unexcused violation

¹⁰ For similar opinions from the Court of Appeals, see Am. United Life Ins. Co. v. Douglas, 808 N.E.2d 690, 705 (Ind. Ct. App. 2004) (violation of "state statutory and federal regulatory law in selling the product"), *trans. denied*; Phoenix Natural Res., Inc. v. Messier, 804 N.E.2d 842, 847-848 (Ind. Ct. App. 2004) (violation of Flood Control Act by mining company), *reh'g denied*; Indiana Trucking v. Harber, 752 N.E.2d 168, 172-173 (Ind. Ct. App. 2001) (violation of Federal Motor Carrier Safety Regulations incorporated into Indiana statutory law), *trans. not sought*; Lever Bros. Co. v. Langdoc, 655 N.E.2d 577, 580-581 (Ind. Ct. App. 1995) (violation of city sewer use ordinance), *trans. not sought*; Rubin v. Johnson, 550 N.E.2d 324, 329 (Ind. Ct. App. 1990) (violation of gun restriction laws), *trans. denied*; Ray v. Goldsmith, 400 N.E.2d 176 (Ind. Ct. App. 1980) (violation of municipal ordinance governing abandoned refrigerators), *trans. denied*; Cook v. Ormsby, 45 Ind. App. 352, 354-355, 89 N.E. 525, 526 (1909) (violation of statute requiring that manufacturing establishments guard all saws while in use), *trans. denied*.

of a statutory duty constitutes negligence *per se* “if the statute or ordinance is intended to protect the class of persons in which the plaintiff is included and to protect against the risk of the type of harm which has occurred as a result of its violation”. Plesha v. Edmonds ex rel. Edmonds, 717 N.E.2d 981, 986 (Ind. Ct. App. 1999), *trans. denied*, (citing French v. Bristol Myers Co., 574 N.E.2d 940, 943 (Ind. Ct. App. 1991), *trans. denied*); *see also* State v. Snyder, 732 N.E.2d 1240, 1244 (Ind. Ct. App. 2000), *trans. not sought*; Lever Bros. Co. Langdoc, 655 N.E.2d 577, 580 (Ind. Ct. App. 1995), *trans. not sought*; Rubin v. Johnson, 550 N.E.2d 324, 329 (Ind. Ct. App. 1990), *trans. denied*; Smith v. Cook, 172 Ind. App. 610, 613, 361 N.E.2d 197, 199 (1977), *trans. not sought*. The fact that a statutory violation may result in separate harm or penalty “will not prevent an action for damages resulting therefrom”. French. 574 N.E.2d at 943.

Other jurisdictions agree with Indiana’s common law that statutory rules of law which protect the most vulnerable of our citizens establish standards of care and that violations of such statutes constitute negligence *per se*. See, Franz v. Manor Care, Inc., 64 Pa.D. & C.4th 457, 467-469 (Pa.Com.P.2003), in which it was held that the OBRA regulations are evidence of standards of conduct, and that the defendant’s failure to comply with the regulations is evidence of negligence. *See also*, McCain v. Mariner Health Care, Inc., 279 Ga.App. 410, 412-413, 631 S.E.2d 435, 437-438 (2006) *cert. den.* (Alleged violations of Medicare and Medicaid regulations and statutes were sufficient to state claims for negligence and negligence *per se*); Brogdon ex rel. Cline v. National Healthcare Corporation, 103 F.Supp.2d 1322, 1333 (N.D.Ga.2000) (Medicare and Medicaid participation requirements are relevant to the degree of care and skill required of nurses in malpractice cases in Georgia).

Indiana Pattern Jury Instruction 17.01 provides guidance in the analysis of non-delegable duties and statutory violations. Specifically, the ICF/MR laws, statutes and standards of care were enacted for the express purpose of protecting facility residents. Every ICF/MR is compelled to follow the laws applicable to the operation and regulation of their facility which are in full force and effect. Violation of the laws, statutes and standards of care are without excuse or justification as the facility is compensated to follow the same in the care of its residents. Thus, violation of the same constitutes negligence *per se*.

Despite the limitations that are imposed on the recovery of punitive damages under Indiana law,¹¹ the pursuit of punitive damages is a useful tool to prevent the Defendant from admitting liability in cases involving egregious care and conduct or outrageous injury.

¹¹ Our general assembly has limited the amount that may be recovered as punitive damages to no more than the greater of three times the amount of compensatory damages or fifty thousand dollars. I.C. 34-51-3-4, I.C. 34-51-3-5. In addition, I.C. 34-51-3-6 provides that when punitive damages are awarded in a civil case, the party against whom the judgment is entered shall pay the punitive damage award to the clerk of the court where the action is pending. Upon receiving the payment, the clerk must then pay the plaintiff twenty-five percent of the award and pay the remaining seventy-five percent to the State Treasurer, who is to deposit the funds into the Violent Crimes Compensation Fund. Plaintiff’s counsel is not entitled to be paid a fee for recovering the seventy-five percent of a punitive damage award that goes to the State. Cheatham v. Pohle, 789 N.E. 2d 467 (Ind. 2003).

The purpose of punitive damages is to punish the wrongdoer and deter him and others from similar conduct in the future.¹² The standard for determining whether punitive damages may properly be awarded is whether the plaintiff has proved, by clear and convincing evidence, that the defendant acted with malice, fraud or oppressiveness which was not the result of a mistake of fact or law, mere negligence, or other human failing, or that the defendant engaged in willful and wanted misconduct¹³.

¹² Wohlwend v. Edwards, 796 N.E. 2d 781 (Ind. App. 2003), Stroud v. Lints, 760 N.E. 2d 1176 (Ind. Ct. App. 2003), Bright v. Kuehl, 650 N.E. 2d 311 (Ind. Ct. App. 1995).

¹³ Wohlwend v. Edwards, 796 N.E. 2d 781 (Ind. App. 2003).

It must be emphasized that an award of compensatory damages is a prerequisite to the consideration of punitive damages.¹⁴ Whether a party may recover punitive damages is usually a question of fact for the fact finder to decide. Cheatham v. Pohl, 789 N.E. 2d 467 (Ind. 2003), Reed v. Central Soya Company, Inc., 621 N.E. 2d 1069 (Ind. 1993). Such a determination must be made by the jury at the conclusion of the evidence at trial.

Punitive damages may be substantiated, in part, by evidence of the following:

I. Facility operators' conscious and deliberate violation of Federal and Indiana laws promulgated to protect the health, safety and well-being of residents.

II. Prior instances of institutional failure and client neglect demonstrate a pattern of egregious conduct and conscious indifference.

III. Violation of group home placement agreement constitutes fraud and/or gross negligence.

IV. Willful and wanton failure to comply with adequate staffing ratio.

V. Conscious disregard of Defendant's corporate policies, despite the knowledge that a client may be subject to imminent danger of serious bodily injury or death. Such violations may include:

- A. Violation of abuse and neglect policy;
- B. Violation of medication room policy;
- C. Violation of resident's rights policy;
- D. Violation of corporate policy requiring staff knowledge of client condition; and,
- E. Violation of missing resident policy.

Prior to representation, Counsel must consider and do the following:

I. The preexisting mental and physical condition of the claimant;

II. The familial relationship and support structure involved, including whether the client is married, has children, friends, a spiritual advisor, former co-employees;

III. The involvement by support structure members, including frequency and duration of visits, claimant medical care, lodging of complaints or concerns with facility representatives, etc.;

IV. Obtain all medical records and bills;

V. Consult with expert witnesses to review appropriate documentation, including, a nurse, institutional expert, life care consultant and the like;

¹⁴ Crabtree v. Estate Of Crabtree, 837 N.E. 2d 135 (Ind. 2005), Cheatham v. Pohle, 789 N.E. 2d 467 (Ind. 2003).

- VI. A review of the facility survey and/or incident investigation;
- VII. Determine whether any substantiated violations or other findings were issued and if the violations caused or contributed to claimant's injuries.

Upon undertaking representation of a client in a case against an ICF/MR, Counsel should proceed as follows:

- I. Obtain a complete copy of the facility records, plans of action (i.e. Individual Support Plan, Individual Behavior Plan, etc.), corporate protocols, procedures and policies;
- II. Obtain a copy of the facility training manuals and institutional guidelines;
- III. Obtain a complete copy of all survey's and investigation files;
- IV. Meet with Indiana State Board of Health Surveyors (and representatives of any other investigative agency, including Child Protective Services, Prosecutor's office and law enforcement) to review survey and/or investigation results, and to determine whether there is a pattern of conduct or other similar incidents;
- V. Notice an on-site inspection, which should be documented by photographs and videotape;
- VI. Initiate comprehensive discovery, including caregiver depositions, 30B6 (corporate depositions) and propound written discovery, samples of which are set forth below.

Sample Request for Admissions:

1. XXX is a group home facility, owned, operated and staffed by Facility.
2. XXX is a licensed residential facility which provides a family living environment including supervision and care necessary to meet the physical, emotional and social needs of its residents.
3. A restraint is a physical device, method or drug used on a resident to control dangerous behavior.
4. Self injurious behavior means any chronic behavior that results in injury to the person's own body.
5. On XXX, the XXX County Court determined that Resident was a danger to himself and to others.
6. That Resident's medical records and bills attached hereto are true and accurate copies of the same.
7. That Resident's medical records and bills attached hereto are admissible for all purposes.
8. Prior to Resident's elopement, Facility did not visually monitor clients with a potential elopement risk at 15 minute intervals, regardless of the client's activity or location.
9. Prior to Resident's elopement, the staff at the Facility (did not provide pedestrian skills training on a daily basis to its clients).
10. Prior to Resident's elopement, Facility did not require Facility staff to

immediately contact law enforcement agencies in the event of client elopement.

11. Prior to Resident's elopement, Facility did not require Facility staff to monitor alarms at such facility to determine if the same were operational.

12. Prior to Resident's elopement, window alarms at the facility were not operational.

13. Resident requires 24 hour attendant care.

14. Resident is unable to perform activities of daily living.

15. As a result of Resident's elopement, Facility was placed on immediate jeopardy, meaning that Facility failed to comply with Indiana and Federal law and that such non-compliance was likely to cause serious harm, injury, impairment or death to a resident.

16. Resident was off grounds at Facility on more than occasion, without supervision, between XXX and XXX.

17. On XXX, Facility neglected Resident.

18. Facility failed to provide evidence of a thorough investigation relative to Residents's elopement from the residential group home known as the facility which elopement resulted in serious injuries.

19. Indiana and Federal law required that Facility possess an individual program plan stating the specific objectives necessary to meet a client's needs.

20. On XXX, Facility violated Indiana and Federal law by its failure to possess an individual program plan stating the specific objectives necessary to meet Resident's needs.

21. Resident's Individualized Support Plan failed to address Residents's identified safety needs relative to pedestrian safety training/skills.

22. Facility neglected to implement a written policy and procedure relative to Resident's elopement from Facility.

23. On XXX, Facility neglected to ensure a system was in place to monitor and maintain operation of window alarms at Facility.

24. On XXX, Facility neglected to ensure Resident's behavior of exiting the group home was tracked and/or addressed to ensure Resident's safety.

25. On XXX, at the time of Resident's elopement, Faculty employees, XXX, were on duty at Facility.

26. Resident requires redirection regarding pedestrian skills, therefore constant supervision in the community is required.

27. Prior to Resident's admission at Facility, he/she had a history of elopement, including wandering or running away.

28. Prior to XXX, Resident was an elopement risk at Facility.

29. Facility did not provide special training on how to monitor Resident after previous elopements.

30. Prior to Resident's elopement, Facility did not address, with the staff, the importance of client safety and supervision.

31. Facility owned and operated a residential group home known as the Facility.

32. On XXX, the Facility Administrator was XXX.

33. Facility was established in XXX.

34. The average client stay at Facility is XXX days.

35. The average per diem, per client, is \$XXX.

36. Facility is not equipped to accommodate clients confined to a wheelchair.
37. Facility staff provide services to physically challenged clients.
38. Facility's target population is adolescent males with mental retardation and other developmental disabilities.
39. Ratio of Facility Staff to clients, at night, is X:X.
40. Ratio of Facility Staff to clients, during the day, is X:X.
41. Resident eloped from Facility on more than one occasion prior to XXX.
42. Clients eloped from the Facility on more than one occasion between XXX and XXX.
43. Indiana and Federal law required that Facility develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of the client.
44. On XXX, Facility violated Indiana and Federal law by its failure to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of Resident.
45. Indiana and Federal law required that Facility ensure that specific governing body and management requirements are met.
46. On XXX, Facility violated Indiana and Federal law by its failure to ensure that specific governing body and management requirements were met concerning Resident.
47. Indiana and Federal law required that Facility exercise general policy, budget, and operating direction over Facility.
48. On XXX, Facility violated Indiana and Federal law by its failure to exercise general policy, budget, and operating direction over Facility.
49. Indiana and Federal law required that Facility ensure that specific client protection requirements are met.
50. On XXX, Facility violated Indiana and Federal law by its failure to ensure that specific client protection requirements, on behalf of Resident, were met.
51. Indiana and Federal law required that Facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of Resident.
52. On XXX, Facility violated Indiana and Federal law by its failure to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of Resident.
53. Indiana and Federal law required that Facility have evidence that all alleged violations are thoroughly investigated.
54. On XXX, Facility violated Indiana and Federal law by its failure to provide evidence that all substantiated violations, including Residents's elopement, were thoroughly investigated by Facility.

Sample 30(B)(6) Notice of Deposition

NOTICE OF DEPOSITION PURSUANT TO TRIAL RULE 30(B)(6)

TO ALL PARTIES OF INTEREST:

PLEASE BE ADVISED that the Plaintiffs, by counsel, will take the deposition of

the **Defendant, Facility's employees or other designated representatives**, pursuant to Rule 30(B)(6) of the Indiana Rules of Trial Procedure, at the offices of **XXX**, beginning at **XXX a.m./p.m.** on **XXX**. The depositions will be taken before a Notary Public or other officer authorized to administer oaths, and will continue from day to day until completed. You are invited to attend and cross examine. The matters which will be covered in the depositions are as follows:

1. The incident involving Resident on XXX, including all investigations and other information concerning the same. Such area of inquiry will include, but not be limited to, a review of certain statutory violations (W102, W104, W122, W149, W154, W227) as substantiated in the Department of Health and Human Services, Centers for Medicare and Medicaid Survey completed on or about XXX and Facility's response to the same.

2. Facility's policies and procedures, before and after XXX, concerning, but not limited to, Abuse and Neglect of Children and Missing Residents.

3. The services received by Resident at the XXX.

4. The security, supervision, and monitoring of residents, including Resident at the XXX as well as residents at any Facility.

5. All incidents where residents left the XXX or any other Facility without permission.

6. All claims pending, resolved or dismissed against Facility alleging lack of supervision, elopement or other statutory or regulatory violations.

7. All regulatory or statutory authority, licences, certifications or other qualifications that enable Facility to provide group home services to persons such as Resident.

8. The exact amounts billed and paid for each service, medication and for any other item rendered to Resident, including who was billed, who paid and in what amount.

9. The salaries paid to Facility's employees, including but not limited to, its Administrator, President, and/or CEO, for the years of XXX and XXX, and the factors which went into bonus payment, including but not limited to, the level of staffing at Facility's facilities.

10. The Medicare and Medicaid provider agreements that were in effect at Facility in XXX and XXX.

11. The budget setting process, including annual budget, annual expense reports for the years XXX and XXX, including the factors and persons involved in reaching a budget amount for staffing during that time frame.

12. The survey or investigation results for any survey or investigation conducted by any federal, state or local governmental agency during XXX and XXX of Facility, including citations, violations, suspensions, fines or penalties as a result thereof.

13. Facility's policy concerning investigation of neglect situations and/or allegations of neglect, as well as missing persons. Such inquiry shall include but not be limited to policies related to security and elopement of residents, including Resident, as well as the length of time between resident observation and notification of law enforcement personnel.

14. The selection of the window alarm placed in Resident's room prior to the incident, its operation, etc. as well as other alarms present at the XXX, if any, prior to and after XXX.

15. Resident's Individual Support Plan and other educational and skills assessments.

16. Facility's policy, training, education and documentation related to the pedestrian safety skills assessment and training of residents, including Resident. Such area of inquiry shall include before and after the incident involving Resident on XXX.

17. All profit and loss statements, as well as tax returns or other documentation evidencing the net worth of Facility from XXX to the present.

18. The governing body of Facility and its creation and implementation of policies and procedures throughout its facilities, including but not limited to, general policy, budget and operating directions.

19. Facility's training and education of its employees.

20. Client Visualization Checklist, including creation, policy and procedure.

21. Alarm Checklist, including creation, policy and procedure.

The defendant, Facility, is hereby requested to designate to testify at the Deposition, in accordance with Trial Rule 30(B)6), one or more officers, directors, managing agents, executive officers or other persons duly authorized and consenting to testify on its behalf and is to set forth for each person designated the matters on which he or she will testify.

Pursuant to Trial Rules 30(B)6) and 34 of the Indiana Rules of Trial Procedure, notice is further given that the Defendant, Facility, is requested to produce on the day prior to the taking of the deposition on XXX and XXX a.m/p.m. at a location to be mutually agreed upon between counsel, the following documents and tangible things which are in its possession and to permit counsel for the Plaintiff to inspect and copy

any of these documents. The items to be produced are as follows:

1. All documentation reviewed, relied upon or responsive to Resident's requested areas (1 through 21, incorporated as if fully set forth herein) of 30(B)(6) Deposition Notice.
2. All documentation related to Provider Number 15G456 and/or Facility Identification Number 970.
3. All Facility's documentation concerning policies that relate to residents, including, but not limited to security, elopement, pedestrian skills, missing persons, resident care, abuse and neglect.
4. All documentation prepared, reviewed, authorized or disseminated, concerning Resident, including employee notes, records, e-emails, investigation reports, etc.
5. All documentation generated in response to various investigations concerning Resident's incident on XXX.