IN THE SUPREME COURT OF THE STATE OF NEVADA

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually;,

Plaintiffs,

vs.

VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z;,

Defendants.

Supreme Court No.:

District Court No.: A-19-788787-C

RESPONDENTS' APPENDIX VOLUME III

S. BRENT VOGEL
Nevada Bar No. 6858
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INDEX TO APPENDIX VOLUME III

Number	Document	Date	Pages
E	Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center's Motion for Attorneys' Fees Pursuant to N.R.C.P. 68, N.R.S. §§ 17.117, 7.085, 18.010(2), and EDCR 7.60	2/2/2022	**297-422**

this 24th day of February, 2023

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Adam Garth

S. Brent Vogel
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Tel. 702.893.3383

Attorneys for Respondent Valley Health System, LLC dba Centennial Hills Hospital Medical Center

CERTIFICATE OF SERVICE

I hereby certify that on this 24th day of February, 2023, a true and correct copy of **RESPONDENTS' APPENDIX VOLUME III** was served by electronically filing with the Clerk of the Court using the Odyssey E-File & Serve system and serving all parties with an email-address on record, who have agreed to receive electronic service in this action.

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By */s/ Heidi Brown*
An Employee of
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behavior throughout the duration of her stay at CHH, or any complaints Plaintiffs' decedent may have had concerning any employee of CHH.

RESPONSE TO INTERROGATORY NO. 20:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, Plaintiff responds as follows:

Please see Answer to Interrogatory No. 19.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 21

State with specificity the act(s) or omission(s) of CHH that you allege fell below the standard of care or breached a legal duty owed to Plaintiffs' decedent, and the factual and medical basis that supports each allegation.

RESPONSE TO INTERROGATORY NO. 21:

Plaintiff objects to this Interrogatory as it calls for an expert medical opinion which he is not qualified to provide. Plaintiff further objects to this Interrogatory as it seeks to invade Plaintiff's attorney/client privilege and/or the attorney work product doctrine.

Without waiving said objections, Plaintiff answers as follows:

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing. See medical affidavit attached to the Complaint.

. . .

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INTERROGATORY NO. 22

State with specificity each act or omission of every defendant other than CHH named in this action that you allege fell below the standard of care or breached a legal duty owed to you, and the factual and medical basis that supports each allegation as to each such defendant. In responding to this Interrogatory, please be sure to differentiate the specific negligence attributable to each defendant separately and in detail.

RESPONSE TO INTERROGATORY NO. 22:

Objection. Plaintiff objects to this Interrogatory as it calls for an expert medical opinion which he is not qualified to provide. Plaintiff further objects to this Interrogatory as it seeks to invade Plaintiff's attorney/client privilege and/or the attorney work product doctrine.

Without waiving said objections, Plaintiff answers as follows: See medical affidavit attached to the Complaint.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 23

Identify all notes, records, documents, reports, correspondence and memoranda containing facts supporting the allegations of the Complaint referring to the negligence or wrongful conduct of CHH, or any other defendant.

RESPONSE TO INTERROGATORY NO. 23:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

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Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 24

Identify all notes, records, documents, reports, correspondence and memoranda containing facts supporting the allegations of the Complaint referring to the negligence or wrongful conduct of CHH, or any other defendant.

RESPONSE TO INTERROGATORY NO. 24:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 25

Identify all correspondence, notes, records, or memoranda from or by any Defendant with regard to this lawsuit and/or any person believed to be an employee of CHH.

. . .

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RESPONSE TO INTERROGATORY NO. 25:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 26

Identify all records, reports, and memoranda including but not limited to in-patient and out-patient records, nurses' notes, doctors' notes, doctors' reports, x-ray reports, operation records, progress notes, laboratory tests, notes and reports, correspondence files, insurance files, accident files, medical histories, bills or statements for services rendered by any health care provider and related to the care or treatment involved in this lawsuit or any other person named as a DOE or ROE in this action with reference to the treatment received by the patient whose care is involved in this lawsuit.

RESPONSE TO INTERROGATORY NO. 26:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

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Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 27

Identify all x-rays, CT scans, medical testing, and pathology slides and specimens related to any acts alleged in this lawsuit.

RESPONSE TO INTERROGATORY NO. 27:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 28

Identify all diaries, calendars, notes, telephone logs or other writings that reflect any of the care and treatment or alleged conversations or contacts that occurred between Plaintiffs' decedent or anyone acting on Plaintiffs' decedent's behalf, with any of the defendants named in the Complaint regarding the subject of the lawsuit.

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RESPONSE TO INTERROGATORY NO. 28:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 29

Identify all diaries, calendars, notes or telephone logs that are relevant to any of the damages prayed for in the Complaint.

RESPONSE TO INTERROGATORY NO. 29:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

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INTERROGATORY NO. 30

Identify all written or recorded statements or notes of any individual or entity concerning medical care, treatment or acts which are the subject matter of this lawsuit.

RESPONSE TO INTERROGATORY NO. 30:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 31

Identify any and all documents or writings with respect to liens claimed or made by any government agency or entity including, but not limited to, those arising out of the provision of health care services or benefits to Plaintiffs' decedent under Medicare, Medicaid or Workers Compensation, relating to the subject matter of this lawsuit.

RESPONSE TO INTERROGATORY NO. 31:

Objection. Defendant seeks information that is not discoverable due to the collateral source rule. This request is irrelevant, unduly prejudicial, and is not reasonably calculated to lead to the admission of evidence pursuant to the *per se bar* on collateral source evidence. See Khoury v. Seastrand, 377 P.3d 81 (2016) (evidence of payments showing provider discounts or "write

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downs" is irrelevant); Tri-County Equipment & Leasing v. Klinke, P.3d 593 (2012); Proctor v. Castelletti, 112 Nev. 88, 90, 911 P.2d 853, 854 (1996); Winchell v. Schiff, 124 Nev. 938, 945-46, 193 P.3d 946, 951 (2008); and Bass-Davis v. Davis, 122 Nev. 442, 453-54, 134 P3d 103, 110 (2006). The Nevada Supreme Court has created "a *per se* rule barring the admission of a collateral source of payment for an injury into evidence for *any purpose*." Khoury, 377 P.3d at 94, citing Proctor. Further, defendants seek discovery outside the scope of NRCP 26(b)(1) as it is not relevant to any party's claims or defenses and is disproportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.

Without waiving said objections, I am not aware of any liens.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 32:

Identify any and all documents or writings identified in your responses to Special Interrogatories, Set One, propounded by CHH.

RESPONSE TO INTERROGATORY NO. 32:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

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Without waiving these objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 33:

Identify all documents or writings reflecting any and all income losses incurred or to be incurred by each Plaintiff as a result of the alleged negligence of CHH, or any of them, as set forth in your Complaint.

RESPONSE TO INTERROGATORY NO. 33:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists.

Without waiving said objections, for information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 34

Identify each and every document, paper, statement, memorandum, photograph, picture, plat, record, letter, recording or other exhibit which you reasonably expect to offer into evidence at the time of trial.

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RESPONSE TO INTERROGATORY NO. 34:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists, and it seeks the premature disclosure of trial exhibits information.

Without waiving said objections, Plaintiff will disclose trial exhibits in accordance with the Nevada Rules of Civil Procedure. For information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 35

Identify and describe in detail all medications Plaintiffs' decedent was prescribed within the five (5) years prior her admission to CHH including, but not limited to, who prescribed the medication, when the medication was prescribed, the nature of the medication, and where the prescription was filled.

RESPONSE TO INTERROGATORY NO. 35:

Objection. Plaintiff objects to this Interrogatory because it seeks the disclosure of information pertaining to unrelated medical conditions which are not at issue in this litigation, and it seeks the disclosure of information that is irrelevant and not reasonably calculated to lead to the discovery of admissible evidence.

Without waiving said objections, I don't recall the medications that Rebecca was taking during that timeframe.

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Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 36:

Please state the full date of the Plaintiffs' decedent's death and identify in specific detail any findings of an autopsy report.

RESPONSE TO INTERROGATORY NO. 36:

Objection. Plaintiff objects to this interrogatory because it seeks the disclosure of information that is unduly burdensome in that the information being sought is equally available to both parties by way of the parties initial and supplemental document disclosures and witness lists, and it seeks the premature disclosure of trial exhibits information.

Without waiving said objections, according to the Death Certificate, Rebecca's date of death is noted as May 11, 2017. For further information that may be responsive to this Interrogatory, please refer to the parties' initial and supplemental document disclosures and witness lists.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 37:

Please identify all collateral sources for payment of Plaintiffs' decedent's medical care that is the subject of your Complaint pursuant to NRS 42.021 including, but not limited to, personal health insurance information.

RESPONSE TO INTERROGATORY NO. 37:

Objection. This Request seeks documentation in violation with the collateral source rule. Proctor v. Castelletti 112 Nev. 88, 911 P.2d 853 (1996).

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Without waiving said objections, I do not recall the name of the company that provided health insurance to Rebecca Powell.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

INTERROGATORY NO. 38

State all factors which led you to conclude that any co-defendant physician or medical practice with which he/she is affiliated was an agent, servant or employee of CHH.

RESPONSE TO INTERROGATORY NO. 38:

Plaintiff assumes that physicians working in CHH are employees of CHH and/or Valley Health System, LLC and Universal Health Service, Inc. Defendants have not disclosed any information, either in initial or supplemental disclosures, to disabuse him of this assumption. Plaintiff reserves the right to amend and/or supplement this response as discovery remains ongoing.

INTERROGATORY NO. 39

Did you ever have any notice that any co-defendant physician or medical practice with which that physician is affiliated was an independent contractor from CHH? If yes, please state when you received such notice and the specific information you received pertaining thereto.

RESPONSE TO INTERROGATORY NO. 39:

Not to Plaintiff's knowledge or understanding.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

. . .

. . .

INTERROGATORY NO. 40

State the evidence you have to demonstrate that CHH possessed the right to control the conduct with regard to the work to be done and the manner of performing it by any individual you claim to be an agent of CHH who you assert was in any way negligent in the care and treatment of you during your admission to CHH for the time period pertaining to the incident referred to in your Complaint.

RESPONSE TO INTERROGATORY NO. 40:

Please see responses to interrogatory numbers 38 and 39.

Plaintiff reserves the right to amend and/or supplement this Answer as discovery remains ongoing.

PAUL PADDA LAW, PLLC

/s/ Paul S. Padda
Paul S. Padda, Esq.
James P. Kelly, Esq.
4560 South Decatur Boulevard, Suite 300
Las Vegas, Nevada 89103
Attorneys for Plaintiffs

Dated this 1st day of September, 2020.

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DECLARATION OF BRIAN POWELL PER NRS 53.045

1. My name is **BRIAN POWELL**, and I am over the age of 18 and competent to make this Declaration. All matters stated herein are within my personal knowledge and are true and correct.

2. I have read the foregoing **RESPONSES TO DEFENDANT VALLEY HEALTH SYSTEM, LLC'S FIRST SET OF INTERROGATORIES TO PLAINTIFF ESTATE OF REBECCA POWELL THROUGH BRIAN POWELL AS SPECIAL ADMINISTRATOR** and know the contents thereof; that the same is true of my own knowledge, except for those matters therein stated upon information and belief, and as to those matters, I believe them to be true.

3. I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct.

Executed this 27TH day of AUGUST, 2020.

BRIAN POWELL

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CERTIFICATE OF SERVICE

Pursuant to Rule 5(b) of the Nevada Rules of Civil Procedure, I certify that I am an employee of Paul Padda Law, PLLC and that on this 1st day of September, 2020, I served a true and correct copy of the above and foregoing document on all parties/counsel of record in the above entitled matter through hand service and/or efileNV eservice.

/s/ Jennifer C. Greening
An Employee of Paul Padda Law, PLLC

EXHIBIT 3

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

JULIE KOTCHEVAR
Administrator, DPBH

VACANT
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE
727 Fairview Dr., Suite E, Carson City, NV 89701
Telephone: 775-684-1030, Fax: 775-684-1073
dpbh.nv.gov

February 5, 2018

Brian Powell
Po Box 750131
Las Vegas, NV 89136

Re: Complaint Number NV00049271

Dear Mr. Powell,

With reference to your complaint against Centennial Hills Hospital Medical Center, an unannounced inspection was completed on 09/21/2017 to investigate your concerns about care and services.

During the investigation, the State Inspector interviewed patients/residents, reviewed their records, interviewed staff, and made observations while the facility or agency was in operation. The facility's or agency's actions were evaluated using applicable state and/or federal rules and regulations to determine if they were in compliance.

Based on the completed investigation, it was concluded that the facility or agency had violation(s) with rules and/or regulations. The Bureau will take appropriate measures to ensure the facility/agency is well-informed of the specifics of violation(s), and that they will exercise their due diligence in preventing similar incidents in the future. A copy of the of the report is enclosed.

Thank you for reporting your concerns. Please know that your voice will help improve the services of health facilities and agencies. If we can be of further assistance, please contact the office, at 702-486-6515 in LV, 775-684-1030 in Carson City.

Sincerely,

DPBH Complaint Coordinator

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5086HOS	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL HILLS HOSPITAL MEDICAL CEN	6900 N DURANGO DR LAS VEGAS, NV 89149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted at your facility and completed on 9/21/17 in accordance with Nevada Administrative Code, Chapter 449, Hospital. The census at the time of the survey was 270. The sample size was five. There were two complaints investigated. Complaint #NV00049271 was substantiated. The allegation a patient in respiratory distress was unattended and was not upgraded to a higher level of care was substantiated (See Tag S 300). Complaint #NV00049721 with the following allegations could not be substantiated: Allegation 1: sterile technique was not implemented when suturing a re-opened surgical incision. Allegation 2: a re-opened surgical incision was sutured without using local anesthesia. Allegation 3: pain medication was not administered in a timely manner. Allegation 4: an anesthesia vial was left at bedside in a patient's room. The investigation into the allegations included: Review of five clinical records including the patient of concern. Interviews were conducted with the Chief of Nursing Operations (CNO) and an Emergency	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5086HOS	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL HILLS HOSPITAL MEDICAL CEN	6900 N DURANGO DR LAS VEGAS, NV 89149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Continued From page 1 Department Physician. Observation of a medical surgical hospitalization unit including two patient rooms. Review of the facility policies title Pain Management, Wound Care Therapeutic Support Services Guidelines, Sterile Products: Aseptic Technique, Hand Hygiene and Drug Storage. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiency was identified:	S 000		
S 300 SS=G	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure a patient in respiratory distress was monitored and received the necessary care for 1 of 5 sampled residents (Resident #2). Findings include:	S 300		10/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5086HOS	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL HILLS HOSPITAL MEDICAL CEN	6900 N DURANGO DR LAS VEGAS, NV 89149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 300	Continued From page 2 Patient #2 Patient #2 was admitted on 5/3/17, with diagnoses including intentional medication overdose and acute respiratory failure. A Physician progress note dated 5/9/17 at 2:06 PM, documented the patient did not complain of shortness of breath (SOB). The patient was status post intubation with Methicillin Resistant Staphylococcus Aureus (MRSA) pneumonia. The Pulmonologist consultation report dated 5/9/17 at 5:49 PM, indicated the patient did not have inflammation of the pleura, no blood in sputum, secretions were compatible with aspiration and MRSA. The treatment plan included breathing treatment, oxygen as needed and to decrease steroids. The Nursing progress dated 5/10/17 at 2:00 AM, documented the patient had a non-productive cough and SOB. The patient received oxygen at 2 liters per minute (lpm) and a breathing treatment as needed. The progress note did not document the patient's vital signs. On 5/10/17 at 3:41 AM, the clinical record documented the following vital signs: heart rate 76 beats per minutes (bpm) and respiratory rate 16 breaths per minute (br/m). The vital signs report did not document the blood pressure (B/P) or oxygen saturation (SPO2). The patient was receiving oxygen at 3 lpm via nasal cannula. On 5/10/17 at 8:00 AM, the clinical record documented the following vital signs: temperature 36.6 Fahrenheit, heart rate 96 bpm, respiratory rate 18 br/m, B/P 133/76, SPO2 96% with oxygen at 2 lpm via nasal cannula.	S 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5086HOS	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL HILLS HOSPITAL MEDICAL CEN	6900 N DURANGO DR LAS VEGAS, NV 89149

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S 300	Continued From page 3 On 5/10/17 at 3:04 PM, the clinical record documented the following vital signs: heart rate 98 bpm, respiratory rate 20 br/m, B/P 133/76 and SPO2 95% with oxygen at 3 lpm via nasal cannula. The Nursing progress note dated 5/10/17 at 3:13 PM, documented the patient was resting in bed with SOB and fatigue. The patient was monitored with cameras due to being on a legal hold. The Nursing progress note dated 5/10/17 at 4:11 PM, revealed the patient complained of labored breathing. A physician was notified and orders were obtained for a chest x-ray and arterial blood gases. The progress note documented the patient was treated with breathing treatments and Ativan without satisfactory results. The progress note did not document vital signs. The Respiratory Therapist (RT) progress note dated 5/10/17 at 4:32 PM, documented the patient complained of respiratory distress when a radiology test was being conducted. The facility Rapid Response Team (RRT) was activated and checked the patient. The patient was returned to her room with the following vital signs: heart rate 115 bpm, SPO2 98% with oxygen at 6 lpm and a respiratory rate 28 br/m. Arterial blood gas (ABG) analysis was drawn with no critical results. The chest X-ray results dated 5/10/17 at 4:32 PM, documented persistent bilateral interstitial infiltrates with no changes since the previous chest-X-ray. The Pulmonologist consultation dated 5/10/17 at 5:15 PM, documented the patient complained of dyspnea (difficult or labored breathing) when a	S 300		

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S 300	Continued From page 4 radiology study was being conducted and the RRT was activated. The patient did not have inflammation of the pleura (membranes that cover the lungs) and the chest X-ray showed some changes, but not fluids in the pleura. The increased dyspnea was possibly caused by "too rapid taper steroids". The treatment plan was to resume the steroids every eight hours, breathing treatment and pulmonary hygiene. Steroids were resumed as per Pulmonologist recommendation. The RT treatment report dated 5/10/17 at 10:22 PM, revealed the patient was receiving Oxygen via nasal cannula at 3 litter per minute (LPM) with an Oxygen saturation of 92 percent (%). The RT evaluation prior to a respiratory treatment performed on 5/10/17 at 11:51 PM, revealed breath sounds were diminished in all pulmonary lobes. The Medication Administration Record (MAR) dated 5/10/17 at 11:52 PM, documented Ipratropium 0.02 %, Levalbuterol 0.63 milligrams (mg) and Acetylcysteine 20 inhalation were administered. The patient's vital signs were documented as follows: pulse 100 bpm and respiratory rate at 22 br/m. The post respiratory treatment evaluation performed on 5/11/17 at 12:10 AM, revealed unchanged breath sounds (diminished) in all pulmonary lobes. The patient was receiving Oxygen via nasal cannula at 3 litter per minute (LPM) with an Oxygen saturation of 95%. The Respiratory therapy treatment report dated 5/11/17 at 2:00 AM, lacked the patient's respiratory status information or vital sign data. The respiratory therapy treatment note was blank.	S 300		

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S 300	Continued From page 5 The Nursing progress note dated 5/11/17 at 3:15 AM, documented the patient was checked by two Registered Nurses (RN). The patient complained of anxiety and difficulty breathing. A physician and RT were notified and an order for Ativan was obtained. The nursing progress note indicated the patient kept pulling the Oxygen off, and RT recommended to monitor the patient closely. The Nurse Supervisor was notified about the need of a sitter to monitor the patient. The Camera Room was notified to check the patient via surveillance camera for removing the Oxygen. A technician at the Camera Room indicated the room could not be seen clearly through the camera and suggested to move the patient to another room with a camera. The note documented the patient seemed relaxed after the administration of the medication Ativan. The patient's vital signs were not documented in this note. There was no evidence the patient was changed to another room as suggested by the Camera Room technician. The RT evaluation prior to a respiratory treatment performed on 5/11/17 at 4:08 AM, revealed the breath sounds were diminished in all pulmonary lobes. The patient's Oxygen saturation was 90% and Oxygen was administered with a non-rebreather mask, however, the rate of Oxygen flow was not documented. The following vital signs were documented: heart rate of 130 bpm and respiratory rate of 30 br/m. There was no evidence the attending physician was notified about the increased heart rate and respiratory rate. The MAR dated 5/11/17 at 4:18 AM, documented Ipratropium 0.02 %, Levalbuterol 0.63 mg and Acetylcysteine 20 inhalation were administered.	S 300		

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S 300	Continued From page 6 The patient's vital signs were documented as follows: pulse 130 bpm and respiratory rate at 30 br/m. The post respiratory treatment evaluation performed on 5/11/17 at 4:47 AM, revealed unchanged breath sounds (diminished) in all pulmonary lobes. The patient was receiving Oxygen via non-rebreather mask with Oxygen at 15 lpm, SPO2 of 90% and unchanged breath sounds. There was no evidence the attending physician was notified about the change in the patient's condition. The Nursing progress note dated 5/11/17 at 8:57 AM, documented at approximately 6:10 AM the patient was found unresponsive with the Oxygen mask in her feet and Cardio-Pulmonary Resuscitation (CPR) was initiated. The Respiratory therapy progress note dated 5/11/17 at 10:20 AM, indicated therapist entered the room during a Code Blue and CPR was initiated. The note documented a physician pronounced the patient at 6:50 AM and CPR ended. The Legal 2000 (Legal hold) Patient Frequency Observation Record date 5/11/17, revealed the patient was monitored in room 701 via camera every 15 minutes from 5/10/17 at 7:00 PM though 5/11/17 at 5:00 AM. The record documented the patient was awake/alert all the time, except on 5/10/17 at 11:00 PM and on 5/11/17 from 5:00 AM to 6:00 AM when it was documented the patient was sleeping. The record indicated a nurse called the sitter at 4:20 AM, the patient removed the intravenous (IV) lines, but they could not see the incident on monitor and suggested to change the patient to room 832. The record revealed at 6:10	S 300		

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S 300	Continued From page 7 AM, Code Blue was announced. The record indicated the patient "last appeared to be sitting in close to upright position with fingers possible in mouth for approx. (approximately) one hour". Clinical record lacked documented evidence the patient's vital signs were monitored on 5/11/17 from 4:47 AM through 6:10 AM, when the patient was found unresponsive. There was no evidence a physician or the Rapid Response Team (RRT) were notified about the abnormal vital signs obtained at 4:08 AM, 4:18 AM, 4:47 AM and the patient's change in condition. The record did not document if the patient was moved to another room with a better camera resolution to monitor if Oxygen mask was removed. The RN who provided care to the patient on 5/11/17, submitted a statement dated 8/4/17, which indicated the patient was complaining of shortness of breath (SOB) from the previous shift and the RT provided breathing treatments several times but the patient was uncooperative. The patient was medicated with Ativan. The RN stated the attending physician was notified about the SOB and an order for a computerized tomography (CT) was obtained. Due to the SOB and anxiety, the CT could not be performed and the physician ordered another dose of Ativan. The RN indicated after the medication was administered, vital signs stabilized and the patient fell asleep at approximately 4:15 AM. A Certified Nursing Assistant (CNA) and the RN rotated hourly to check the patient. The statement documented the vital signs were at baseline and the patient was monitored via camera. The RN continued to provide care to other patients and hourly rounds were performed by a CNA at 5:00 AM and "all was well". The RN's statement continued that at no point it was believed the	S 300		

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S 300	Continued From page 8 patient was in critical distress because the patient's condition was related to anxiety and the concerns had been reported to the Charge Nurse. The discharge summary dated 5/23/17, revealed the attending physician had been notified on 5/10/17 at 5:00 PM, when the patient complained of shortness of breath. The physician ordered arterial blood gases (ABG) and a chest X-ray. The physician documented the chest-X-ray and the ABG results were reviewed and an RN was directed to contact a Pulmonologist for an evaluation. The discharge summary indicated the attending physician was notified on 5/11/17 in the morning the patient expired. There was no evidence the attending physician was notified of the patient's increased respiratory and heart rate obtained at 4:08 AM and 4:47 AM. On 8/2/17 at 1:50 PM, the Chief of Nursing Operations (CNO) indicated Patient #2 should have been monitored closely based on the vital signs and condition. The CNO acknowledged the Rapid Response Team (RRT) should have been activated and the patient upgraded to a higher level of care. On 9/21/17 at 12:26 PM, the facility Process Improvement Manager indicated the patient was not monitored by telemetry and the cardiac monitoring documentation available for 5/11/17 was the electrocardiogram performed during the Code Blue. On 8/2/17 at 2:22 PM, an observation was conducted on the behavioral monitoring unit where staff monitored patients in their room via camera. A CNA (sitter) and a RN were on duty. The RN explained the purpose of the monitoring was to ensure the patients with psychiatric	S 300		

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S 300	Continued From page 9 behaviors were safe in their rooms. If a patient was out of bed, pulled lines out or got out the room, the nurse was notified immediately. The RN indicated it was only a visual monitoring and it was not capable of monitoring vital signs or if the patient was breathing or not. On 9/21/17 at 10:38 AM, a CNA explained rounds were performed every hour and as needed to each room. The CNA checked for comfort, pain or other issues or concerns the patients manifested. If there was any change in the patient's condition, the CNA notified the Licensed Nurse immediately. Vital signs were obtained by CNAs. If any of the vital signs were out of the normal parameters, the vital signs would be repeated and the nurse would be notified. The CNA described normal parameter for vital signs: B/P: 130/60, HR:60 bpm, RR: 14-16 br/m, SPO2: 91% and above. On 9/21/17 at 10:47 AM, another CNA indicated rounds were performed every hour and as needed. The CNA explained during the rounds they checked the patients for comfort, pain, distress or other concerns from the patient. The CNA verbalized vital signs were obtained by CNAs and the normal parameters were described as follow: B/P: 120/60, HR: 60 -88 bpm, SPO2: above 92% and RR 16-18 br/m. If any of the vital signs were out of parameter, the nurse would be notified. On 9/21/17 at 11:02 AM, a RN explained normal vital signs were: B/P: 100/60, HR: no more than 100 bpm, RR: 16-20 br/m and SPO2 no less than 90%. If a patient presented with a HR of 140 bpm and RR of 30 br/m, the physician must be notified immediately and the RRT activated.	S 300		

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S 300	Continued From page 10 On 9/21/17 at 11:20 AM, an RT Supervisor explained non-rebreather mask was used as the last resort when a patient had respiratory problems that did not improve with breathing treatment, pulmonary hygiene and the SPO2 was lower than 90%. The RT Supervisor indicated if a non-rebreather mask was placed, the patient had to be upgraded to the next level of care. The RT Supervisor stated any RT could notify the physician and the RRT if after an assessment it was determined a patient was in respiratory distress. The RT Supervisor confirmed according to the vital signs documented in the record on 5/11/17 at 4:08 AM and 4:47 AM, Patient #2 was in respiratory distress and required an upgrade of the level of care. The RT Supervisor explained SPO2 lower than 90%, changes in skin color, the use of the accessory respiratory muscles, increase in heart and respiratory rates and abnormal arterial blood gases could be identified such as signs and symptoms of respiratory distress. The RT Supervisor verbalized the normal SPO2 was 90% or above but depended of the patient's condition. On 9/21/17 at 12:01 PM, the RT who provided care to Patient #2 on 5/10/17 during the day, had been worked with the patient since she was extubated and transferred from Intensive Care to the med-surge unit. The RT was present when the patient complained of a respiratory distress in the radiology unit and the RRT was activated. An Emergency Department physician responded to the incident, stabilized the patient and transferred back to her room. After that time, the RT provided a breathing treatment several times throughout the day but vital signs were stable. The RT explained a non- rebreather mask was used when a patient was not oxygenating (SPO2 was lower than 90%) and required an upgrade level of	S 300		

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S 300	Continued From page 11 care. After reviewing Patient #2's clinical record for 5/11/17 at 4:08 AM and 4:47 AM, the RT concluded the physician should have been notified, the RRT activated and the level of care upgraded. Facility policy titled RRT dated December 2016, documented the RRT was established to aid in the preservation of patient life based on an early recognition of life threatening conditions. The policy documented the RRT could be activated when changes occurred in a patient that included acute change in heart rate less than 40 or more than 130 bpm, respiratory rate less than 8 or more than 28 br/m, acute change in saturation less than 90% despite oxygen and shortness of breath. Severity: 3 Scope: 1 Complaint # NV00049271	S 300		

EXHIBIT 4

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DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF REBECCA POWELL, through Brian Powell as Special Administrator; DARCI CREECY, individually; TARYN CREECY, individually; ISAIAH KHOSROF, individually; LLOYD CREECY, individually; Plaintiffs, vs. VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; ROES A-Z; Defendants.	CASE NO. A-19-788787-C DEPT. XXX (30) **ORDER DENYING DEFENDANTS CONRADO CONCIO, M.D. AND DIONICE JULIANO, M.D.'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT**

The above-referenced matter was scheduled for a hearing on September 25, 2019. Appearing on behalf of Plaintiffs were Paul S. Padda, Esq. and Suneel J. Nelson, Esq. Appearing on behalf of Defendants the movant, was Brad J. Shipley, Esq. and Zachary J. Thompson, Esq.

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I.

PROCEDURAL POSTURE

1. On February 4, 2019, Plaintiffs filed a Complaint alleging medical malpractice, wrongful death and negligent infliction of emotional distress ("NIED"). Plaintiffs attached to their Complaint a sworn affidavit from Dr. Sami Hashim, M.D. in support of their first cause of action alleging medical malpractice.

2. On June 12, 2020, Defendants Conrado Concio, M.D. and Dionice Juliano, M.D. filed a motion to dismiss Plaintiffs' Complaint alleging that Plaintiffs failed to timely file their Complaint within the statute of limitations time of one year pursuant to NRS 41A.097(2) and also failing to meet the threshold requirements of NRS 41A.071 for the claims of negligent infliction of emotional distress and professional negligence.

3. On June 13, 2019 Defendant Vishal Shah, M.D. filed a joinder to Defendants Conrado, M.D. and Dionice Juliano, M.D.'s motion to dismiss.

4. On June 26, 2019, Defendant Centennial Hills Hospital filed a joinder to Defendants Conrado, M.D. and Dionice Juliano, M.D.'s motion to dismiss.

5. On September 23, 2019, Defendant Universal Health Services, Inc. filed a joinder to Defendants Conrado, M.D. and Dionice Juliano, M.D.'s motion to dismiss.

6. The motion to dismiss and related matters were heard by the Court on September 25, 2019.

7. After considering the papers on file in this matter and the arguments of counsel, the Court hereby renders the following findings of fact and conclusions of law:

I.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

8. The Court, addressing the statute of limitations issue, noted that the Supreme Court has been clear that the standard of when a claimant "knew or reasonably should have known" is generally an issue of fact for a jury to decide. However, the Court also noted that in this case, it does appear that the Complaint was not filed until a substantial period after the date of Rebecca Powell's death. Therefore, Defendants may revisit the statute of limitations issue in

the future through a motion for summary judgment at which point the Court will reconsider the issue at that time. (Transcript 18:4-13).

9. The Court further stated there is at least an insinuation that there was concealment, and the Court understands the argument that you cannot hold one defendant responsible for another defendant's concealment. However, if there was concealment in this case, it also arguably prevented the Plaintiffs from having the inquiry notice they needed in order to comply with the statute of limitations. (Transcript 18:14-23).

10. The Court further stated that, in medical malpractice cases, an issue of fact is determined when that inquiry notice starts, and arguably, the inquiry notice may not start until Plaintiffs receive the pertinent records (Transcript 18:24-19:3).

11. The Court further stated regarding a Nevada Rule of Civil Procedure 12(b)(5) motion based upon a "failure to state a claim upon which relief can be granted" that Defendants must show that "under no circumstances would Plaintiffs able to prevail." At this point in the litigation, the Court determined that this an issue of fact to be determined at a later date as Defendants have not met their burden. (Transcript 19:4-7).

12. With regard to the NIED claim, Court stated that Plaintiffs' correctly pled the claim, and Plaintiffs' Complaint meets the requirements of NRS 41A.071. However, there is inconsistency within Plaintiffs' Affidavit which creates a genuine issue of fact. Therefore, some arguments may be brought up in a motion for summary judgment that the Court will consider at a later time after more evidence is available (Transcript 19:12-19:25).

13. Defendant Centennial Hills Hospital Medical Center's motion to dismiss Plaintiffs' Complaint based upon NRS 41A.097 and NRCP 12(b)(5) must be denied (Transcript 19:25-20:2).

14. The Court concludes that Plaintiffs' Complaint should not be dismissed at this time with the evidence available to the Court.

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III.

ORDER

Based upon the foregoing,

IT IS HEREBY ORDERED that Defendants Conrado Concio, M.D. and Dionice Juliano, M.D.'s Motion to Dismiss Plaintiffs' Complaint, and the subsequent joinders to that motion, on the grounds that (1) Plaintiffs untimely filed their complaint to satisfy the requirements of NRS 41A.097 and (2) that Plaintiffs failed to meet the threshold pleading requirements pursuant to NRS 41A.071 regarding Plaintiffs' claims of negligent infliction of emotional distress and professional negligence is DENIED without prejudice.

Dated this _____ day of _____, 2021.

Dated this 6th day of February, 2021

JERRY A. WIESE, II
DISTRICT COURT JUDGE
EIGHTH JUDICIAL DISTRICT COURT
DEPARTMENT 30

DBB 4BE A98C E349
Jerry A. Wiese
District Court Judge

Respectfully submitted by:

PAUL PADDA LAW

By: */s/ Paul S. Padda*
Paul S. Padda, Esq.
Nevada Bar No. 10417
4650 S. Decatur Boulevard, Ste. 300
Las Vegas, Nevada 89103

Attorneys for Plaintiffs

Dated this 4th day of February 2021.

Approved as to Form and Content By:

JOHN H. COTTON & ASSOCIATES, LTD.

By: */s/ Brad J. Shipley*
Brad J. Shipley, Esq.
Nevada Bar No. 12639
7900 West Sahara Ave, Suite 200
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Attorneys for Defendants Dionice S. Juliano, M.D., Conrad Concio, M.D.and Vishal S. Shah, M.D.

From: Brad Shipley
To: Jennifer Greening; Garth, Adam
Cc: Vogel, Brent; Rokni, Roya; Whitbeck, Johana; Armantrout, Heather; Atkinson, Arielle; Paul Padda
Subject: RE: Powell v. Valley Health - Proposed Orders re: 9/25/2019 Hearing
Date: Thursday, February 4, 2021 12:56:32 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

We have no objection to either order. You may use my e-signature for approval of the proposed orders.

Brad J. Shipley, Esq
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From: Jennifer Greening <Jennifer@paulpaddalaw.com>
Sent: Thursday, February 4, 2021 12:51 PM
To: Garth, Adam <Adam.Garth@lewisbrisbois.com>; Brad Shipley <bshipley@jhcottonlaw.com>
Cc: Vogel, Brent <Brent.Vogel@lewisbrisbois.com>; Rokni, Roya <Roya.Rokni@lewisbrisbois.com>; Whitbeck, Johana <Johana.Whitbeck@lewisbrisbois.com>; Armantrout, Heather <Heather.Armantrout@lewisbrisbois.com>; Atkinson, Arielle <Arielle.Atkinson@lewisbrisbois.com>; Paul Padda <psp@paulpaddalaw.com>
Subject: RE: Powell v. Valley Health - Proposed Orders re: 9/25/2019 Hearing

Thank you, Mr. Garth.

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EXHIBIT 5

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ORDR
PAUL S. PADDA
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Tele: (702) 366-1888
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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

ESTATE OF REBECCA POWELL, through Brian Powell as Special Administrator; DARCI CREECY, individually; TARYN CREECY, individually; ISAIAH KHOSROF, individually; LLOYD CREECY, individually;

Plaintiffs,

vs.

VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; ROES A-Z;

Defendants.

CASE NO. A-19-788787-C
DEPT. XXX (30)

ORDER DENYING DEFENDANT CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT

The above-referenced matter was scheduled for a hearing on September 25, 2019. Appearing on behalf of Plaintiffs was Paul S. Padda, Esq. and Suneel J. Nelson, Esq. Appearing on behalf of Defendant Centennial Hills Hospital Medical Center, the movant, was Brad J. Shipley, Esq. and Zachary J. Thompson, Esq.

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I.

PROCEDURAL HISTORY

1. On February 4, 2019, Plaintiffs filed a Complaint alleging medical malpractice, wrongful death and negligent infliction of emotional distress ("NIED"). Plaintiffs attached to their Complaint a sworn affidavit from Dr. Sami Hashim, M.D. in support of their first cause of action alleging medical malpractice.

2. On June 19, 2019, Defendant Centennial Hills Hospital Medical Center filed a motion to dismiss pursuant to Nevada Rule of Civil Procedure ("NRCP") 12(b)(5) alleging that Plaintiffs failed to timely file their Complaint within the statute of limitations time of one year pursuant to NRS 41A.071.

3. On September 23, 2019, Defendant Universal Health Services, Inc. filed a joinder to Defendant Centennial Hills Hospital Medical Center's motion to dismiss.

4. The motion to dismiss and related matters were heard by the Court on September 25, 2019 ("the hearing").

5. After considering the papers on file in this matter and the arguments of counsel, the Court hereby renders the following findings of fact and conclusions of law:

I.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

6. The Court, addressing the statute of limitations issue at the hearing, noted that the Supreme Court of Nevada has been clear that the standard of when a claimant "knew or reasonably should have known" is generally an issue of fact for a jury to decide. However, the Court also noted that in this case it does appear that claim was not filed until a substantial period after the date of Rebecca Powell's death. Therefore, the Court determined at the hearing that some arguments may be brought up later in a motion for summary judgment that the Court will consider following the filing of such a motion. (Transcript 18:4-13).

7. The Court further stated at the hearing that there is at least an insinuation that there was concealment, and the Court understands the argument that you cannot hold a Defendant responsible for another Defendants concealment. However, if there is concealment,

it arguably prevents the Plaintiffs from having the inquiry notice they need in order to comply with the statute of limitations. (Transcript 18:14-23).

8. The Court further stated at the hearing that an issue of fact is determined when that inquiry notice starts, and arguably, the inquiry notice may not start until a Plaintiff receives the pertinent records (Transcript 18:24-19:3).

9. The Court further stated at the hearing that an NRCP 12(b)(5) motion for "failure to state a claim upon which relief can be granted," requires a defendant to show that "under no circumstances would the plaintiffs be able to prevail." The Court found that Defendants's motion did not meet this standard. Therefore, the Court determined this to be an issue of fact to be determined at a later date (Transcript 19:4-7).

10. The Court finds and concludes that Defendant Centennial Hills Hospital Medical Center's motion to dismiss Plaintiffs' Complaint based upon NRS 41A.097 and NRCP 12(b)(5) must be denied (Transcript 19:25-20:2).

11. The Court also finds and concludes that Plaintiffs' Complaint should not be dismissed at this time with the evidence available to the Court.

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III.

ORDER

Based upon the foregoing,

IT IS HEREBY ORDERED that Defendant Centennial Hills Hospital Medical Center's Motion to Dismiss Plaintiffs' Complaint, and the subsequent joinders to that motion, on the grounds that Plaintiffs untimely filed their Complaint to satisfy the requirements of NRS 41A.097 is DENIED without prejudice.

Dated this _____ day of _____, 2021.

Dated this 6th day of February, 2021

JERRY A. WIESE, II
DISTRICT COURT JUDGE
EIGHTH JUDICIAL DISTRICT COURT
DEPARTMENT 30

109 83D 7B85 F30D
Jerry A. Wiese
District Court Judge

Respectfully submitted by:

PAUL PADDA LAW

By: /s/ Paul S. Padda
Paul S. Padda, Esq.
Nevada Bar No. 10417
4650 S. Decatur Boulevard, Ste. 300
Las Vegas, Nevada 89103

Attorneys for Plaintiffs

Dated this 4th day of February 2021.

Approved as to Form and Content By:

LEWIS BRISBOIS BISGAARD & SMITH

By: /s/ Adam Garth
S. Brent Vogel, Esq.
Nevada Bar No. 6858
Adam Garth, Esq.
Nevada Bar No. 15045
6385 S. Rainbow Boulevard, Ste. 600
Las Vegas, Nevada 89118

Attorneys for Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center

From:	Garth, Adam
To:	Jennifer Greening; Brad Shipley
Cc:	Vogel, Brent; Rokni, Roya; Whitbeck, Johana; Armantrout, Heather; Atkinson, Arielle; Paul Padda
Subject:	RE: Powell v. Valley Health - Proposed Orders re: 9/25/2019 Hearing
Date:	Thursday, February 4, 2021 12:40:51 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png Logo_e6253148-26a1-47a9-b861-6ac0ff0bc3c4.png

You can sign my e-signature to the stipulation and submit for filing regarding the Centennial Hills order only. We can take no position regarding the other order as that pertains to co-defendant's motion and he will need to provide his approval.

Adam Garth

LEWIS BRISBOIS

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Partner
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From: Jennifer Greening <Jennifer@paulpaddalaw.com>
Sent: Thursday, February 4, 2021 12:34 PM
To: Garth, Adam <Adam.Garth@lewisbrisbois.com>; Brad Shipley <bshipley@jhcottonlaw.com>
Cc: Vogel, Brent <Brent.Vogel@lewisbrisbois.com>; Rokni, Roya <Roya.Rokni@lewisbrisbois.com>; Whitbeck, Johana <Johana.Whitbeck@lewisbrisbois.com>; Armantrout, Heather <Heather.Armantrout@lewisbrisbois.com>; Atkinson, Arielle <Arielle.Atkinson@lewisbrisbois.com>; Paul Padda <psp@paulpaddalaw.com>
Subject: [EXT] RE: Powell v. Valley Health - Proposed Orders re: 9/25/2019 Hearing

Attached is the hearing transcript for your review.

Thank you.

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EXHIBIT 6

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DISTRICT COURT
CLARK COUNTY, NEVADA
-oOo-

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as an Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually, Plaintiffs, vs. VALLEY HEALTH SYSTEM, LLC (doing Business as "Centennial Hills Hospital Medical Center"), a foreign limited liability Company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z, Defendants.	CASE NO.: A-19-788787-C DEPT. NO.: XXX ORDER

The above-referenced matter was scheduled for a hearing on November 4, 2020, with regard to Defendant Valley Health System LLC's (Valley's) and Universal Health Services, Inc.'s (Universal's) Motion for Summary Judgment Based upon the Expired Statute of Limitations. Defendants Dionice Juliano, M.D., Conrado Concio, M.D., and Vishal Shah, M.D. joined the Motion for Summary Judgment. Additionally, Defendant, Juliano's Motion for Summary Judgment and Defendants Concio and Shaw's Motion for Partial Summary Judgment on Emotional Distress Claims is on calendar. Finally, Plaintiff's Counter-Motion to Amend or Withdraw Plaintiffs' Responses to Defendants' Requests for Admissions is on calendar. Pursuant to A.O. 20-01 and subsequent administrative orders, these matters are deemed "non-essential," and may be decided after a hearing, decided on the papers, or continued. This Court has determined that it

would be appropriate to decide these matters on the papers, and consequently, this Order issues.

Defendants, Valley's and Universal's Motion for Summary Judgment Based upon the Expiration of the Statute of Limitations.

On May 3, 2017 Rebecca Powell ("Plaintiff") was taken to Centennial Hills Hospital, a hospital owned and operated by Valley Health System, LLC ("Defendant") by EMS services after she was discovered with labored breathing and vomit on her face. Plaintiff remained in Defendant's care for a week, and her condition improved. However, on May 10, 2017, Plaintiff complained of shortness of breath, weakness, and a drowning feeling. In response to these complaints, Defendant Doctor Vishal Shah ordered Ativan to be administered via IV push. Plaintiff's condition did not improve. Defendant, Doctor Conrado Concio twice more ordered Ativan to be administered via IV push, and Plaintiff was put in a room with a camera in order to better monitor her condition. At 3:27 AM on May 11, 2017, another dose of Ativan was ordered. Plaintiff then entered into acute respiratory failure, resulting in her death.

Plaintiff brought suit on February 4, 2019 alleging negligence/medical malpractice, wrongful death pursuant to NRS 41.085, and negligent infliction of emotional distress. Defendant previously filed a Motion to Dismiss these claims, which was denied on September 25, 2019. The current Motion for Summary Judgment was filed on September 2, 2020. Defendants Dionice Juliano, MD, Conrado Concio, MD, and Vishal Shah, MD joined in this Motion on September 3, 2020. Plaintiff filed their opposition September 16, 2020. Defendant filed its reply on October 21, 2020 and Defendants Dionice Juliano, MD, Conrado Concio, MD, and Vishal Shah, MD joined the reply on October 22, 2020.

Defendant claims that, pursuant to NRS 41A.097 Plaintiff's claims were brought after the statute of limitations had run. In pertinent part, NRS 41A.097 states in pertinent part: "an action for injury or death against a provider of health care may not be commenced more than 3 years after the date of injury or 1 year after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first." NRS 41A.097(2). There appears to be no dispute that the Complaint was filed within 3 years after the date of injury (or death). The issue is whether the Complaint was filed within 1 year after the Plaintiffs knew or should have

known of the injury. Defendants claim that they fall under the definition of a "provider of health care" under NRS 41A.017 and that all of Plaintiff's claims sound in professional negligence. Therefore, all the claims are subject to NRS 41A.097.

Defendant claims that Plaintiff was put on inquiry notice of the possible cause of action on or around the date of Plaintiff's death in May of 2017 and therefore the suit, brought on February 4, 2019, was brought after the statute of limitations had tolled. Defendant makes this claim based on several theories. Defendant claims that since Plaintiffs are suing for Negligent Infliction of Emotional Distress, and an element of that claim is contemporaneous observation, that Plaintiff was put on notice of the possible claim on the date of Ms. Powell's death. Alternatively, Defendant argues that since Plaintiff ordered and received Ms. Powell's medical records no later than June 2017, they were put on notice upon the reception of those records. Finally, Defendant argues that since Plaintiffs made two separate complaints alleging negligence, they were aware of the possible claim for negligence and thus on inquiry notice. (On May 23, 2017, Defendants provide an acknowledgement by the Nevada Department of Health and Human Services ("HHS") that they received Plaintiff Brian Powell's complaint made against Defendants. And on June 11, 2017, Plaintiff Brian Powell filed a complaint with the Nevada State Board of Nursing alleging negligence in that Decedent was not properly monitored.)

Plaintiff argues that the date of accrual for the statute of limitations is a question of fact for the jury and summary judgment is not appropriate at this stage where there are factual disputes. Plaintiffs claim they were not put on inquiry notice of Defendant's negligence until they received the February 5, 2018, HHS report and therefore the complaint, filed on February 4, 2019, was brought within the one-year statute of limitations. Plaintiff makes this claim based on several pieces of evidence. First, while the medical records were mailed to Plaintiffs on June 29, 2017, there is no evidence that shows the records were ever received. Additionally, on June 28, 2017, Plaintiffs were informed via the Certificate of Death, that Ms. Powell's death was determined to be a suicide. This prevented Plaintiff from ever considering negligence contributed to her death. Plaintiffs argue the first time they could have suspected negligence was when they received the report from HHS on February 5, 2018, that stated the facility

had committed violations with rules and/or regulations and deficiencies in the medical care provided to Decedent.

Plaintiff claims that Defendant's present Motion for Summary Judgment is just a regurgitation of Defendant's prior Motion to Dismiss on the same facts in violation of Eighth Judicial District Court Rule (EJDCR) 2.24(a). Plaintiff claims this Motion is a waste of time, money, and resources that rehashes the same arguments that the court had already decided, and the Motion should be denied pursuant to EJDCR 2.24(a).

Summary judgment is appropriate if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any disputed material fact and that the moving party is entitled to a judgment as a matter of law. NRCP 56(c). The tolling date ordinarily presents a question of fact for the jury. *Winn v. Sunrise Hospital and Medical Center*, 128 Nev. 246, 252 (2012). "Only when the evidence irrefutably demonstrates that a plaintiff was put on inquiry notice of a cause of action should the district court determine this discovery date as a matter of law." *Id.* A plaintiff discovers an injury when "he knows or, through the use of reasonable diligence, should have known of facts that would put a reasonable person on inquiry notice of his cause of action." *Massey v. Linton*, 99 Nev. 723 (1983). The time does not begin when the plaintiff discovers the precise facts pertaining to his legal theory but when there is a general belief that negligence may have caused the injury. *Id.* at 728.

There is a suggestion in the Defendants' Reply Brief that the Plaintiffs may have been arguing that any delay in filing the Complaint may have been due to a fraudulent concealment of the medical records, and that such a defense needs to be specifically pled. This Court has not interpreted the Plaintiff's position to be one that the records were "fraudulently concealed," only that there was no evidence that they had timely received them. This Court will not take a position on this issue at this time, as it is not necessary as part of the Court's analysis, and it does not change the opinion of the Court either way.

Although the Complaints filed by Brian Powell, suggest that Plaintiff may have at least been on inquiry notice in 2017, the fact that the family was notified shortly after the decedent's death that the cause of death was determined to be a "suicide," causes this Court some doubt or concern about what the family knew at that time period.

Since the family did not receive the report from the State Department of Health and Human Services, indicating that their previously determined cause of death was in error, it is possible that the Plaintiffs were not on inquiry notice until February 4, 2019. This Court is not to grant a Motion to Dismiss or a Motion for Summary Judgment on the issue of a violation of the Statute of Limitations, unless the facts and evidence irrefutably demonstrate that Plaintiff was put on inquiry notice more than one year prior to the filing of the complaint. This Court does not find that such evidence is irrefutable, and there remains a genuine issue of material fact as to when the Plaintiffs were actually put on inquiry notice. Such issue is an issue of fact, appropriate for determination by the trier of fact. Consequently, Summary Judgment would not be appropriate, and the Motion for Summary Judgment, and the Joinders thereto, must be denied.

Defendant, Juliano's Motion for Summary Judgment, and Defendant Concio and Shah's Motion for Partial Summary Judgment on Emotional Distress Claims.

On or about 05/03/17, 41-year-old Rebecca Powell was transported to Centennial Hospital. Rebecca ultimately died on 05/11/17. Plaintiffs allege that the death was due to inadequate and absent monitoring, a lack of diagnostic testing, and improper treatment. Furthermore, Plaintiffs allege that Rebecca Powell's negligent death caused them Negligent Infliction of Emotional Harm.

Defendant, Doctor Dionice Juliano, argues that based on the discovery which has taken place, the medical records, and specifically his own affidavit, there are no material facts suggesting he was responsible for the care and treatment of Rebecca Powell after May 9, 2017.[1] Further, Defendant argues that for a claim for Negligent Infliction of Emotional to survive, the plaintiff must be physically present for the act which is alleged to have inflicted that emotional distress.

Defendants further argue that Summary Judgment is warranted because the Plaintiff failed to timely respond to Requests for Admission, and consequently,

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[1] Dr. Dionice Juliano's Affidavit indicates that the patient was admitted on May 3, 2017, by the physician working the night shift. Dr. Juliano saw her for the first time on May 4, 2017, and was her attending physician, until he handed her off at the end of a "week-on, week-off" rotation on Monday, May 8, 2017. He had no responsibility for her after May 8, as he was off duty until Tuesday, May 16, 2017. The Plaintiffs' Complaint is critical of the acts or omissions which occurred on May 10 and 11, 2017.

pursuant to NRCP 36, they are deemed admitted. Defendants argue that Plaintiffs have no good cause for not responding.

Plaintiffs argue that Defendants prematurely filed their motions since there is over a year left to conduct discovery. Moreover, Plaintiffs argue that Defendants acted in bad faith during a global pandemic by sending the admission requests and by not working with Defendants' counsel to remind Plaintiffs' counsel of the missing admission requests. Moreover, since Defendants have not cited any prejudice arising from their mistake of submitting its admission requests late, this Court should deem Plaintiffs' responses timely or allow them to be amended or withdrawn. Plaintiffs ask this Court to deny the premature motions for Summary Judgment and allow for discovery to run its natural course.

Pursuant to NRCP 56, and the relevant case law, summary judgment is appropriate when the evidence establishes that there is no genuine issue of material fact remaining and the moving party is entitled to judgment as a matter of law. All inferences and evidence must be viewed in the light most favorable to the non-moving party. A genuine issue of material fact exists when a reasonable jury could return a verdict for the non-moving party. See NRCP 56, *Ron Cuzze v. University and Community College System*, 123 Nev. 598, 172 P.3d 131 (2008), and *Golden Nugget v. Ham,* 95 Nev. 45, 589 P.2d 173 (1979), *and Oehler v. Humana, Inc.*, 105 Nev. 348 (1987). While the pleadings are construed in the light most favorable to the non-moving party, however, that party is not entitled to build its case on "gossamer threads of whimsy, speculation, and conjecture." *Miller v. Jones*, 114 Nev. 1291 (1998).

With regard to the Requests for Admissions, NRCP 36(a)(3) provides that a matter is deemed admitted unless, within 30 days after being served, the party sends back a written answer objecting to the matters. Here, Plaintiff's counsel failed to respond to Defendants' counsel request for admissions during the allotted time. Defendants' counsel argues that Plaintiffs should not be able to withdraw or amend their responses because their attorney was personally served six different times and emailed twice as notice that they were served the admission requests. On the other hand, Plaintiffs' counsel argued that their late response was due to consequences from the unprecedented global pandemic that affected their employees and work. NRCP 36(b) allows the Court to permit the admission to be withdrawn or amended if it would

promote the presentation of the merits. Since Nevada courts, as a public policy, favor hearing cases on its merits, and because this Court finds that the global pandemic should count as "good cause," this Court will allow Plaintiffs' late responses to be recognized as timely responses. They were filed approximately 40 days late, but the Court finds that the delay was based on "good cause," and that they will be recognized as if they had been timely responses.

Under *State v. Eaton*, 101 Nev. 705, 710 P.2d 1370 (1985), to prevail in a claim for Negligent Infliction of Emotional Distress, the following elements are required: (1) the plaintiff was located near the scene; (2) the plaintiff was emotionally injured by the contemporaneous sensory observance of the accident; and (3) the plaintiff was closely related to the victim. The Plaintiffs argue that although there has been a historical precedent requiring the plaintiff to have been present at the time of the accident. This Court previously held in this case that the case of *Crippens v. Sav On Drug Stores*, 114 Nev., 760, 961 P.2d 761 (1998), precluded the Court from granting a Motion to Dismiss. Although the burden for a Motion for Summary Judgment is different, the Court is still bound by the Nevada Supreme Court's decision in *Crippins*, which indicated, "it is not the precise position of plaintiff or what the plaintiff saw that must be examined. The overall circumstances must be examined to determine whether the harm to the plaintiff was reasonably foreseeable. Foreseeability is the cornerstone of this court's test for negligent infliction of emotional distress." Id. The Court still believes that the "foreseeability" element is more important than the location of the Plaintiffs, pursuant to the Court's determination in Crippins, and such an analysis seems to be a factual determination for the trier of fact. Consequently, Summary Judgment on the basis of the Plaintiff's failure to be present and witness the death of the decedent, seems inappropriate.

With regard to the argument that Dr. Juliano did not participate in the care of the Plaintiff during the relevant time period, the Plaintiff's objection simply indicates that the motion is premature, but fails to set forth any facts or evidence to show that Dr. Juiliano was in fact present or involved in the care of the decedent during the relevant time period. The Court believes that this is what the Nevada Supreme Court was referring to when it said that a Plaintiff is not entitled to build its case on "gossamer threads of whimsy, speculation, and conjecture." *Miller v. Jones*, 114 Nev.

1291 (1998). As the Plaintiffs have been unable to establish or show any facts or evidence indicating that Dr. Juliano was present during the relevant time period, the Court believes that no genuine issues of material fact remain in that regard and Dr. Juliano is entitled to Summary Judgment. With regard to all other issues argued by the parties, the Court finds that genuine issues of material fact remain, and summary judgment would therefore not be appropriate.

Based upon the foregoing, and good cause appearing,

IT IS HEREBY ORDERED that Defendants Valley's and Universal's Motion for Summary Judgment Based upon the Expiration of the Statute of Limitations, and all Joinders thereto are hereby **DENIED**.

IT IS FURTHER ORDERED that Defendant Juliano's Motion for Summary Judgment is hereby **GRANTED**, and Dr. Juliano is hereby Dismissed from the Action, without prejudice.

IT IS FURTHER ORDERED that the Defendants, Concio and Shah's Motion for Partial Summary Judgment on the Negligent Infliction of Emotional Distress Claims is hereby **DENIED**. All joinders are likewise **DENIED**.

IT IS FURTHER ORDERED that because the Court has ruled on these Motions on the papers, the hearing scheduled for November 4, 2020, with regard to the foregoing issues is now moot, and will be taken off calendar.

Dated this 28th day of October, 2020.

Dated this 29th day of October, 2020

JERRY A. WIESE II
DISTRICT COURT JUDGE
EIGHTH JUDICIAL DISTRICT COURT
DEPARTMENT XXVI

Jerry A. Wiese
District Court Judge

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Estate of Rebecca Powell, Plaintiff(s) vs. Valley Health System, LLC, Defendant(s)	CASE NO: A-19-788787-C DEPT. NO. Department 30

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 10/29/2020

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If indicated below, a copy of the above mentioned filings were also served by mail via United States Postal Service, postage prepaid, to the parties listed below at their last known addresses on 11/2/2020

John Cotton	John H. Cotton & Associates, LTD. Attn: John H. Cotton 7900 W. Sahara Ave. - Suite 200 Las Vegas, NV, 89117
Paul Padda	Paul Padda Law, PLLC c/o: Paul Padda 4560 S. Decature Blvd, Suite 300 Las Vegas, NV, 89103

EXHIBIT 7

ORDR

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF REBECCA POWELL, through Brian Powell as Special Administrator; DARCI CREECY, individually; TARYN CREECY, individually; ISAIAH KHOSROF, individually; LLOYD CREECY, individually;

Plaintiffs,

vs.

VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; ROES A-Z;

Defendants.

CASE NO. A-19-788787-C
DEPT. 30

ORDER DENYING DEFENDANT VALLEY HEALTH SYSTEM, LLC'S MOTION TO STAY ON ORDER SHORTENING TIME

The above-referenced matter was scheduled for a hearing on November 25, 2020 with regard to Defendant Valley Health System's Motion for Stay. Pursuant to Administrative Order 20-01, and subsequent administrative orders, this matter was deemed "non-essential," and as

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such, this Court has determined that it would be appropriate to decide this matter on the papers. A minute order was circulated on November 23, 2020 to the parties, the contents of which follows:

On May 3, 2017, Plaintiff was found by EMS at her home. She was unconscious, labored in her breathing, and had vomit on her face. EMS provided emergency care and transported her to Defendant Hospital, and she was admitted. Plaintiff continued to improve while she was admitted. However, on May 10, 2017 Plaintiff complained of shortness of breath, weakness, and a "drowning feeling." One of her doctors ordered Ativan to be administered via an IV push. On May 11, another doctor ordered two more doses of Ativan and ordered several tests, including a chest CT to be performed. However, the CT could not be performed due to Plaintiff's inability to remain still during the test. She was returned to her room where she was monitored by a camera to ensure she kept her oxygen mask on. Plaintiffs, in their complaint, alleged the monitoring was substandard and Defendant should have used a better camera or in person monitoring, among other theories of substandard care. Another dose of Ativan was ordered at 3:27 AM and Plaintiff entered into acute respiratory failure, which resulted in her death. The other named Plaintiffs claimed they were in Decedent's hospital room and observed Defendant's negligence.

Plaintiffs ordered Decedent's medical records on May 25, 2017; however, there were issues with delivery, and it is unclear exactly when Plaintiffs received them. Decedent s husband, a named Plaintiff, filed a complaint with the State of Nevada Department of Health and Human Services ("HHS") sometime before May 23, 2017. Approximately six weeks after the death of Decedent, Plaintiffs received the death certificate which listed the cause of death as a suicide from Cymbalta Intoxication. On February 5, 2018 HHS responded to Plaintiff s complaint. The letter said that after an investigation, HHS concluded that the facility had committed violations by not

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following rules and/or regulations as well as finding there were deficiencies in the medical care provided to Decedent.

On February 4, 2019, Plaintiff's filed suit alleging negligence/medical malpractice, wrongful death pursuant to NRS 41.085, and negligent infliction of emotional distress. Defendant did not file an answer but filed a Motion to Dismiss on June 19, 2020 alleging the statute of limitations had tolled. Plaintiff answered the motion. The court denied the Motion to Dismiss on September 25, 2019. Defendant filed an Answer to Plaintiff s complaint on April 15, 2020.

Defendants Valley Health System, LLC and Universal Health Services, Inc. then filed a 'Motion for Summary Judgment Based Upon the Expiration of the Statute of Limitations.' Defendants Dionice Juliano, M.D., Conrado Concio, M.D., and Vishal Shah, M.D. joined the Motion for Summary Judgment. Additionally, Defendant Juliano filed a Motion for Summary Judgment, and Defendants Concio and Shaw filed a Motion for Partial Summary Judgment on Emotional Distress Claims. Plaintiffs filed a Counter-Motion to Amend or Withdraw Plaintiffs Responses to Defendants Requests for Admissions. All of these items were on the November 04, 2020 calendar. An Order deciding these motions was filed on October 29, 2020. The Order denied Defendants, Valley Health System and Universal s Motion for Summary Judgment and related Joinders; granted Defendant Juliano s Motion for Summary Judgment, and dismissed Dr. Juliano from the case without prejudice; and denied Defendants Concio and Shah s Motion for Partial Summary Judgment on the Emotional Distress Claims.

Now, Defendant Valley Health System, LLC (VHS) seeks an order staying the case pending an appeal of the October 29, 2020, Order denying its Motion for Summary Judgment Based Upon the Expiration of the Statute of Limitations. Defendant VHS alleges that it may be irreparably prejudiced by having to continue defending this action and potentially being forced

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to try all issues when the matter raised by the aforesaid Motion is case dispositive.

This matter has been pending since February, 2019. It is currently set for trial on May 23, 2022. Initial expert disclosures are to be made on or before June 18, 2021, rebuttal expert disclosures are due on August 27, 2021, and discovery is to be completed on or before October 28, 2021. Valley argues that it is currently preparing a Petition for Writ of Mandamus, and is first seeking a stay with the district Court pursuant to NRAP 8(a)(1)(A). The decision whether to grant a motion for a stay in proceedings is left to the sound discretion of the Court. Nevada Tax Commission v. Brent Mackie, 74 Nev. 273, 276 (1958). The factors to be considered by the Court when considering whether to issue a stay in the proceedings when an appellate issue is pending before the Nevada Supreme Court are (1) whether the object of the writ petition will be defeated if the stay is denied; (2) whether the petitioner will suffer irreparable or serious injury if the stay is denied; (3) whether the real party in interest will suffer irreparable or serious injury if the stay is granted; and (4) whether petitioner is likely to prevail on the merits in the writ petition. NRAP 8(c); Fritz Hansen A/S v. Eighth Judicial District Court, 116 Nev. 650, 657 (2000).

Defendant, VHS argues that each of the 4 factors weigh in favor of granting a stay. The Plaintiffs, on the other hand, argue that none of the factors weigh in favor of the Defendant. This Court finds and concludes as follows: 1) Trial is currently not scheduled until May of 2022, and consequently, even if a stay is denied, it is likely that the Supreme Court would rule on the "potential" Writ of Mandamus, prior to the parties going to Trial. Consequently, the Court does not find that the purpose of the writ petition would be defeated if the stay were denied. 2) The only injury or damage that the Petitioner would suffer if the stay were denied, would be continued litigations and the costs associated therewith. The Court has consistently held that ongoing litigation and the expenses associated therewith do not cause "irreparable harm." Consequently,

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the Court does not find that the Petitioner would suffer irreparable harm or serious injury if the stay were denied. 3) Although the Plaintiffs are correct that memories dim as time passes, such a fact applies to all witnesses equally Plaintiff's witnesses as well as Defendants' witnesses. Consequently, the Court does not find that the Plaintiffs would suffer irreparable or serious injury if the stay were granted. 4) The Court cannot find that the Petitioners are likely to prevail on the merits, as this Court previously found, and continues to believe, that the Death Certificate identifying Ms. Powell's cause of death as a "suicide," may have tolled the statute of limitations, in that such a conclusion or determination by the Medical Examiner, would clearly not suggest "negligence" on the part of any medical care provider. Although the Defendants suggest that the Plaintiffs possessed inquiry notice much earlier, the Court could not find that the families questioning of the cause of death equated with inquiry notice of negligence. Consequently, this Court concluded that when the Plaintiffs knew or should have known, of the alleged negligence of the Defendants, was an issue of fact which overcame the Defendants' Motion for Summary Judgment. Consequently, the Court cannot find that there is a likelihood of success on the merits.

Another issue which is important in this Court's analysis, is the fact that a Writ has apparently not yet been filed. If the Court were to grant the Stay as requested, it is possible that 6 months, or even a year from now, the Writ may still not be filed, so the Court would have stayed the case for no reason.

. . .

. . .

. . .

Based upon all these reasons, considering the relevant factors set forth above, finding that they weigh in favor of the non-moving party, and good cause appearing,

IT IS HEREBY ORDERED that the Defendant's Motion for Stay is hereby **DENIED**.

Dated this _____ day of December, 2020.

Dated this 17th day of December, 2020

JERRY A. WIESE, II
DISTRICT COURT JUDGE
EIGHTH JUDICIAL DISTRICT COURT
DEPARTMENT 30

A98 223 863E 6997
Jerry A. Wiese
District Court Judge

Respectfully submitted by:

PAUL PADDA LAW

/s/ Paul S. Padda

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CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Estate of Rebecca Powell, Plaintiff(s) vs. Valley Health System, LLC, Defendant(s)	CASE NO: A-19-788787-C DEPT. NO. Department 30

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

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EXHIBIT C

RIS

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DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually,

Plaintiffs,

vs.

VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z,

Defendants.

Case No. A-19-788787-C

Dept. No.: 30

DEFENDANT VALLEY HEALTH SYSTEM, LLC DBA CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S REPLY IN FURTHER SUPPORT OF MOTION FOR ATTORNEYS' FEES PURSUANT TO N.R.C.P. 68, N.R.S. §§ 17.117, 7.085, 18.010(2), AND EDCR 7.60

Hearing Date: February 9, 2022
Hearing Time: 9:00 a.m.

Defendant VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center") by and through its counsel of record, S. Brent Vogel and Adam Garth of the Law Firm LEWIS BRISBOIS BISGAARD & SMITH LLP, hereby file their Reply in Further Support of Their Motion for Attorneys' Fees Pursuant to N.R.C.P. 68 and N.R.S.§§ 17.117, 7.085, 18.010(2) and EDCR 7.60.

This Motion is based upon the Memorandum of Points and Authorities below, Defendant's

Motion in Chief, the pleadings and papers on file herein, any oral argument which may be entertained by the Court at the hearing of this matter.

DATED this 2nd day of February, 2022

LEWIS BRISBOIS BISGAARD & SMITH LLP

By */s/ Adam Garth*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiffs' entire opposition is predicated on a false assertion that they possessed a viable case in the first instance. To put Plaintiffs' argument in the proper light, they effectively state "We were winning until we lost everything, but since we thought we were winning, we had a good faith basis to proceed." So, according to Plaintiffs, as long as they won a number of battles but still lost the war, they are on firm ground – not so.

Their entire argument is that because this Court repeatedly denied dismissal attempts by the respective defendants despite clear, convincing, and irrefutable evidence of inquiry notice which each and every plaintiff possessed, they are somehow absolved from either their malpractice or unethical practice of pursuing a case which was dead on arrival when filed. The overarching factor, which Plaintiffs seem to "gloss over," is the Nevada Supreme Court held that the "district court manifestly abused its discretion when it denied summary judgment."[1] In other words, it was so plainly obvious at the outset of the litigation that Brian Powell's two State agency complaints, standing alone, let alone Plaintiffs sought and obtained Ms. Powell's complete medical record from CHH, that this case should have been dismissed a year ago at the latest when the summary judgment motion was made.

Even more stunning in this case, as the Supreme Court also pointed out, was that Plaintiffs possessed the entire medical record for the decedent from CHH within one month of her death.[2] Either possession of the record or the State agency complaints was sufficient to trigger the commencement of inquiry notice, let alone the two combined. All other arguments advanced by Plaintiffs disregard their lawyer's incompetence in prosecuting a lawsuit he refused to admit was legally non-revivable, and where he failed to provide any evidence which formed the basis of his own concocted theories of alleged confusion as to cause of death or some fraudulent concealment of records. Plaintiffs' counsel failed to interpose an affidavit or declaration from any plaintiff in this case even suggesting these as a basis to support his theory, and for good reason – either it was

[1] Exhibit "B" to CHH's motion in chief, p. 2
[2] Exhibit "B" to CHH's motion in chief, pp. 3-5

a lie and could not be presented to the Court, or it was gross incompetence to fail to support any claim with admissible evidence in opposition to unopposed evidence in support of a motion for summary judgment. Either way, Plaintiffs' counsel acted in bad faith here.

If Plaintiffs' procedural bad faith was not enough, Plaintiffs had no good faith factual basis for starting the lawsuit. What will be plainly evident below is that Plaintiffs' counsel commenced this action with their usual "go to" physician expert (who they regularly drop as an expert once time for expert exchanges, but utilize in an effort to get over the NRS 41A.071 hurdle) on some half-baked theory that Ms. Powell was overdosed on Ativan which suppressed her breathing and caused her death. After CHH demonstrated through unimpeachable expert reporting and evaluations that given the timing of the Ativan, it had almost completely metabolized in Ms. Powell long before her death and had no effect whatsoever on the outcome of her hospital course. Even more revealing was the fact that CHH's experts concluded, and upon which Plaintiffs' experts actually agreed, that Ms. Powell died from an acute mucous plug event, not Ativan overdosing or anything else, an event which was not predictable. Her demise was predetermined by her own suicide attempt and resulting aspiration pneumonia which created a cascading decline in her health condition, that only temporarily improved, but which cold not be reversed by the best of care.[3] Plaintiffs' counsel spends considerable time in opposition attempting to garner sympathy due to the death of Ms. Powell which was precipitated by her own purposeful actions and had nothing whatsoever to do with the care she received at CHH. This is another perpetration of the continuing web of lies by Plaintiffs' counsel which has been put to an end by the Nevada Supreme Court due to Plaintiffs' counsel's improper advancement of an expired lawsuit.

What is even more disturbing is that Plaintiffs' counsel attempts to legitimize their actions by asserting that a previously scheduled mediation somehow validates their claims. Nothing can be further from the truth. CHH attempted to limit the constant hemorrhaging of money and time devoted to this illegitimate lawsuit which was only being given oxygen by repeated denials of a

[3] Exhibit "D" hereto consisting of CHH's initial and rebuttal expert disclosures demonstrating the complete absence of an underlying good faith factual basis for lawsuit.

pause in expenses while this matter worked its way through the Nevada Supreme Court for final determination of its legitimacy. As previously noted in CHH's motion in chief, Plaintiffs vehemently opposed any efforts to stem of tidal wave of expenses, opposing any motion for a stay on multiple occasions. They forced an increase in costs and expenses and now do not want to pay for their actions.

In short, Plaintiffs' gambled, lost, and now have to pay up. Denial of this motion would represent an invitation to lawyers to commence lawsuits late, encourage them to not provide any evidentiary support for positions they take, and after presented with an opportunity to walk away free and clear after being shown the impropriety of their actions, to continue to pursue baseless and untenable litigation. The Nevada Supreme Court would likely be interested in weighing in on this issue as well.

II. LEGAL ARGUMENT

A. The Beattie Factors Weigh Completely In Favor of CHH

In awarding attorneys' fees pursuant to NRCP 68, the district court must analyze the following factors: "(1) whether the plaintiffs claim was brought in good faith; (2) whether the defendants' offer of judgment was reasonable and in good faith in both its time and amount; (3) whether the plaintiff's decision to reject the offer and proceed to trial was grossly unreasonable or in bad faith; and (4) whether the fees sought by the offeror are reasonable and justified in amount." *Beattie v. Thomas,* 99 Nev. 579, 588-89, 688 P.2d 268, 274 (1983). However, no single *Beattie* factor is determinative, and a review of the factors shows this Court should award CHH its attorneys' fees. *Frazier v. Drake*, 131 Nev. 632, 642, 357 P.3d 365, 372 (Nev. App. 2015). While this Court's order need not go into detail regarding each and every *Beattie* factor, its findings must be supported by substantial evidence. *Logan v. Abe*, 131 Nev. 260, 266, 350 P.3d 1139, 1143 (2015). The district court abuses its discretion if the *Beattie* factors are not supported by substantial evidence. *Id.*

Further, attorneys' fees are warranted even with a finding that two of the *Beattie* factors weigh in favor of the moving party. *See Lafrieda v. Gilbert*, 435 P.3d 665 (Nev. 2019) (upholding district court's award of attorneys' fees when it found the offer of judgment was reasonable in both time and amount and the fees were necessary and reasonably incurred.) In the instant case, all four

factors weigh completely in CHH's favor.

B. Plaintiffs' Lawsuit Was Brought in Bad Faith

As previously demonstrated in CHH's motion in chief and in the introduction above, Plaintiffs' lawsuit was not brought in good faith. The mere fact that a 41 year old woman died, due to her own suicide attempt, does not require CHH to open its checkbook and pay. Plaintiff had both procedural and substantive hurdles to overcome, neither of which they did.

The Nevada Supreme Court cited multiple times which Plaintiffs received inquiry notice in this case. Specifically the Court stated:

> Here, **irrefutable evidence demonstrates that the real parties in interest were on inquiry notice by June 11, 2017 at the latest**, when real party in interest Brian Powell, special administrator for the estate, filed a complaint with the State Board of Nursing. There, Brian alleged that the decedent, Rebecca Powell, "went into respiratory distress" and her health care providers did not appropriately monitor her, abandoning her care and causing her death. Thus, Brian's own allegations in this Board complaint demonstrate that he had enough information to allege a prima facie claim for professional negligence-that in treating Rebecca, her health care providers failed "to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care." NRS 41A.015 (defining professional negligence); *Winn*, 128 Nev. at 252-53; 277 P.3d at 462 (explaining that a "plaintiffs general belief that someone's negligence may have caused his or her injury" triggers inquiry notice).[3] **That the real parties in interest received Rebecca's death certificate 17 days later, erroneously listing her cause of death as suicide, does not change this conclusion**.[4] Thus, the real parties in interest had until June 11, 2018, at the latest, to file their professional negligence claim. Therefore, their February 4, 2019 complaint was untimely.
>
> **3 The evidence shows that Brian was likely on inquiry notice even earlier. For example, real parties in interest had observed in real time, following a short period of recovery, the rapid deterioration of Powell's health while in petitioners' care. Additionally, Brian had filed a complaint with the Nevada Department of Health and Human Services (NDHHS) on or before May 23, 2017. Similar to the Nursing Board complaint, this complaint alleged facts, such as the petitioners' failure to upgrade care, sterilize sutures properly, and monitor Powell, that suggest he already believed, and knew of facts to support his belief, that negligent treatment caused Powell's death by the time he made these complaints to NDHHS and the Nursing Board.**
>
> 4 **The real parties in interest do not adequately address why tolling should apply under NRS 41A.097(3)** (providing that the limitation period for a professional negligence claim "is tolled for any period during which the provider of health care has concealed any act, error or omission upon which the action is based"). Even if they did, such an argument would be unavailing, as the medical

> records provided were sufficient for their expert witness to conclude that petitioners were negligent in Powell's care. *See Winn*, 128 Nev. at 255, 277 P.3d at 464 (holding that tolling under NRS 41A.097(3) is only appropriate where the intentionally concealed medical records were "material" to the professional negligence claims). Finally, we have not extended the doctrine of equitable tolling to NRS 41A.097(2), and the real parties in interest do not adequately address whether such an application is appropriate under these facts. *See Edwards v. Emperor's Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006) (refusing to consider arguments that a party did not cogently argue or support with relevant authority).
>
> **Given that uncontroverted evidence demonstrates that the petitioners are entitled to judgment as a matter of law** because the complaint is time-barred under NRS 41A.097(2), see NRCP 56(a); *Wood*, 121 Nev. at 729, 121 P.3d at 1029 (recognizing that courts must grant summary judgment when the pleadings and all other evidence on file, viewed in a light most favorable to the nonmoving party, "demonstrate that **no genuine issue as to any material fact [remains]** and that the moving party is entitled to a judgment as a matter of law" (internal quotations omitted)) . . .[4]

Let's review the timing of the notice. Independent from anything that Brian Powell did with reporting alleged and suspected medical negligence to two State agencies, Plaintiff Taryn Creecy sought and obtained a Probate Court order directing that she be permitting to obtain Ms. Powell's medical records from CHH, and that court order was issued on May 24, 2017, 13 days after Ms. Powell's death.[5] Does Plaintiffs' counsel expect that everyone is so stupid as to believe that Ms. Creecy sought a complete copy of the medical records from CHH for fun? Who requests medical records from a hospital for a deceased individual if not to review them to determine what happened due to some suspected impropriety of care? The Supreme Court noted that CHH presented "uncontroverted evidence" that Plaintiffs' received a complete copy of Ms. Powell's entire CHH medical chart which was demonstrated to this Court on the motion for summary judgment and again on appeal through the affidavits of CHH's custodian of records and the medical records retrieval service which processed Ms. Creecy's order for the records. Due to an improper address provided by Ms. Creecy, the records were sent twice, the last time on June 29, 2017.[6] As the Supreme Court noted in its writ of mandamus order, Plaintiffs proffered a theory of fraudulent concealment but

[4] Exhibit "B" to CHH's motion in chief, pp. 3-5 (emphasis supplied)
[5] Exhibit "E" hereto
[6] Exhibit "G"

failed to demonstrate any evidence of it. The Supreme Court acknowledged that Plaintiffs were in full possession of the entire medical record which was available to them and at least partially reviewed by their medical expert in support of his NRS 41A.071 declaration.

In an effort to extricate themselves from the mess of their own creation, Plaintiffs' counsel erroneously seeks *en banc* reconsideration of the Supreme Court's order in this case, falsely stating that the only evidence of inquiry notice here was Brian Powell's two State agency complaints, and that noting that his complaints were initiated without knowledge of the remaining Plaintiffs in this case (an assertion which is unsupported by any evidence whatsoever in the record but is again being unethically advanced by ethically bankrupt counsel). That motion is almost assuredly doomed to failure.

Plaintiffs further contends in their pending motion in Supreme Court that only the Estate's claims could be barred by the statute of limitations since it was Brian Powell, the Estate's special administrator, who allegedly "went rogue" and filed these complaints without any knowledge by other Plaintiffs. Thus, Plaintiffs' counsel asserts the remaining Plaintiffs cannot be bound by Mr. Powell's rogue actions. Again, to think everyone is so stupid as to believe that nonsense is insulting to say the least. Plaintiffs' counsel conveniently omitted that all of the Plaintiffs prosecuted this lawsuit having received records from CHH independent from any State agency complaints. In *Christina Kushnir, M.D. et al. v. Eighth Judicial District* Court, 137 Nev. Adv. Op. 41 (2021), the Court of Appeals stated that NRS 41A.097's one year discovery period for the purposes of inquiry notice in a professional negligence case begins to run when a party receives the complete medical record and "had facts before him that would have led an ordinarily prudent person to investigate further." Plaintiffs' possession of the hospital records in this case coupled with their expert's ability to review them and opine on the alleged malpractice for NRS 41A.071 purposes commenced the running of the statute of limitations.

Conspicuously absent from Plaintiffs' opposition on this motion as well as to the Supreme Court in their motion for *en banc* reconsideration, is any citation to this binding authority and the cases preceding it. Thus, the mere possession of the complete medical record in June, 2017 by Plaintiffs commenced the running of the statute of limitations here. The Nevada Supreme Court's

decision in this case made that perfectly clear. Thus, Plaintiffs lacked a good faith basis for their claim in the first place since they possessed the medical records within 6 weeks of Ms. Powell's death any did nothing to preserve their rights for 20 months thereafter before filing this illegitimate and untimely lawsuit. This fact alone presents evidence of bad faith.

Moreover, the Nevada Supreme Court also stated in footnote 3 to its decision cited above, "The evidence shows that Brian was likely on inquiry notice even earlier. For example, real parties in interest had observed in real time, following a short period of recovery, the rapid deterioration of Powell's health while in petitioners' care." In other words, Plaintiffs made assertions in the case that they personally observed Ms. Powell's rapid deterioration. By so asserting, they admit they were on the very inquiry notice required. Again, Plaintiffs' counsel conveniently forgets to highlight his claim on Plaintiffs' behalf in this regard since it will not support the misrepresentation of facts he now attempts to perpetrate on this Court in opposition to the instant motion.

In summary, Plaintiffs' bad faith has been determined in three different ways – (1) possessing the entire medical record on or about June 29, 2017, (2) all Plaintiffs allegedly witnessing Ms. Powell's rapid deterioration of condition, and (3) two State agency complaints specifically alleging malpractice and requesting investigations. Any one of these is sufficient for inquiry notice. All combined, it screams inquiry notice. All of this information was within Plaintiffs' exclusive possession at the time of the lawsuit's filing. For Plaintiffs' counsel to manufacture a nonsensical and completely unsubstantiated claim of "confusion", lacking any shred of evidentiary support, demonstrates the very bad faith for which the penalties of the statutes and rules were established to deter. Therefore, this was a bad faith lawsuit by Plaintiffs' and their counsel, plain and simple.

C. CHH's Offer of Judgment Was Brought in Good Faith in Both Timing and Amount

Plaintiffs' opposition to this factor is based upon the galling and false claim that just because Ms. Powell died at CHH at the age of 41, CHH's offer of judgment should have included a cash award to Plaintiffs rather than a waiver of over $58,000 in costs and fees precipitated by Plaintiffs' bad faith lawsuit.

CHH's Offer was reasonable as to time. The Offer was served on August 28, 2020. CHH's

motion for summary judgment was served on September 2, 2020, 5 days after the Offer and well within the time to accept it, 9 days to be exact. Moreover, the Offer was made about 1½ years from the lawsuit's commencement. As previously demonstrated herein, on the original motion for summary judgment, on appeal to the Nevada Supreme Court, and in the Supreme Court's decision thereon, every single one of the Plaintiffs was on inquiry notice of alleged malpractice in three different ways, where only one means was sufficient to commence the running of the statute of limitations. These were made abundantly clear in CHH's summary judgment motion pending coterminously with the Offer. Plaintiffs were the parties in exclusive possession of evidence of inquiry notice. The fact that this Court previously denied CHH's predecessor counsel's motion to dismiss did not delegitimize the arguments which were only amplified and irrefutably demonstrated by CHH in its motion for summary judgment to which a wholly different standard applied and to which Plaintiffs were obligated to provide evidence in opposition thereto. This they failed to do, and the Supreme Court noted it.

Moreover, Plaintiffs were in possession of CHH's respective requests for production of documents and interrogatories six weeks prior to the motion for summary judgment having been filed, and they produced the "smoking gun" documents demonstrating irrefutable evidence of inquiry notice prior to the motion for summary judgment having been made and even while said motion was pending before this Court prior to the final submission of the motion. Plaintiffs were on notice of the statute of limitations issues even as early as the motion to dismiss made by predecessor counsel in July, 2019, just months after commencing this action, yet they still pursued their untenable claim while in full possession of the documents which defeated it.

Plaintiffs' counsel further falsely assumes that because this Court denied CHH's summary judgment motion, an error corrected by the Nevada Supreme Court, that somehow provides cover to Plaintiffs for their improper commencement of the action in the first place. It does not. CHH's Offer was made based upon Plaintiffs' exclusive possession of the very evidence necessary to defeat their assertions of a lack of inquiry notice. Therefore, the timing of the Offer was completely proper.

Likewise, the amount of fees and costs sought by CHH are completely reasonable and are at least supported by persuasive authority, i.e. *Busick v. Trainor,* 437 P.3d 1050 (Nev. 2019) which

notes that a waiver of costs is sufficient consideration. An offer of judgment containing only a mutual waiver of attorneys' fees and costs in exchange for a dismissal of a lawsuit is not nominal, and may constitute a reasonable offer made in good faith. *See Busick v. Trainor*, 2019 Nev. Unpub. LEXIS 378 at *6-8 (No. 72966 March 28, 2019). In *Busick*, the plaintiffs alleged $ 1-3 million dollars in damages in a medical malpractice claim. In preparing for trial, the defendant served an offer of judgment on the plaintiffs for a mutual waiver of attorneys' fees and costs. *Id.* At the time the offer of judgment was made, the defendant had incurred approximately $ 95,000 in costs. Since an award of costs is mandated under NRS 18.020, the district court found the waiver of such is a meaningful sum to be included in the offer of judgment, and awarded defendant its costs and attorneys' fees pursuant to NRCP 68.

In this case, CHH's Offer was to waive over $58,000 in costs and fees. Plaintiffs did nothing about the Offer, which under the Rule, expired after 14 days. In a separate memorandum of costs, which Plaintiffs failed to timely move to retax, CHH provided supporting authority for same. On this motion, CHH offered to present to this Court for *in camera* inspection (to preserve attorney/client privilege and work product privilege) to provide time sheets for all time keepers and all invoices, costs, disbursements and fees. What have Plaintiffs offered – nothing. They provide not one shred of evidence that the costs are unreasonable or any basis for so stating. The only unreasonable factor in Plaintiffs' counsel's mind is that they lost and have now subjected their clients to a judgment due to their counsel's hubris. Lest we forget here – it was CHH which attempted to reduce costs here by seeking stays of discovery. Plaintiffs opposed those efforts at every turn. Plaintiffs now oppose paying for the costs they forced CHH to incur. Unfortunately for Plaintiffs, the law provides a recovery mechanism to counter Plaintiffs' efforts. In fact, it can be assumed that Plaintiffs purposefully sought to increase CHH's costs to extract a settlement despite the untenable claim they advanced as a dead lawsuit at its filing.

All of these demonstrate Plaintiffs' bad faith, pure and simple. Given the likelihood of Plaintiffs losing on this issue, the offered waiver of the right to seek reimbursement of costs was reasonable in both timing and amount, especially given the multiple opportunities for Plaintiffs to be on notice of the issue.

D. Plaintiffs' Decision to Reject the Offer of Judgment Was in Bad Faith and Grossly Unreasonable

Plaintiffs claim that since this Court kept allowing Plaintiffs to win instead of properly dismissing this case from the outset, or at a minimum, when irrefutable evidence of inquiry notice was supplied by CHH to which Plaintiffs interposed **nothing in opposition**, they were justified in rejecting the Offer. Timing of the Offer does not support Plaintiffs' counsel's assertion. As previously noted, CHH's summary judgment motion was made 5 days after the Offer. Plaintiffs knew they possessed irrefutable evidence of inquiry notice by having received the medical records of Ms. Powell more than three years earlier. They knew they provided the records to their medical expert who opined thereon. Plaintiffs' expert, Dr. Sami Hashim, stated in clear terms the following:

> **Based upon the medical records**, the patient did not and with high probability could not have died from the cause of death stated in the Death Certificate. The patient died as a direct consequence of respiratory failure directly **due to below standard of care violations as indicated by her medical records and reinforced** by the Department of Health and Human Services – Division of Health Quality and Compliance Investigative Report.[7]

(Emphasis supplied). **Dr. Hashim noted that he primarily relied upon the very medical records which Plaintiffs obtained in May/June, 2017, and the HHS Report was only a "reinforcement" of what was contained in the medical records**.

The issue from the commencement of this action involved the timeliness of it. Plaintiffs' counsel's sole argument is that "there was no bad faith as Plaintiffs wholeheartedly believed in their causes of action which was supported by the report issued by HHS in February of 2018." First of all, Plaintiffs' counsel's belief in their causes of action is of no moment here. The sole issue is whether Plaintiffs possessed the very information they needed, and were on notice of the law regarding same, when they commenced the action, to have commenced a timely lawsuit. They possessed all necessary information on multiple fronts but nevertheless pursued a case which was dead on arrival. Plaintiffs alleged that they watched Ms. Powell rapidly deteriorate during her stay at CHH. The Supreme Court said that was sufficient inquiry notice.

Plaintiffs sought and obtained a Probate Court order granting them access to Ms. Powell's

[7] Exhibit "F" hereto, ¶6(B)

entire CHH medical record. Before commencing the lawsuit, Plaintiffs' counsel obtained the records provided by CHH to Plaintiffs and forwarded them to Dr. Hashim to obtain his opinion for NRS 41A.071 purposes. There was no other mechanism in place to obtain the records other than what Plaintiffs engaged since no lawsuit was pending to provide said records pursuant to NRCP 16.1. Plaintiffs' counsel knowingly advanced a completely unsubstantiated and unsupported theory of either confusion by his clients or fraudulent concealment by CHH. As noted by the Supreme Court, neither theory had any basis whatsoever. Thus, Plaintiffs' counsel purposely failed to support their opposition to irrefutable evidence warranting summary judgment on the inquiry notice issue, underscoring their bad faith here.

Finally, Plaintiffs possessed and then provided evidence of Plaintiffs' inquiry notice by supplying the two State agency complaints. The Supreme Court considered that as additional irrefutable evidence of Plaintiffs' inquiry notice. Now, Plaintiffs' counsel attempts to deflect from their own incompetence and claim that the Supreme Court imposed a standard never contemplated, namely that all of the Plaintiffs were bound by the State agency complaints initiated by Brian Powell. Again, Plaintiffs' counsel presents no evidence of that, just their own assertion which is not only improper, but false. Plaintiffs' bad faith is further underscored by the fact that they tacitly admit that the Estate's claims in this case were made in bad faith because the State agency complaints were made solely by Brian Powell on behalf of the Estate, not on behalf of the remaining Plaintiffs. By so admitting, Plaintiffs' counsel acknowledges that, at a minimum, the Estate possessed sufficient inquiry notice by June 11, 2017, and that the Estate's lawsuit was untimely when filed. That is further evidence of bad faith by pursuing a claim known to be untimely.

Additionally, Plaintiffs blocked every opportunity CHH provided to "stop the financial bleeding" by staying the litigation while this case dispositive issue made its way through the courts. They opposed two stay motions and a motion to reconsider a stay. They opposed a motion to dismiss and a motion for summary judgment, presenting not one shred of evidence by anyone with personal knowledge of the facts, supporting their claim of a timely commencement of the action. They forced CHH to incur substantial legal costs and expenses to defend the action, requiring the engagement of counsel along with multiple experts, to pursue a lawsuit they knew could not be maintained from

the start. Furthermore, they provided unresponsive answers to discovery requests seeking to avoid addressing the underlying claims in the lawsuit necessitating EDCR 2..34 conferences and their supplementation of a large number of discovery responses. At every turn and opportunity, Plaintiffs stonewalled providing materials and information supportive of their claims while placing CHH in the position of having to incur massive expenses to obtain that to which it was legally entitled and seek dismissal of what Plaintiffs clearly knew was an untenable claim. The Plaintiffs' failure to accept CHH's Offer of Judgment was both in bad faith and grossly unreasonable.

E. Costs and Fees Sought By CHH Are Both Reasonable and Justified

In what has to be the most ridiculous, baseless and nonsensical argument yet, Plaintiffs' counsel stated in opposition that "it is Defendant [sic] continued filing of Motions based upon the same theory that Plaintiffs did not file their lawsuit within the prescribed statute of limitations that drove up Defendant's fees." So, to boil it down to its simplest "logic", because CHH pursued its rights, filed a motion for summary judgment based upon statute of limitations which should have been granted as the Supreme Court noted, and because Plaintiffs filed an untimely lawsuit, it is CHH's fault that Plaintiffs' counsel pursued an untenable case.

What drove up costs from the first dollar was the filing of an untimely lawsuit. The fact that Plaintiffs were allowed to get away with it for so long underscores the need for costs and fees to be imposed. Plaintiffs drove up the costs and fees here by initiating the lawsuit and then, when unrebutted evidence of their counsel's practice failures was plainly evident and presented for all to see, Plaintiffs' counsel chose to press forward with an unwinnable case. As this Court is aware, Plaintiffs are not without a remedy here. If Plaintiffs engaged their counsel prior to the expiration of the statute of limitations, it was a clear breach of the standard of care to have not timely filed the lawsuit. The issue if the lawsuit's timeliness has already been fully adjudicated. Plaintiffs' counsel already admitted in their opposition to this motion that they had a completely viable case against CHH if not for that darn statute of limitations. Thus, we have judicial determination of a breach in the standard of care, depending upon when Plaintiffs' counsel was engaged, and an admission by said counsel as to the viability of Plaintiffs' underlying case. Plaintiffs may then pursue a legal malpractice case against Mr. Padda's office, and since he so firmly believes that just because Ms.

Powell died, Plaintiffs are entitled to something, he can feel free to pay them.

An analysis of the *Beattie* factors shows that an award of attorneys' fees to CHH from the time of the Offer of Judgment served on Plaintiffs to the present is warranted and appropriate.

F. Amount of Fees Incurred

When awarding fees in the offer of judgment context under N.R.C.P. 68 and N.R.S. 17.115 [currently N.R.S. 17.117], the district court must also consider the reasonableness of the fees pursuant to *Brunzell v. Golden Gate National Bank,* 85 Nev. 345, 455 P.2d 31 (1969). *Id.* When determining the amount of attorneys' fees to award, the District Court has wide discretion, to be '"tempered only by reason and fairness"' *Shuette v. Beazer Homes*, 121 Nev. 837, 864 (2005).[8] If the district court's exercise of discretion is neither arbitrary nor capricious, it will not be disturbed on appeal. *Schouweiler,* 101 Nev. at 833.

"In determining the amount of fees to award, the [district] court is not limited to one specific approach; its analysis may begin with any method rationally designed to calculate a reasonable amount, so long as the requested amount is reviewed in light of the . . . *Brunzell* factors." *See Haley v. Eighth Judicial Dist. Court*, 128 Nev. 171 (2012); *see also, Gunderson v. D.R. Horton, Inc*., 319 P.3d 606, 615-616, 130 Nev. Adv. Rep. 9 (2014).

The following four *Brunzell* factors are to be considered by the court:

> (1) the qualities of the advocate: ability, training, education, experience, professional standing and skill;
>
> (2) the character of the work to be done: its difficulty, its intricacy, its importance, time and skill required, the responsibility imposed and the prominence and character of the parties where they affect the importance of the litigation;
>
> (3) the work actually performed by the lawyer: the skill, time and attention given to the work;
>
> (4) the result: whether the attorney was successful and what benefits were derived.

Brunzell v. Golden Gate, at 349-50.

[8] Reasonable attorneys' fees also include fees for paralegal and non-attorney staff "whose labor contributes to the work product for which an attorney bills her client." *See Las Vegas Metro. Police Dep't v. Yeghiazarian,* 312 P.3d 503, 510 (Nev. 2013).

From August 28, 2020 to present, the attorneys' fees incurred by CHH are as follows:

Partner Adam Garth	405.6 hours	$91,260.00
Partner Brent Vogel	39.8 hours	$ 8,955.00
Associate Heather Armantrout	33.1 hours	$ 6,404.85
Paralegal Arielle Atkinson	46.9 hours	$ 4,221.00
Paralegal Joshua Daor	0.1 hours	$ 90.00
	Total	**$110,930.85**

Plaintiffs provide not one shred of evidence of justification in opposition to the instant motion to demonstrate that the fees associated herewith are not in line with what is charged in the community, and the fact that the hourly rates are even below average. A consideration of the *Brunzell* factors shows that the recovery of the entire billed amount of feels from August 28, 2020, to present is entirely appropriate.

G. Award of Pre-NRCP Rule 68 Offer of Judgment Costs and Fees Pursuant to NRS 7.085

Despite Plaintiffs' counsel's entreaties to the contrary, this case was not brought in good faith for all of the reasons articulated hereinabove and in CHH's motion in chief. Plaintiffs had no viable case from the inception. It was not even close. Moreover, all of the evidence concerning the timing issues in this case fell squarely within the exclusive possession of Plaintiffs, not CHH. They knew when they requested the medical records and received them. They knew what they allegedly witnessed at the hospital. They knew they went to Probate Court for the express purpose of obtaining Ms. Powell's medical records. They knew they pursued two State agency inquiries into the allegations of malpractice they requested be undertaken. Through their lawyer only, without interposing anything during the pendency of the motions, they feign ignorance of the State agency investigations when it comes to commencing the statute of limitations clock, but then collectively utilize the results of those investigations to prosecute the lawsuit on behalf of all Plaintiffs, not just the Estate. In other words, Plaintiffs want to selectively apply what works for them, but eliminate what injures their case when it comes time to pay up. They cannot have it both ways. The law was clearly made out that possession of the entirety of the medical records provides inquiry notice.

Plaintiffs' report to the State agencies alleging the very malpractice they allege in this case is another. Moreover, Plaintiffs claimed to be bystanders during Ms. Powell's rapid deterioration at the time of the alleged incident. Each of these alone provided the requisite inquiry notice and all of the rules associated with the respective conditions for such notice were firmly established. Unfortunately for Plaintiffs, they hired a lawyer who failed to either know or follow them and have now been subjected to costs and fees.

NRS § 7.085 defines the very behavior exhibited by Plaintiffs' counsel in this case. There could not have been a more textbook example of inquiry notice than what existed in this case, but still Plaintiffs' counsel persisted in not only lying about the facts, but **failed to interpose any evidence opposing the irrefutable evidence of inquiry notice provided by CHH.** How much more egregious can such conduct be? Plaintiffs' counsel even has the audacity to accuse our firm of unethical conduct in calling them out for their lies, misrepresentations and professional incompetence.

As NRS 7.085 states within its terms, courts are mandated to hold parties and their counsel accountable and to liberally construe the facts ibn favor of the prevailing party who demonstrates the impropriety of litigation pursued without legal basis for doing so. As noted by a sister Department, "NRS 7.085 essentially provides, where an attorney violates NRS 18.010(2), NRCP 11 or EDCR 7.60, the delinquent lawyer may be required to personally pay the additional costs, expenses and/or attorney's fees in all appropriate situations. Notably, as shown above, NRS 18.010(2)(b), EDCR 7.60 and NRS 7.085 do not require Defendants to be "prevailing parties" and attorneys' fees may be awarded without regard to the recovery sought." *Berberich v. S. Highland Cmty. Ass'n*, 2019 Nev. Dist. LEXIS 130, *11 (Nev. Dist. Ct., Case No. A-16-731824-C, January 29, 2019).

Hereinabove and in CHH's motion in chief, CHH provided a long documented recitation of case law and facts which specifically and directly contradict anything and everything advanced by Plaintiffs' counsel in this matter. Plaintiffs' counsel did everything he could to force CHH to incur expenses. He filed a case well beyond the statute of limitations, despite clear case law demonstrating when inquiry notice commences. He was faced with two motions on the issue and misrepresented

the facts. He provided not one shred of evidence to support his personal theories about confusion, refusing and unable to produce any supporting evidence. He provided no support for a suggestion of fraudulent concealment, and opposed any motions for a stay of proceedings while the statute of limitations issue made its way through the appellate system. In short, Plaintiffs' counsel advanced a case which was dead on arrival. He knew it, was reminded of it, and pursued it anyway, hoping for a judicial lifeline. The Supreme Court made certain to cover all possible avenues for Plaintiffs' counsel's attempt to scurry away from his late and improper case filing. Adding insult to injury, he did everything he could to increase expenses. Elections have consequences. Those consequences are sanctions under NRS 7.085 which include the $58,514.36 in pre-NRCP 68 offer fees and expenses incurred from the commencement of this litigation. Based upon Plaintiffs counsel's violation of the two prongs of NRS 7.085, the Supreme Court has determined:

> The language of NRS 7.085 is straightforward. Subsection 1 of NRS 7.085 provides **that district courts "shall" hold attorneys** "personally" liable for "additional costs, expenses and attorney's fees" under certain circumstances. **If the statutory conditions are met, "the court shall" impose a sanction of taxable fees and costs "reasonably incurred because of such conduct**." *Id* With respect to "such conduct," the statute requires no more than what it states: in relevant part, that "a court find[] that an attorney has" (i) "[brought or] maintained ... a civil action" that (ii) either (a) "is not well-grounded in fact," (b) "is not warranted by existing law," or (c) "is not warranted ... by a[] [good faith] argument for changing the existing law." See NRS 7.085(1)(a). Subsection 2 requires Nevada courts to "liberally construe" subsection 1 "in favor of awarding costs, expenses and attorney's fees in all appropriate situations." NRS 7.085(2) (emphasis added).

Washington v. AA Primo Builders, Ltd. Liab. Co., 440 P.3d 49 (Nev. 2019) (Emphasis supplied). "The statutes are clear—parties who bring and maintain an action without grounds shall have attorney fees imposed against them." *Lopez v. Corral*, Nos. 51541, 51972, 2010 Nev. LEXIS 69, at *24, 2010 WL 5541115 (Dec. 20, 2010).

There is no clearer case for the imposition of attorney's fees than this one. Plaintiffs' case was entirely frivolous as it was knowingly filed beyond the statute of limitations. Even if it was not known from the outset, which the evidence clearly demonstrated that it was, it became abundantly clear that the Plaintiffs themselves not only suspected, but actually accused CHH of malpractice and sought investigations by the State into their allegations. Plaintiffs supplied the very evidence damning their own assertions of "confusion" which make Plaintiffs' counsel's advancement thereof

all the more egregious.

Thus, in addition to all NRCP Rule 68 post offer fees and costs, CHH requests that sanctions be imposed against Plaintiffs' counsel for all pre-NRCP Rule 68 costs and fees totaling $58,514.36 in accordance with NRS 7.085.

H. EDCR 7.60 Authorizes the Imposition of Fines, Costs, and/or Attorneys' Fees Due to an Attorney's Presentation of Frivolous Opposition to a Motion or Who Multiplies the Proceeding in a Case to Increase Costs

Again, in opposition to CHH's instant motion, Plaintiffs' counsel decided to take the "best defense is a good offense" approach to this section's relief. The only problem is that the offense is far from good. Plaintiffs' counsel states that fees increased for two reasons: (1) CHH filed multiple motions pertaining to dismissal, summary judgment and for stays, forcing Plaintiffs to respond, and (2) CHH propounded extensive discovery in an effort to ascertain the theory of liability and causation associated with Plaintiffs' untenable claim, as well as additional supporting documentation of Plaintiffs' inquiry notice which Plaintiffs' provided during the pendency of the motion for summary judgment, to wit, Plaintiffs' State agency complaints.

So what is Plaintiffs' counsel really saying – Plaintiffs could file a lawsuit where the statute of limitations expired 8 months before, and CHH was not permitted to ascertain any discovery to contradict that, and was not permitted to obtain Plaintiffs' substantiation for their underlying claims. Plaintiffs' assertion in this regard is not only meritless, it is the most foolish argument they made in this case, and that is really saying something. The better perspective, and the one by which the statutes require the matter be viewed, is that had Plaintiffs' counsel properly ascertained the state of the law, they would have recognized their lawsuit was filed too late. Once they were advised of it on multiple occasions, they were given the opportunity to extricate themselves for no costs but instead, they doubled down and then lost their entire case. Bringing an untenable lawsuit from the beginning is what caused Plaintiffs' to be in this position, not anything CHH did.

Plaintiffs' counsel commenced and maintained a completely unsustainable action from the beginning. They knowingly possessed the full medical file. They went to court to obtain an authorization to get the medical file. They never denied receiving the medicals, and in fact, utilized the medicals they did receive to obtain a medical affidavit for use with the Complaint. They

knowingly possessed multiple complaints to State agencies alleging malpractice against CHH and requesting formal investigations thereof. Then, for purposes of the motion for summary judgment, Plaintiffs' counsel feigned confusion on his client's behalf as to decedent's cause of death (a fact which none of the Plaintiffs confirmed in any sworn statement or testimony). After creating chaos for no reason, when given the opportunity to prevent CHH from incurring further costs, Plaintiffs' counsel opposed any request for a stay of proceedings, three times in this case, requiring the continued discovery process, expert evaluations and export reporting. They refused to agree to postpone the trial date to allow this matter to make its way through the Supreme Court, with knowledge that the Court would be ruling one way or another on this case dispositive issue. In all, Plaintiffs' counsel knowingly caused enormous costs on CHH only to have the very issues raised in this Court result in a total dismissal. CHH should not be required to pay for Plaintiffs' folly, especially when Plaintiffs' counsel purposely looked to increase expenses while pursuing a defunct case from the outset. Thus, EDCR 7.60 provides a further avenue of deterrence to attorneys, like Plaintiffs' counsel, who engage in these unnecessary and flagrantly frivolous lawsuits which are dead before they are even filed, justifying an award of **$110,930.85** in attorneys' fees per N.R.C.P. 68 and N.R.S.§§ 17.117, plus **$58,514.36** in pre-NRCP 68 offer fees and expenses pursuant to N.R.S.§§ 7.085, 18.010(2) and EDCR 7.60.

I. CHH Is Also Entitled to Its Fees and Costs Per NRS 18.010(2)

Likewise, CHH is entitled to an award of his attorney's fees and costs under NRS §18.010(2)(b) and Plaintiffs' opposition is unavailing in this regard. It has been determined by this State's highest Court that Plaintiffs possessed inquiry notice as late as June, 2017, merely a month after Ms. Powell's death, but by their own admissions as to their contemporaneous observance of events, as early as the time of her death on May 11, 2017. In other words, the Supreme Court already determined that Plaintiffs' case was groundless because it was filed too late. Anything else is immaterial. Plaintiffs' counsel made the foolhardy move to file a lawsuit 8 months beyond the latest date to do so, failed to support any motion by CHH with any evidentiary support for their fallacious and concocted theories, and now claim that they either did not commence, or even more egregiously continued to maintain a knowingly untenable claim in light of the overwhelming and

uncontroverted evidence submitted by CHH. they had a fair chance to back out gracefully but thumbed their nose at it and are now crying that it is unfair to hold them accountable. That is precisely what the Legislature did by enacting this statute – hold lawyers like Plaintiffs' counsel accountable for untenable lawsuits and the creation of increased costs to attempt to strongarm a defendant into a settlement. Plaintiffs' plan failed miserably and now is time to pay the piper.

For the reasons discussed above, CHH respectfully requests an award of attorney's fees and costs that it incurred in this matter, and enter an order awarding **$110,930.85** in attorneys' fees per N.R.C.P. 68 and N.R.S.§§ 17.117, plus **$58,514.36** in pre-NRCP 68 offer fees and expenses pursuant to N.R.S.§§ 7.085, 18.010(2) and EDCR 7.60.

III. CONCLUSION

Based upon the legal authority and reasons stated above, Defendants respectfully request the Court grant their Motion and award them **$110,930.85** in attorneys' fees per N.R.C.P. 68 and N.R.S.§§ 17.117, plus **$58,514.36** in pre-NRCP 68 offer fees and expenses pursuant to N.R.S.§§ 7.085, 18.010(2) and EDCR 7.60.

DATED this 2nd day of February, 2022.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ *Adam Garth*

S. BRENT VOGEL
Nevada Bar No. 006858
ADAM GARTH
Nevada Bar No. 15045
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Tel. 702.893.3383
Attorneys for Attorneys for Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center

CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of February, 2022, a true and correct copy of **DEFENDANT VALLEY HEALTH SYSTEM, LLC DBA CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S REPLY IN FURTHER SUPPORT OF MOTION FOR ATTORNEYS' FEES PURSUANT TO N.R.C.P. 68, N.R.S. §§ 17.117, 7.085, 18.010(2), AND EDCR 7.60** was served by electronically filing with the Clerk of the Court using the Odyssey E-File & Serve system and serving all parties with an email-address on record, who have agreed to receive electronic service in this action.

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By /s/ *Heidi Brown*
An Employee of
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EXHIBIT D

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DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually;, Plaintiffs, vs. VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z;, Defendants.	Case No. A-19-788787-C Dept. No. 30 **DEFENDANT VALLEY HEALTH SYSTEM, LLC DBA CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S INITIAL EXPERT DISCLOSURE**

Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center, by and through their attorneys of record, S. Brent Vogel and Adam Garth of Lewis Brisbois Bisgaard & Smith, LLP, hereby discloses the following expert witness, pursuant to NRCP 16.1 as follows:

. . .

. . .

. . .

1. Hiren Shah, M.D.
2730 North Dayton Street
Chicago, Illinois 60614

Dr. Hiren Shah is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, standard of care, causation, medical treatment, prognosis, and costs of medical expenses. Dr. Shah has been board certified in Internal Medicine in Chicago, Illinois since 2002. He is medical staff in the Department of Internal Medicine at Northwestern Memorial Hospital currently. **Exhibit A** hereto is Dr. Shah's *Curriculum Vitae.* **Exhibit B** hereto is Dr. Shah's testimony list. **Exhibit C** hereto is Dr. Shah's fee schedule. **Exhibit D** hereto is Dr. Shah's initial expert report.

Dr. Shah is expected to testify, *inter alia*, that the care and treatment provided to Rebecca Powell was within the applicable standard of care, consistent with his Report, and will further testify the acts of Centennial Hills Hospital Medical Center did not cause the damages alleged by Plaintiffs. Dr. Shah is also expected to provide opinions regarding the facts in this case as they relate to his medical specialties, which may include but are not limited to rebuttal testimony. Dr. Shah reserves the right to supplement and/or revise his Report as new information is provided.

2. Abraham M. Ishaaya, M.D., F.C.C.P., F.A.A.S.M., F.A.C.G.S., M.A.C.G.S.
5901 West Olympic Boulevard, Suite 200
Los Angeles, CA 90036

Dr. Abraham Ishaaya is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, standard of care, causation, medical treatment, prognosis, and costs of medical expenses. Dr. Ishaaya is board certified on The American Board of Internal Medicine, Pulmonary Medicine, Sleep Medicine, and Geriatrics. Dr. Ishaaya has been an expert witness since 2003. He is currently a assistant clinical professor at UCLA School of Medicine.

Exhibit E hereto is Dr. Ishaaya's *Curriculum Vitae.* **Exhibit F** hereto is Dr. Ishaaya's fee schedule. **Exhibit G** hereto is Dr. Ishaaya' s trial appearances and depositions list. **Exhibit H** hereto is Dr. Ishaaya's initial expert report.

Dr. Ishaaya is expected to testify, *inter alia*, that the care and treatment provided to Rebecca Powell was within the applicable standard of care, consistent with his Report, and will

further testify the of Centennial Hills Hospital Medical Center did not cause the damages alleged by Plaintiffs. Dr. Ishaaya is also expected to provide opinions regarding the facts in this case as they relate to his medical specialties, which may include but are not limited to rebuttal testimony. Dr. Ishaaya reserves the right to supplement and/or revise his Report as new information is provided.

3. Richard Ruffalo, M.D., Pharm.D., M.A., F.A.C.C.P.
   11 Sea Shell
   Newport Coast, California 92657

Dr. Ruffalo is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, standard of care, causation, medical treatment, prognosis, and the pharmacology. Dr. Ruffalo is in fellowship with American College of Clinical Pharmacology as well as an affiliate since 1987. Since 1986, he has been a member of Alpha Omega Alpha, National Medical Honor Society. **Exhibit I** hereto is Dr. Ruffalo's s *Curriculum Vitae.* **Exhibit J** hereto is Dr. Ruffalo's s fee schedule. **Exhibit K** hereto is Dr. Ruffalo's initial expert report.

Dr. Ruffalo is expected to testify, *inter alia*, that the care and treatment provided to Rebecca Powell was within the applicable standard of care, consistent with his Report, and will further testify the of Centennial Hills Hospital Medical Center did not cause the damages alleged by Plaintiffs. Dr. Ruffalo is also expected to provide opinions regarding the facts in this case as they relate to his medical specialties, which may include but are not limited to rebuttal testimony. Dr. Ruffalo reserves the right to supplement and/or revise her Report as new information is provided.

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. . .

Defendant specifically reserves the right to designate any witnesses designated by any party. Defendant further reserves the right to supplement this list as any witnesses become known through the course of discovery.

DATED this 18th day of June, 2021.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ *Adam Garth*

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Attorneys for Attorneys for Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center

CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of June, 2021, a true and correct copy of **DEFENDANT VALLEY HEALTH SYSTEM, LLC DBA CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S INITIAL EXPERT DISCLOSURE** was served by electronically filing with the Clerk of the Court using the Odyssey E-File & Serve system and serving all parties with an email-address on record, who have agreed to receive electronic service in this action.

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By /s/ *Roya Rokni*
An Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

Exhibit A

Exhibit A

HIREN SHAH, M.D.
2730 N. Dayton Street
Chicago, Illinois 60614
(312) 330-4096 / hshah@nmh.org

EDUCATION

2000 - 2002 **KELLOGG SCHOOL OF MANAGEMENT** Evanston, IL
NORTHWESTERN UNIVERSITY
Master of Business Administration degree, June 2002
- Majors in healthcare management, economics, and management strategy

1992 – 1996 **DREXEL UNIVERSITY SCHOOL OF MEDICINE** Philadelphia, PA
Doctor of Medicine, June 1996

1987 - 1992 **UNIVERSITY OF PENNSYLVANIA, Philadelphia, PA**
Bachelor of Arts in neuroscience, June 1992

GRADUATE MEDICAL EDUCATION

1999 **UNIVERSITY OF PENNYSLVANIA MEDICAL CENTER** Philadelphia, PA
Fellow, Quality and Disease Management / Fellow, DoctorQuality, Inc.

THOMAS JEFFERSON UNIVERSITY HOSPITAL Philadelphia, PA
1997-1999 ***Resident, Department of Internal Medicine***
1996-1997 ***Intern, Department of Internal Medicine***

PROFESSIONAL EXPERIENCE- Administrative Appointments

NORTHWESTERN MEMORIAL HOSPITAL Chicago, IL
2008-2016 ***Medical Director***
20010-2012 ***Director, Clinical Affairs, Division of Hospital Medicine***
2004-2007 ***Associate Director, Divi ion of Hospital Medicine***

PROFESSIONAL EXPERIENCE- Faculty Appointments

NORTHWESTERN UNIVERSITY, F EINBERG SCHOOL OF MEDICINE Chicago, IL
2007-present ***Assistant Professor of Medicine***
2002-2007 ***Clinical Instructor of Medicine***

PROFESSIONAL EXPERIENCE- Hospital Appointments

2002-present **NORTHWESTERN MEMORIAL HOSPITAL** Chicago, IL
Medical Staff, Department of Internal Medicine

2000 **PERMANENTE MEDICAL GROUP** Vallejo, CA
Associate Physician

BOARD CERTIFICATION AND MEDICAL LICENSURE

2002-present	State of Illinois (036107424)
2000-2002	State of California (A70699) - inactive
1999-2000	State of Pennsylvania (MD-068814-L) – inactive
1999	Diplomat, American Board of Internal Medicine

COMMITTEE MEMBERSHIP

2008-present	Medical Peer Review Committee
2007-present	Strategic Planning Committee, Division of Hospital Medicine
2007-present	Productivity and Billing Committee, Division ofHospital Medicine
2007-present	Feinberg School of Medicine, Clinical Competency Committee
2007-present	Patient Care Committee
2007-present	Department of Medicine Quality Committee-Sitter Utilization
2006-present	Department of Medicine Quality Management Committee
2006-present	Pharmacy and Therapeutics, Medication Safety Subcommittee
2006-present	Executive Utilization Management Committee
2006-present	Utilization Management, Department ofMedicine Subcommittee
2005	Hospitalist Budget Committee, Chair
2004-2005	Medical Records Committee
2004-2005	Timely Comfort Care Orders Committee, Clinical Sponsor
2004-2006	Physician Clinical Information Systems LeadershipCommittee
2004-2005	Congestive Heart Failure Leadership Committee
2004-2006	Pneumonia Project Leadership Committee, Clinical Sponsorand Member
2003-2004	Computer Physician Order Entry Committee
2004	Hospitalist/Attending Service Reform WorkingGroup
2003	Hospitalist Attending Service Operations Committee
2002	Healthcare Biotechnology Conference Committee, Northwestern University
2001	Business of Healthcare Conference Committee, Northwestern University
2001	Student Health Insurance Reform Committee and Working Group, NorthwesternUniversity

TEACHING EXPERIENCE

2006-present	Medical Decision Making, Conference Leader
2005-present	Organization and Economics of Medicine, Lead Lecturer and Course Teacher
2005	Patient, Physician and Society, Physical Exam Skills, Conference Leader
2003, 2004	Organization and Economics of Medicine, Conference Leader
2003-present	Northwestern Service Ward Attending, Resident and Medical Student Clinical Teaching
2003-present	Medicine Consult Service Attending, Department of Internal Medicine
2002-2003	Patient, Physician and Society, Physical Exam Skills, Conference Leader

PROFESSIONAL AND SCIENTIFIC SERVICE

2009	Senior Fellow, Society of Hospital Medicine
2008-present	Chapter Support Committee, Society of Hospital Medicine
2008	Research and Abstract Judge, Society of Hospital Medicine Annual Meeting
2007-present	Journal of Hospital Medicine
2006-present	Journal Reviewer- Journal of General Internal Medicine
2005	Innovations in Medical Education Abstract Review Committee, Society of General InternalMedicine

HONORS AND AWARDS

2012	Partner in Care, Leadership in Observation Unit, Northwestern Memorial Hospital
2011	Excellence in Quality Improvement, Best Project, Northwestern Memorial Hospital
2008	Outstanding Reviewer Award, Journal of Hospital Medicine

2006	Best Resident Teacher Award, Section of Hospital Medicine 2004
	Best Resident Teacher Award, Section of Hospital Medicine 2002
	Dean's List, Kellogg School of Management
1987	Miriam P. Webb Memorial Scholarship, University of Pennsylvania

SCHOLARLY BIBLIOGRAPHY

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Shah H, Masica A, Chun E, Jaffer A. Hospital-Based Quality Improvement in Stroke Prevention for Patients with Non-Valvular Atrial Fibrillation, Society of Hospital Medicine. Philadelphia.

RESEARCH ACTIVITY

2007-2008	Blue Cross and Blue Shield of Illinois, Technology Assessment Center, Research Associate.
1990-1992	University of Pennsylvania, research fellow Department of Environmental and Pulmonary Medicine, Supervisor, Sheldon Fienstein, MD, PHD Genetic Cloning research of pulmonary surfactant gene "A Portion of the Surfactant SP-A Gene Consists of a Pseudogene" presented at annual research symposium, January 1992
1998-1999	Thomas Jefferson University Hospital, research fellow Office of Health Policy and Clinical Outcomes, Supervisor, David Nash, MD, MBA Examined collaboration between Academic Medical Centers, HMOs, and Pharmaceutical Industry in clinical outcomes studies, 1998-1999

PRESENTATIONS- available upon request

PROFESSIONAL AND SCIENTIFIC ACTIVITY
Society of Hospital Medicine, Senior Fellow
Board of Internal Medicine, Diplomat

Exhibit B

Exhibit B

Northwestern Memorial® Hospital

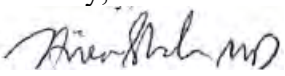
Division of Hospital Medicine
Hiren M. Shah, MD SFHM
Chicago, Illinois 60611
Phone: 312.926.3681

December 15, 2019

Please find below a list of cases in which I have provided trial testimony as a medical expert.

1. New Hampshire- testimony on behalf of plaintiff- Guyer vs NH Medical Center
2. Ohio- testimony on behalf of plaintiff- West vs Hawley
3. Indiana- testimony on behalf of plaintiff- Hammer vs Adams
4. IL- Cook county- testimony on behalf of defense- Paula Chibe vs Manzar
5. Ohio- testimony on behalf of plaintiff- Rodney Pugh vs Mercy Health/St. Joseph's Hospital
6. New York- testimony on behalf of plaintiff- Inguitti vs Strong Memorial Hospital
7. Michigan- testimony on behalf of plaintiff- Baker vs. Goldfaden
8. Illinois- testimony on behalf of defense- Sandoval vs Advocate
9. Illinois- testimony on behalf of defense- Mertins vs. Northwest Community Hospital
10. Illinois- testimony on behalf of defense- Altiveros vs Advocate
11. Illinois- testimony on behalf of defense- Winters vs St. Alexius Medical Center
12. Maryland- testimony on behalf of the plaintiff- Walsh vs Kim
13. Nevada- testimony on behalf of the defense- Center vs Rives
14. Nevada- testimony on behalf of the defense- Chicarelli vs North Vista
15. Florida- testimony on behalf of plaintiff- Brown vs Orlando Health

Sincerely,



Hiren Shah, MD SFHM

Exhibit C

Exhibit C

Hiren Shah, M.D., MBA

Fee Schedule 2021

$475/hr to review records, and for discussions and consultations
$600/hr for deposition testimony (3hr min)
$6000/day for out of town trial testimony

Exhibit D

Exhibit D

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June 5, 2021

Adam Garth
6385 South Rainbow Blvd., Suite 600
Las Vegas, NV 89118

Dear Adam:

Thank you for the opportunity to review the case of Ms. Rebecca Powell and her admission to Centennial Hills Hospital on 5/03/2017. I am a physician licensed and currently practicing medicine in the State of Illinois. In 1999, I became board certified in Internal Medicine and have maintained my board certification. I am an Assistant Professor of Medicine at the Feinberg School of Medicine at Northwestern University and have been a practicing internist and hospitalist for over 15 years during which time I have managed the evaluation, workup, and treatment of hospitalized medical patients. I routinely evaluate and admit patients who have respiratory infections, pneumonia, and agitation and who require antibiotic and airway clearance treatments. I also coordinate care with consultants such as pulmonologists and infectious disease physicians in patients with acute and chronic infections. Thus, I am familiar with the standard of care in the evaluation and treatment of patients who have conditions similar to Ms. Powell, whose case I have reviewed in this report. In the preceding five years, I spent more than 95% of my professional time in the clinical practice of medicine in each year.

My background has also included numerous leadership positions at Northwestern, including Associate Director of Hospital Medicine, Director of Clinical Affairs and Medical Director at Northwestern Memorial Hospital. In these capacities, I have had supervisory oversight for the care and treatment provided by our hospitalist group of over 80 physicians to patients similar to Ms. Powell and can speak to the acceptable standard of care issues as well as causation in this case. Please find attached a CV which further provides my experience and qualifications.

I have reviewed the following to provide a basis of my opinions:
1) Medical records from the admission to Centennial Hills Hospital on 5/3/2017(CHH00001-01166);
2) Complaint with affidavit;
3) Records from plaintiff's disclosure including autopsy findings; and
4) Centennial Hills Hospital policy and records including event reporting and health care peer review, patient rights and responsibilities, policy sentinel events, and rapid response teams.

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Case Summary:

5/3/2017

Ms. Powell was a 41-year-old female who was found unresponsive at her home in the early morning hours of 5/3/2017. She was found lying in vomit and reportedly had ingested an overdose amount of Ambien and Cymbalta, which was suspected given empty bottles found by her bedside. Upon arrival by EMS, she was in distress and was intubated in the field. EMS brought her to Centennial Hills Hospital Medical Center after she was stabilized. She was seen in the emergency room by Dr. Suresh Rodil and Dr. Kevin Hyer. An emergency room history and physical was entered at 3:13 AM on 5/3/2017. It indicated that there was concern for possible aspiration and there was hypotension upon arrival to the emergency room. There were no visible signs of trauma. Vitals included heart rate 102, and blood pressure 89/52. Ms. Powell was placed on a ventilator upon arrival. She was acidotic with a pH of 7.251 on an arterial blood gas done at 3:38 AM. WBC count was 9.36 and creatinine was elevated at 1.07. After multiple doses of IV fluids, her blood pressure improved. She was then admitted to the intensive care unit and the admitting hospitalist was notified. The emergency room note was signed by Suresh Rodil at 5:44 AM.

A history and physical was performed by hospitalist physician Dr. Trent Richardson who documented a note at 5:59 AM. He indicated that the patient had acute respiratory failure from an apparent intentional drug overdose. He documented that Ms. Powell's daughter lived with her and had seen her at about 8:00 or 9:00 PM taking doses of Benadryl. Throughout the evening, she was monitored by her daughter and became progressively less responsive. Dr. Richardson confirmed there was nonbloody emesis, and bottles of Ambien and Cymbalta that had been recently filled were found empty by the bedside. He indicated the patient had acute respiratory failure and polysubstance overdose with altered mental status.

CT brain without contrast showed no acute abnormality. Chest x-ray showed clear lungs. Right upper quadrant ultrasound showed only gallstones. Pulmonary and critical care was consulted at 21:45.

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Dr. Christopher Breeden from pulmonary and critical care medicine documented an admission consultation at 21:45. He further supported the history that was documented by the emergency room doctor and the hospitalist. He indicated that Mrs. Powell's daughter had checked on her mother at 2:30 AM and found her with emesis in her bed in an unresponsive state. The last witnessed normal was at approximately 10:00 PM the night prior. Dr. Breeden felt the patient's respiratory secretions were consistent with aspiration. Antibiotics were started to treat for aspiration pneumonia. Dr. Breeden's diagnosis was drug ingestion with suicidal intent requiring intubation.

5/4/2017

The hospitalist the following day, Dr. Dionice Juliano, documented a note at 11:12 AM. He indicated that due to agitation, Ms. Powell required a lot of sedation on ventilation. Arterial blood gas showed an improved pH of 7.28 relative to that at admission. He indicated that there was ongoing encephalopathy that was toxic and metabolic in nature due to an unintentional drug overdose. Suspected drugs were Benadryl, Ambien, Cymbalta, and alcohol. There was concern for aspiration pneumonia with the patient being treated on IV ceftriaxone. Urine drug screens and serum toxicology screens were ordered.

Dr. Christopher Breeden documented a note the next day at 13:49. He indicated the patient was sedated and intubated and was having gastric-looking contents from the endotracheal tube the night prior. Chest x-ray that day showed an appearance of an infiltrate on the left. There was suggestion of significant airway secretions. Given the gastric contents in the ET tube and a new infiltrate on a chest x-ray, a bronchoscopy was ordered to evaluate for infection. One dose of vancomycin was given and ceftriaxone was continued. Tube feeds were provided through an oral gastric tube.

Dr. Breeden performed a fiberoptic bronchoscopy and bronchoalveolar lavage. There were significant mucosal purulent appearing secretions noted. Corticosteroids were added given the degree of secretions and Zosyn was planned in addition to vancomycin.

5/5/2017

Dr. Juliano documented a note at 11:35 AM. He noted the bronchoscopy findings. Given the secretions on bronchoscopy, the diagnosis of aspiration pneumonia was further supported. Cultures from the bronchoalveolar lavage were to be followed. ABG showed an improving pH at 7.33. At 18:44, Dr. Breeden documented a progress note. He documented that there were still

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ongoing secretions from the ET tube and felt the secretions were consistent with aspiration. He continued corticosteroids and antibiotics.

5/6/2017

Dr. Juliano indicated that Ms. Powell was extubated that morning. She was still drowsy. The plan was to continue her current care and to downgrade her out of the ICU if she remained stable. Dr. Breeden documented a note at 16:00. After removing from the patient from the ventilator, Ms. Powell was placed on CPAP and tolerated this well. He indicated that vancomycin and Rocephin were to be continued for aspiration given her secretions and given the findings on bronchoscopy. Steroids were to begin a taper in dose. He suggested downgrading out of the ICU if a bed was needed.

5/7/2017

Dr. Juliano documented a note at 09:38 AM and wrote that a swallow evaluation was successful with a plan to advance her diet as tolerated. Vancomycin and ceftriaxone were continuing. He wrote to downgrade Ms. Powell's care to medicine telemetry.

A speech therapy assessment was performed by Tiffany Vetter at 11:20 AM that indicated Ms. Powell completed an evaluation without any signs of aspiration.

Dr. Gary Skankey from infectious diseases documented a note at 15:38 for an initial consultation. He indicated that the WBC count had begun to increase. Ms. Powell was feeling a little short of breath but better than the day prior. There was minimal cough. His diagnosis was aspiration pneumonia due to MRSA. He recommended continuing vancomycin and to discontinue the Rocephin.

5/8/2017

Ms. Powell was seen by Dr. Skankey on follow up who documented a note at 14:57. He reported Ms. Powell was still a little short of breath. He reported the bronchioloalveolar lavage cultures as showing moderate growth of methicillin-resistant Staphylococcus aureus (MRSA). He recommended continuing vancomycin. A chest x-ray was ordered for the following day.

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Dr. Breeden documented a note at 22:01. He reported that Ms. Powell had some cough and reported feeling swollen. WBC count had decreased to 12.31 from 12.52 the day prior. On 5/6/2017, the WBC count was normal at 9.45. He recommended continuing antibiotics per infectious disease. He also suggested providing diuretic medications to remove fluid.

5/9/2017

Speech therapy evaluated the patient and nurse Joyce Arenas documented at 14:00 that Ms. Powell was cleared to have regular foods.

Ms. Powell was seen by hospitalist, Dr. Vishal Shah, who documented a note at 14:05. He wrote the patient denied any shortness of breath. The patient denied any suicidal ideation at the time. She admitted to taking Ambien the night of her admission. WBC count increased to 13.35 from 12.31 the day prior. His diagnosis was respiratory failure requiring intubation due to MRSA aspiration pneumonia. The plan was to await psychiatric placement.

Dr. Skankey from infectious disease documented a note at 16:33 and wrote that she was improving from MRSA aspiration pneumonia. White blood cells were slowly rising which he felt was due to prior doses of steroids which were being tapered. His plan was to change vancomycin to oral bactrim for 7 more days.

Dr. Breeden documented a note at 17:47 and noted less cough. He recommended continuing the plan of care as outlined previously.

5/10/2017

At 2:00 AM, nurse Bernadine Rebogio documented that Ms. Powell had coughing which was nonproductive. She was short of breath and 2 L of oxygen was placed. Breathing treatments were provided. At 7:00 AM, nurse Nicholas Muir accepted care and noted the patient had complaints of shortness of breath at that time.

At 11:35, Ms. Powell underwent a physical therapy session with Shannon Roling. She indicated that Ms. Powell was exhibiting very shallow and more labored breathing compared to her prior evaluation. Saturations remained in the 90s on 3 L of oxygen. After ambulating 10 feet, she required very long seated rest breaks and had pursed lip breathing. She had significantly decreased oxygen tolerance.

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Dr. Vishal Shah documented a note at 13:16 and indicated that Ms. Powell had no new complaints, and her shortness of breath was better. He remained unsure if the WBC elevations were due to steroids. Ms. Powell's room air oxygenation was 93%. The patient was awaiting oxygen arrangements and for physical therapy clearance prior to possible psychiatry transfer.

At 16:00, nurse Nicholas Muir documented that Ms. Powell was complaining of increased labored breathing and felt like she was drowning. Breathing treatments were ordered and Ativan for anxiety was given by Dr. Shah with no improvement. When Dr. Shah was called, he ordered a stat arterial blood gas and a Chest x-ray.

Respiratory therapy evaluation at 16:31 indicated that there was respiratory distress in the radiology department at the time of the Xray and a rapid response team was activated but Ms. Powell was found to be stable with an oxygen saturation of 98% on 6 liters by nasal canula and had a respiratory rate of 28. The chest x-ray showed bilateral interstitial infiltrates.

In the patient's discharge summary, Dr. Shah documented these events. He documented that earlier that day, the patient had worsening leukocytosis and her bactrim was changed to Zyvox and cefepime and repeat cultures were ordered. Dr. Shah then documented that he was called by the RN at 5:00 PM stating the patient was short of breath. He ordered a stat chest x-ray and an ABG. He advised the nurse to follow-up with the pulmonary doctors for further orders, which was done. A rapid response was also called while the patient was at chest x-ray. Ms. Powell's vital signs were stable including oxygenation. Dr. Shah then noted that the patient was seen by infectious disease and pulmonary medicine after the chest x-ray and a CT angiography of the chest was ordered by the ID doctor.

An arterial blood gas was drawn at 16:32 and indicated a pH of 7.37 with a PO2 oxygen level of 89 on 6 liters of supplemental oxygen given by nasal cannula.

Medication administration records indicate that a 0.5 mg dose of Ativan was given at 16:01 as ordered by Dr. Vishal Shah at 15:54. The dose was administered by nurse Nicholas Muir.

Dr. Skankey then documented a note at 17:05. He noted the patient had extreme shortness of breath and was complaining of a dry feeling in her mouth, her throat, and her lungs. She was unable to cough the respiratory secretions that were present. WBC count had now risen up to 23.14. On 6 L of oxygen, he indicated an ABG showed a PO2 of 89. He noted a chest x-ray that

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day showed prominent bilateral interstitial infiltrates. Dr. Skankey felt that it was necessary to discontinue the bactrim and to start oral Zyvox and IV cefepime given the increase in WBC count and worsening clinical condition. He was concerned about possible sepsis and documented this. He ordered a CT angiography of the chest and wrote to order blood cultures.

Dr. Breeden documented a note at 17:12 indicating that the patient had shortness of breath and that a rapid response was called when the patient was down at chest x-ray. Ms. Powell was then sitting up still having shortness of breath and some cough at the time of Dr. Breeden's evaluation. He wrote to resume steroids every 8 hours. He started low-dose theophylline. He supported the order of a CT angiography of the chest as suggested by Dr. Skankey.

Nurse Michael Pawlak indicated in the note that Ms. Powell had shortness of breath during movement between the bed and the bedside commode which began as early as the start of his 7:00 AM shift. Ms. Powell responded to as needed breathing treatments. He documented that a stat CTA of the chest was ordered at 2:00 AM.

RT evaluation at 22:22 noted a saturation of 92% on 3 liters supplemental oxygen. Vital signs 23:52 indicated a heart rate of 100 and respiratory rate of 22 at the time of nebulizer therapy at 23:52.

5/11/17

Vital signs at 00:10 indicated a heart rate of 101 and a respiratory rate of 20. Ms. Powell was still on 3L of oxygen saturating at 95%.

According to nurse Pawlak's note, as needed Ativan that was ordered in her profile was given at a dose of 0.5 mg dose at 2:20 AM. The patient was then transported to CT scan at 2:30 AM. At approximately 2:40 AM, the CT scanner staff called nurse Pawlak and indicated that the patient could not complete the test due to shortness of breath and anxiety and was returned back to her room. Charge nurse Karen Valdez was then called to assist in assessing the patient.

Nurse Pawlak's note also indicated that Nurse Valdez evaluated Ms. Powell who reported shortness of breath and that the first dose of Ativan was not effective. A page was made to night hospitalist Dr. Coronado Concio to discuss the patient's complaints. She spoke to nurse Valdez and ordered an additional dose of 0.25 mg of Ativan. This was administered by nurse Valdez at 3:27 AM. This second dose of Ativan appeared to be effective in calming Ms. Powell.

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At 3:15 AM, nurse Karen Valdez documented her own version of events. She indicated in her own note that she saw the patient with the primary nurse, RN Pawlak. Ms. Powell was very anxious and was having shortness of breath. Respiratory therapy was notified to evaluate Ms. Powell. Dr. Concio was paged again and ordered an additional dose of Ativan to help the patient relax. The dose was 0.25 mg IV push. The respiratory therapist named Vanessa Mower indicated that Ms. Powell was pulling her oxygen off. It was decided to place Ms. Powell in wrist restraints. Patient did seem to improve. There was a conversation with the camera operator John about visualizing the patient closely.

Respiratory therapist Mower indicated that to facilitate oxygen delivery a face mask was used at approximately 3:00 AM since it was difficult for Ms. Powell to keep her nasal canula in place. Ms. Powell's oxygen saturation was 90% at the time of RT evaluation at 4:08am.

Nurse Pawlak's note indicated that Ms. Powell was more calm and her breathing appeared less labored at approximately 4:15 AM.

A pain assessment at 4:00 AM by nurse Michael Pawlak indicated a score of 0 with no pain. It was reported that a CNA found Ms. Powell to be "ok" at 5:00 AM and was in no distress. Video monitoring every 15 minutes was ongoing and showed nothing out of the ordinary.

Medical administration records confirm that the 0.25 mg Ativan dose was given at 2:23 AM. Another dose of Ativan was given at 3:27 AM and Ms. Powell was reevaluated at 3:42 AM where the dose was found to be effective. She received acetylcysteine nebulizer therapy at 4:18 AM, ipratropium nebulizer at 4:18 AM and Xopenex nebulizer treatment at 4:18 AM.

Vital signs at 4:08 AM and at 4:18am indicated a heart rate of 130 and a respiratory rate of 30 and at 4:47 AM indicated a heart rate of 140 and a respiratory rate of 30.

At 6:10 AM, the patient was found sitting in her bed and unresponsive with the oxygen mask at her feet. Chest compressions, bag ventilation and code blue were initiated at that time.

L2K patient video observation record indicates that John Lotito was monitoring the patient and that Ms. Powell last appeared to be sitting in close to an upright position with fingers possibly in her mouth for approximately 1 hour prior to the code blue event at 6:10 AM. There was no documentation of respiratory distress or any difficulty. Documentation in the L2K flowsheet

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indicates that she was last seen at 6:00 AM by Mr. Lotito. This form was reviewed by charge nurse Karen Valdez who signed the document at 07:10.

Dr. Coronado Concio, the night hospitalist, documented that she was paged to attend a code blue and upon her arrival, Dr. Blumberg indicated that the code had begun around 6:15 AM when the patient was found unresponsive on her bed. Dr. Blumberg intubated the patient upon her arrival and was able to suction a thick mucus plug from her throat. Upon Dr. Concio's arrival at 06:45, the patient had already received 11 units of epinephrine, 3 doses of bicarbonate and maximum doses of a dopamine drip. She had asystole at the start of the code and subsequently PEA. Dr. Concio continued the code blue at the request of Dr. Blumberg. She continued resuscitation for an additional 15 more minutes, but Ms. Powell remained in PEA arrest. After 45 minutes of resuscitation without any improvement, a decision was made to discontinue further care after no signs of pulses were palpated. Time of death was documented at 6:57 AM.

Dr. Vishal documented a discharge summary dated 5/20/2017 at 19:00. He reviewed the clinical course in his note and indicated that he was notified by the night physician that a code event was called early that morning with an unsuccessful resuscitation. He had a face-to-face discussion with the family including Ms. Powell's daughter, husband, son, and a friend. He indicated that the cause of death was cardiopulmonary arrest with an unknown cause at that time.

Standard of care opinions:

Ms. Rebecca Powell was a 41-year-old female who was admitted after suspected ingestion of medications such as Ambien and Cymbalta leading to respiratory failure and unresponsiveness requiring intubation in the field by emergency medical services. After arrival to Centennial Hills hospital, she had evidence of aspiration given oropharyngeal secretions and a rising WBC count along with worsened radiographic findings of pneumonia as noted by the pulmonary physician. Bronchoscopy confirmed the presence of significant secretions within the airways with cultures consistent with MRSA which supported the diagnosis of MRSA aspiration pneumonia. As noted above in the extensive case summary, there was some clinical improvement from the time of her admission on 5/3/2017 supporting extubation on 5/6/2017. There was further clinical improvement until 5/8/2017 when she began to have a rising WBC count. Documentation indicates that it was suspected that this WBC elevation may be due to steroids which were also given, but her subsequent clinical course suggested otherwise. Beginning in the early morning of 5/10/2017 at early as 2:00 AM, her clinical course was consistent with progression of her respiratory infection supported by a history indicating worsening shortness of breath and respiratory difficulty. Her

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WBC had increased significantly to 13.35 on 5/9/2017 and it went further up to 23.14 on 5/10/2017. This level of rise in the WBC was not consistent with steroid effect and given the increased respiratory symptoms, supported a progression of infection. Her worsening shortness of breath was documented on 5/10/2017 by both by pulmonary medicine and infectious disease physician who were concerned with the progression of her pulmonary infection.

On 5/10/2017, Dr. Skankey, the infectious disease physician, was concerned for possible sepsis and documented the need to transition back from oral antibiotics to IV antibiotics. He indicated Ms. Powell had extreme shortness of breath and needed CT imaging to better evaluate the progression of this infection. An x-ray on 5/9/2017 showed ongoing infiltrates. The rapid response team evaluation in the chest x-ray department supported the need for assessment of this change in her respiratory function.

Physical therapy assessment on 5/10/2017 earlier in the day also indicated a markedly different level of performance relative to the prior evaluation. The physical therapist noted that Ms. Powell was short of breath, had pursed lips, and had significantly decreased exercise tolerance. She required long rests in between any activity. Nurse Muir indicated that Ms. Powell had difficulty with movement from bed to commode with more difficulty breathing.

When Dr. Vishal Shah was called about worsening shortness of breath, he appropriately directed the nurse to the infectious disease and pulmonary doctors for further management. He ordered an arterial blood gas that showed Ms. Powell had a significantly decreased oxygen requirement having an oxygen PO2 of only 89 despite being on 6 L of oxygen. This represented difficulty oxygenating due to worsening secretions and airway difficulty. It was within the acceptable standard of care for Dr. Shah to address the patient's anxiety with a small dose of Ativan that had no meaningful effect in causing any respiratory suppression as further hyperventilation due to anxiety would lead to a worsening condition. There is no evidence that this dose of Ativan led to worsening respiratory depression given the preservation of Ms. Powell’s respiratory rate with no evidence of a drop in her respiratory drive to suggest drug-induced suppression. In fact, she remained agitated. Dr. Shah met the acceptable standard of care in the evaluation, and management of Ms. Powell, and nothing that he did or failed to do contributed to her subsequent respiratory failure.

Throughout the night, Ms. Powell had worsening shortness of breath and respiratory difficulty which required nebulizer therapy including an evaluation by the respiratory therapist at 4:00 AM. This event further supports worsening secretions and a need for better respiratory clearance

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strategies. Given Ms. Powell's level of anxiety, the 2 doses of Ativan that she received as ordered by Dr. Concio were appropriate and within the standard of care to address these anxiety symptoms. These doses of Ativan had no effect in decreasing her respiratory drive or causing the subsequent respiratory arrest that occurred at 6:10 AM. Vital signs indicate respiratory rates at 4:08 AM, 4:18 AM and 4:47 AM to be 30. If one hypothesizes that Ativan had a respiratory suppressant effect, there would be an immediate decrease in respiratory drive which there is no evidence of in Ms. Powell's situation. In fact, the respiratory rates of 30 represent a significant increase from her baseline levels of 18-20 and supports that her pathophysiology was advancing and worsening secretions rather than any sedative effect from Ativan. Given the pharmacology of IV Ativan, if there was a sedative effect, this would have been immediately apparent after the dose was given which did not occur after either dose of Ativan.

In addition, Ms. Powell was appropriately monitored on the floor and had multiple contact points by care providers prior to her code blue event at 6:10 AM. A pain assessment was done at 4:00 AM. A respiratory treatment was done at 4:10 AM. Vital signs were obtained at 4:08 AM, 4:18 AM, and 4:47 AM. The patient was evaluated both by the floor nurse and the charge nurse during those early morning hours. Nurse Pawlak indicates that the patient was evaluated at 4:15 AM. A CNA saw Ms. Powell at 5:00 AM. At none of these evaluations, was Ms. Powell in a condition that indicated distress or the need for escalation of care. In addition, L2K patient frequency observation records indicate that Ms. Powell was monitored by video device. She was seen as late as 6:00 AM as documented on the L2K flowsheet by John Lotito. There is no evidence that Ms. Powell had removed her face mask. The face mask was placed by the respiratory therapist for ease of oxygen administration rather than for distress or the need to provide more oxygen than a nasal canula can provide. Ms. Powell's saturations were affected by her agitation and cooperation and remained mostly above 92% and often as high as 95%. At no time were oxygen saturations at a level that indicated distress or transfer to another floor.

In fact, the code blue event occurred just 10 minutes after the last documented visualization by video monitoring which showed nothing out of the ordinary. Although it may have been difficult to see a nasal canula on the monitor, a face mask would be more visible. In any event, there is no evidence that it was not in place for any prolonged period of time. In addition, the standard of care did not require a one-to-one sitter in the room given the adequacy of video monitoring and the patient's condition which was stable but worsening lung infection due to secretions rather than respiratory distress or collapse. Thus, although she had a worsening respiratory infection, there is no evidence that she was in respiratory distress requiring transfer to a higher level of care or the intensive care unit.

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Contrary to the plaintiff expert's opinion, there is no evidence that the dose of Ativan given by Dr. Shah or the two doses given by Dr. Concio had any contribution to respiratory depression or the code blue event. There is ample evidence that Ms. Powell maintained a strong and adequate respiratory effort based on her vital signs and respiratory rate which was as high as 30. In addition, if there was any sedation, it would have been immediate given the method of Ativan deliver was intravenous which is rapidly acting. Thus, Ms. Powell exhibited no sedation or a decrease in respiratory drive as IV Ativan would be expected to provide immediately visible adverse effects. Her agitation and lack of cooperation at the CT scan further supports the fact that the Ativan given 20 minutes earlier did not have a respiratory depressant effect.

The plaintiff's expert affidavit also claims that Ms. Powell had six sedating drugs on her medication list. There is no evidence that any of the agents referenced had a meaningful effect on Ms. Powell's level of alertness or that there was an interaction between any of these drugs and Ativan to cause sedation. Furthermore, the opinion that acetylcysteine, a cough medicine or a drug used with nebulizers, caused sedation in Ms. Powell's' case in not supported by any evidence.

The standard of care did not require a chest x-ray in the early hours after it was determined that Ms. Powell could not cooperate with the CT scan due to shortness of breath. Obtaining a chest x-ray would not have any meaningful effect on the outcome in this case. Ms. Powell was already receiving antibiotics for a known respiratory infection. She was also receiving frequent nebulizer therapy for airway clearance. It was also quite evident from the above events that the indication for imaging was not to obtain and report results to determine pulmonary involvement as indicated in the plaintiff expert's affidavit as it was clear that worsening secretions were ongoing as the cause of Ms. Powell's symptoms. A chest x-ray would not change the medical plan or alter Ms. Powell's management in any way.

A documentation of a differential diagnosis is not required by the standard of care especially if the care provided adhered to the acceptable standard. There is no evidence to support the opinion that the possibility of medication side effects was required as documentation given the clinical course does not support any medication-induced sedation. In addition, the standard of care did not require each of the three physicians outlined in the plaintiff expert's affidavit to evaluate the patient's administered medications.

Transfer to a higher level of care was not required based on Ms. Powell's condition. Although she had a worsening respiratory infection, she was not unstable and did not require any higher level of

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treatment or monitoring. A rapid response team even if activated at the time of the respiratory treatment at 04:10 AM would not have provided any additional care as Ms. Powell responded to the nebulizer therapy and was comfortable as indicated by the assessments subsequently. Ms. Powell's tachycardia as documented in the early morning hours around 4:00 AM was likely due to the recent nebulizer therapy, which can lead to an elevated heart rate. There is no indication that Ms. Powell was in respiratory distress or that the tachycardia was evidence of such. In addition, cardiac monitoring was not required as the IV Ativan was not leading to any cardiac depression. Ms. Powell had no known cardiac disease and rather had a worsening but stable respiratory condition that did not require monitoring on telemetry. Although, Ms. Powell had a documented respiratory rate of 30 at 4:18 and 4:37 AM, this was not sustained as she was subsequently more comfortable as documented by nurse Pawlak and charge nurse Valdez. She was not seen in any distress on the video monitor or at the time of the CNA rounds that occurred at 5:00 AM or during the multiple healthcare provider encounters mentioned above. Her elevated respiratory rates were related to anxiety and agitation and not due to hypoxia as her saturations remained in a range that were appropriately managed by supplemental oxygen.

Ms. Powell's autopsy record indicates a pathologic diagnosis of acute and chronic pneumonia and foreign body giant cells along with pulmonary edema. In addition, both lungs show marked and extensive consolidation of both upper and lower lobes. The lower trachea and major bronchi revealed marked congestion and apparent infection. Microscopic exam also supports acute on chronic inflammation in the lungs.

Thus, as supported by the clinical course and the autopsy findings above, Ms. Powell's most likely cause of death was worsening pneumonia complicated by with acute mucus plugging that led to respiratory failure at 06:10am. Given the extent of her secretions, as documented at the start of her hospital course and their recurrence in the early morning of 5/10/17, along with Dr. Concio's note indicating that Dr. Blumberg had removed a thick mucus plug at the time of the resuscitation, the most likely cause of her respiratory arrest was the large mucus plug that occluded her airway. Vital signs and pulse oximetry reading ranged mostly in the 92 to 98% range on supplemental oxygen, indicating no distress or instability. When Ms. Powell was placed on a face mask with higher flow oxygen, it was to support better oxygen delivery given her hyperventilation and high respiratory rates due to agitation and anxiety rather than due to acute respiratory decompensation as is incorrectly postulated and not supported in the plaintiff's expert affidavit. In fact, although Ms. Powell had worsening pneumonia symptoms due to secretions, she was hemodynamically and otherwise stable such that she did not require transfer to a higher level of care. In addition, as noted above, her tachycardia was likely nebulizer related and also possibly due to agitation and her

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respiratory rates that were recorded as high as 30 were due to hyperventilation due to agitation. An RRT even if called at the time of these vitals were taken would not have led to any additional management. In fact, Ms. Powell's agitation improved, and she was comfortable by the time of the nurse Pawlak's reassessment at 04:15 and the CNA rounds at 05:00. There is no evidence that Ms. Powell had removed her mask or was in any distress that would have required closer monitoring. In addition, at no time did the standard of care require the presence of a sitter despite this been suggested by some hospital staff in this case.

Ms. Powell was also never diagnosed with an anxiety disorder but was rather treated appropriately and within the standard of care of anxiety symptoms. The plaintiff's affidavit states that the code blue event occurred within 90 minutes of the administration of Ativan, which is incorrect. The last dose of Ativan given was at 3:27 AM with the code occurring at 6:10 AM which was 2 hours and 43 minutes later. This gap of time does not support a causal link between the two events given the rapid onset of action of IV Ativan. As noted above, there is no evidence of respiratory suppression from the doses of Ativan that were given based on the respiratory rate and the clinical symptoms and course.

There is no evidence that the care provided by Dr. Dionice had any impact of the clinical course or events of 5/10/17 or the code event. In addition, the standard of care did not require Drs. Dionice, Concio, and Shah to review Ms. Powell's medication list and to document drug side effects or interactions as there was no meaningful effect of Ms. Powell's medications on her clinical status or subsequent course. There is no evidence that medications were the cause of her symptoms or her health status. Finally, the findings of the Department of Health and Human Services provide no evidence that the issues noted had any bearing of Ms. Powell's clinical outcome, which would have been the same regardless of their occurrence.

In summary, the cause of Ms. Powell's death was an acute mucus plug that led to sudden respiratory failure at 6:10 AM on top of superimposed bilateral pneumonia. She had ongoing secretions clinically, progression of lower airway congestion, and bilateral pneumonia at autopsy and was noted to have the removal of a large mucus plug at the time of her code event, which represent the basis of this opinion. Although she had progression of her pneumonia and significant secretions prior to the code blue, there is no indication that she was unstable and required transfer to a different level of care or required additional monitoring. Her increased respiratory rate further supports that she had no sedative effect for respiratory depression from the Ativan or by any other drug that was given by any of the physicians in this case. Her tachycardia was the result of the nebulizer treatment she had received and due to agitation and not due to any form of distress that

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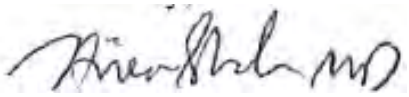
required any action that was not taken in this case. Nothing that the providers did or failed to do resulted in Ms. Powell's code blue and subsequent death.

All my opinions noted above are stated to a reasonable degree of medical probability. Please do not hesitate to contact me should you have any further questions.

Sincerely,



Hiren Shah, MD SFHM

Exhibit E

Exhibit E

CURRICULUM VITAE

ABRAHAM (AVI) M. ISHAAYA, M.D., F.C.C.P.,F.A.A.S.M., F.A.C.G.S., M.A.C.G.S.

ASSISTANT CLINICAL PROFESSOR, UCLA SCHOOL OF MEDICINE

BUSINESS ADDRESS:

5901 W. Olympic Blvd.
Suite 200
Los Angeles, CA 90036
Tel. (323) 954-1788 Fax (323) 954-1822

PERSONAL INFORMATION:

Citizenship: U.S.A.
Languages: English, Hebrew, Russian, Spanish

BOARD CERTIFICATION:

1994 The American Board of Internal Medicine
1996 The American Board of Pulmonary Medicine
1997 The American Board of Sleep Medicine
2006 The American Board of Geriatrics

APPOINTMENTS:

1996-97	Assistant Director, Cedars-Sinai Medical Center Sleep Disorders Center
1996-98	Clinical Instructor, UCLA School of Medicine
1998-Present	Assistant Clinical Professor, UCLA School of Medicine
1998-Present	Fellow, College of Chest Physicians
1998-present	Fellow, American Academy of Sleep Physicians
1999-2001	Director, Century City Hospital Sleep Lab
1999-2003	Director, Brotman Medical Center Sleep Lab
2000-2002	Clinical Chief, Pulmonary Division Brotman Medical Center
1999-2002	Medical Director, Country Villa South Nursing Home
2009-2010	
2001-2003	Director, Pulmonary Rehabilitation Unit, Midway Hospital
2002-2009	Medical Director, Country Villa Cheviot
2002-2006	Medical Director, Los Angeles region, Sleepmed of California
2002-2006	Member, Utilization Review Department, New Vista Nursing Home
2002-2010	Member, Utilization Review Department, Country Villa Wilshire
2002-Present	Director, Respiratory Therapy, Midway/Olympia Hospital
2005-Present	Director, Western Convalescent, Subacute Department
2006-2011	Medical Director, New Vista nursing home
2006	Fellow, American Board of Geriatric Specialists
2006-2011	Medical Director, ICU Brotman Hospital
2007-2014	Corporate Medical Director, Country Villa Health System
2007	Master of the American College of Geriatrics Specialsts
2007-2009	Medical Director, Take Off Bariatric Program
2009-11	Director, Wound and Risk Management, Olympia Medical Center
2008-present	Certified, Hyperbaric Oxygen Therapy
2009-present	Maximus Federal Services Medical Consultant
2010-2011	Medical Director, Shangri La Hospice
2012-present	Chief of Medicine, Miracle Mile Medical Center
2012-present	Medical Director, Concorde School
2012-present	Chief of Medicine, Miracle Mile Medical Center
2014-present	Medical Director, Marina Pointe- Subacute

APPOINTMENTS (continued):

2014-2016 Medical Director, Southern California Hospital, Culver City, Readmission
2016-present Medical Director, Southern California Hospital, Culver City, Respiratory therapy Department

COMMITTEES:

1996-2000 Member, Pharmacy and Therapeutics, Brotman Medical Center
1996-2004 Member, Peer Review Committee, Century City Hospital
2000-2002 Member, Peer Review Committee, Pulmonary Division, Cedars Sinai
2000-2003 Member, Medicine Working Committee, Brotman Medical Center
2000-present Member, Pulmonary and Infection Diseases performance and Improvement Committee, Cedars-Sinai Medical Center
2002-2003 Member, Medical Executive Committee, Brotman Hospital
2002-2007 Member, Medicine Working Committee, Olympia Medical Center
2007- 2010 Member, Peer Review committee, Brotman Hospital

EDUCATION:

1986-1990 University of Maryland Medical School
Baltimore, Maryland
Degree: M.D.
1983-1986 University of California, Los Angeles
Los Angeles, California
Degree: B.S. Psychology/Biology, Cum Laude

POST-GRADUATE TRAINING:

1993-1996 Fellow, Pulmonary & Critical Care
Cedars-Sinai Medical Center, Los Angeles, California
1990-1993 Resident, Internal Medicine
Cedars-Sinai Medical Center, Los Angeles, California

AWARDS & HONORS:

1992 Young Investigators Award
Southern California Pulmonary Research Conference
1993 Paul Rubenstein Award
Excellence in Original Research
Cedars-Sinai Medical Center
1991 Excellence in Research Award, Soloman Scholar
1992 Paul Rubenstein Award
Excellence in Original Research
Cedars-Sinai Medical Center

MEMBERSHIP IN MEDICAL SOCIETIES:

2007-present American Medical Association
2006 American Society of Bariatric Medicine
1993-Present American College of Chest Physicians
1993-Present American Thoracic Society
1997-Present American Sleep Disorders Association
1993-1999 American Israeli Medical Society

ABSTRACTS:

Ishaaya, AM, Nathan SN, Koerner SK, Belman MJ. Accuracy of work of breathing prediction with pressure support ventilation during weaning. ARRD 1992; 145:A518

Ishaaya AAM, Nathan SN, Belman MJ. Work of breathing in the immediate post extubation period. ARRD 1993; 147:A875.

PUBLICATIONS:

Ishaaya AM, Nathan SN, Belman MJ. Work of breathing after extubation. Chest 1995,107: 204-209.

Ishaaya, AM, Nathan SN, Koerner SK, Belman MJ. Prediction of pressure support during weaning from mechanical ventilation. Chest 1993; 103: 1215-1219.

TEACHING:

Academic Year 1996-1997

Sleep Disorders Clinic, fellow teaching (12 months)
Pulmonary Consult Team, fellow and resident teaching (one month)
Pulmonary Clinic, fellow and resident teaching (one month)
Medicine Ward Team, resident and student teaching (one month)

Academic Years 1997-1998, 1998-1999, 1999-2000, 2000-2001, and 2001-2002

Sleep Clinic, fellow teaching (part of a team of sleep medicine specialists, teaching throughout the year).
Pulmonary Consult Team, fellow and resident teaching (one month)
Pulmonary Clinic, fellow and resident teaching (one month)
Medicine Ward Team (one month)

TEACHING Continue:

Academic Years 2003-present

Pulmonary Consult Team, fellow and resident teaching
Pulmonary Clinic, fellow and resident teaching

EXPERT WITNESS:

2003-Present Provide expert witness services including review of records, deposition and court testimony. Testified in both plaintiff and defense.

Exhibit F

Exhibit F

Abraham Ishaaya, M.D., F.C.C.P.
5901 West Olympic Blvd. #200
Los Angeles, CA 90036

MEDICAL LEGAL FEE SCHEDULE – EXPERT WITNESS

Record review, report preparation, conferences, travel	$550.00 / hour
Deposition (Two hours minimum)	$1,000.00 / hour
Appearance as witness (Trial or arbitration)	
Half day	$5,500.00
Full day	$8,500.00

Retainer of $2,000.00 waved.

Full fee will be charged if cancellation occurs less than 48 hours prior to scheduled proceedings.

Sincerely,

Abraham M. Ishaaya M.D., F.C.C.P.
President, Abraham M Ishaaya M.D., A Professional Corporation
Tax ID 30-0004319

Please sign to indicate your agreement to these fees.

_____
Case name

_____ _____
Signature Date

Exhibit G

Exhibit G

TRIAL APPEARANCES/DEPOSITIONS (since 2015)

TRIAL APPEARANCES:

1. United States vs.Villabroza et al. 2016 (defense)
2. Perona vs. Time Warner 2016 (defense)
3. Martinez vs. Avalon 2017 (defense) (Tucson, Arizona)
4. Higgins et al. v. Providence Little Company of Mary Medical Center San Pedro et al. 2017 (defense)
5. People vs. Najee A've 2017 (defense)
6. Haroutunyan v. HPMC, et al 2017 (defense)
7. Kinsella vs. Kaiser 2018 (plaintiff)

DEPOSITIONS:

1. Beatrice Raya v. TRA PAC 2015 (plaintiff)
2. Daniels v. Allstate 2015 (plaintiff)
3. Carlson v. Gaidry 2015 (defense)
4. Villagrana v. Glendale et al 2015 (plaintiff)
5. Taylor v. LCC of South Mountain 2015 (defense)
6. Perona v. TWC 2016 (defense)
7. Guillermina Pulido v County of Orange 2016(plaintiff)
8. Fouche v. Cola et al. 2016 (plaintiff)
9. Smith v. City of LA 2016 (defense)
10. Stickler vs. Optum 2016 (defense)
11. Gomez v. Garcia 2016 (plaintiff)
12. Johnson v. Life Care 2017 (defense)
13. Martinez v. Avalon 2017 (defense)
14. Harmon v. Avalon 2017 (defense)
15. Higgins v. Little Co of Mary 2017 (defense)
16. Keltner v. Magnolia 2017 (defense)
17. Avalon v. Sudarich 2017 (defense)
18. Haroutunyan v. HPMC, et al 2017 (defense)
19. Evans v. Lakshimapathy et al 2018 (defense)
20. Kinsella v. Kaiser 2018 (plaintiff)
21. Millitech v. Shiekha et al 2018 (plaintiff)
22. Lubormiski vs PBAL-BB et al 2018 (defense)
23. Gomez v. Ports of America 2018 (plaintiff)
24. Clark v. First Student 2019 (plaintiff)
25. Dorel vs. MMMC et al 2019 (defense)
26. Lewis, Miletta v. Corizon Health, 2019 (defense)
27. Kudelka vs Specialty hospitals 2020 (defense)

Exhibit H

Exhibit H

I have undertaken an analysis of the above case and formulated opinions based upon my knowledge, experience and training with a reasonable degree of medical certainty regarding the care and treatment provided to Rebecca Powell while she was a patient at Centennial Hills Hospital in Las Vegas, Nevada in May, 2017, on behalf of Centennial Hills Hospital and its employees. To that end, I have reviewed the following medical records and documents in forming my opinions regarding the care and treatment rendered to Rebecca Powell:

1. Complaint with Medical Affidavit;

2. Centennial Hills Hospital records (CHH00001-01166);

3. Rebecca Powell Death Certificate;

4. Affidavit of Death of Rebecca Powell;

5. Clark County Coroner Report of Investigation;

6. Nevada State Board of Nursing Coworker Complaint Report dated June 11, 2017;

7. Letter from DHHS and Complaint Process Fact Sheet to Brian Powell dated May 23, 2017; and

8. Letter and Report from DHHS to Brian Powell dated February 5, 2018;

I am currently director of Western Convalescent Subacute Department, chief of medicine at Miracle Mile Medical Center and currently DOCS surgical hospital, and Medical Director of the Respiratory Department at Southern California Hospital in Culver City, CA. Until recently, I was the director of respiratory therapy at Midway/Olympia Hospital in Los Angeles, CA which shut its doors. I obtained my medical degree from University of Maryland Medical School in 1990. I completed my residency in Internal Medicine at Cedars-Sinai Medical Center in Los Angeles from 1990-1993, followed by a fellowship in pulmonary and critical care medicine at Cedars-Sinai from 1993-1996. I am quadruple boarded in Internal Medicine, Pulmonary Medicine, Sleep Medicine and Geriatrics. I also hold the title of Assistant Clinical Professor of Medicine at the UCLA School of Medicine. A copy of my curriculum vitae outlining my qualifications, educational background and related employment is attached hereto as Exhibit "A".

All the opinions I have formed and express herein are made to a reasonable degree of medical probability.

Rebecca Powell was a 41-year-old female admitted to the hospital with acute respiratory failure due to an apparent drug overdose after being found at home unconscious with labored breathing and vomitus material. Patient was confirmed to have had a prior suicide attempt by her husband, requiring a psychiatric admission. Patient was intubated on arrival to the hospital on May 3, 2017. The initial toxicology screen was negative. She was admitted with an apparent overdose believed to be due to Ambien and Cymbalta. Poison control was notified on admission. Patient was admitted to the ICU where she was also followed by pulmonary and critical care. Infectious disease was also consulted for a diagnosis of aspiration pneumonia. Chest imaging was consistent with bilateral infiltrates. ECG was consistent with sinus tachycardia and a right bundle branch block. Patient was eventually extubated on May 6, 2017. She underwent a bronchoscopy on May 4. Sputum cultures later grew MRSA.

Ms. Powell was subsequently downgraded to floor care. She was showing some improvement on May 10, although chest imaging was notable for bilateral infiltrates and labs for an elevated WBC at 23. She was later seen by Dr. Skankey on May 10 at 1706 and was described as extremely short of breath and was placed on IV Zyvox and Cefepime with repeat cultures ordered. A CT angiogram was as well ordered.

On May 10, at 311PM, Patient was noted to be in bed with complaint of shortness of breath and fatigue, but otherwise no complaint. It was described that camera was on for patient safety, as patient was on a legal hold. On or about 5 PM on May 10, 2017, Ms. Powell was noted to be short of breath and breathing treatments including a stat chest x-ray and arterial blood gas were ordered, by Dr. Shah. The chest x-ray showed no significant new changes with persistence of the bilateral infiltrates. Arterial gas results were performed and were called to the pulmonologist, who documented the findings in his note on May 10.

Patient underwent a rapid response at approximately at 421PM and was placed on 6 liters nasal cannula oxygen. She was seen by the pulmonologist, Dr. Breeden, after the rapid response on May 10, with a note opened at 1715 and electronically signed at 2209, with impression of secretions compatible with aspiration, increased