Reversed and Rendered in Part, Reversed and Remanded in Part, and Memorandum Opinion filed May 16, 2017.

In The

Fourteenth Court of Appeals

NO. 14-16-00792-CV

COURTYARD SNF, LLC D/B/A COURTYARD CONVALESCENT CENTER, Appellant

V.

CHLOE ROBINSON, INDIVIDUALLY AND AS P/O/A FOR OTIS ROBINSON, A DISABLED INDIVIDUAL, LUCY ROBINSON AND DYKE ROBINSON AND AS P/O/A FOR OTIS ROBINSON A DISABLED INDIVIDUAL, Appellees

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On Appeal from the 234th District Court
Harris County, Texas
Trial Court Cause No. 2015-51389

M E M O R A N D U M O P I N I O N

In this health-care liability case, Courtyard SNF, LLC d/b/a Courtyard Convalescent Center appeals the denial of its motion to dismiss the claims against it due to the inadequacy of the original and amended expert reports. Courtyard

contends the expert report served by appellees Chloe Robinson, individually and as P/O/A for Otis Robinson, Lucy Robinson and Dyke Robinson (collectively the "Robinson Parties") was insufficient as it fails to provide a fair summary of the (1) applicable standard of care, (2) manner in which Courtyard failed to meet the standard of care, and (3) causal relationship between Courtyard's failure and the injury. We agree that the expert report falls short of the statutory standards on the issues of breach and causation. We therefore reverse the trial court's order denying the motion to dismiss, render judgment dismissing the Robinson Parties' claims against Courtyard, and remand this case to the trial court with instructions to assess and award Courtyard its reasonable attorney's fees and costs incurred.

I. FACTUAL AND PROCEDURAL BACKGROUND

Otis Robinson suffered a serious stroke rendering him unable to verbally communicate and dependent on others for care. Courtyard admitted him for skilled nursing care. Prior to his admission, Otis Robinson was diagnosed with a subarachnoid hemorrhage (a brain bleed), a persistent vegetative state, pressure ulcers (commonly known as a bed sore), urinary tract infection, acute respiratory failure, tracheostomy, gastrostomy, hypertension, diabetes type II, and hypercholesterolemia. Otis Robinson developed gangrene in both feet as a result of pressure ulcers on his heels in 2014. As a result of the infection, both of his legs were amputated above the knee.

The Robinson Parties brought a medical negligence claim against Courtyard, Advanced Health Care Solutions, 7499 Stanwick Drive LLC, Teddy Lichtschein, Eliezer Scheiner, Khoa Don Nguyen, M.D., Houston Family Physicians, P.A., LQVC Management, Inc., Northland Surgical, P.A., and Huynh Nguyen

Investments, LLC on August 31, 2015.[1] The Robinson Parties alleged Courtyard and the other defendants failed to treat, monitor, and maintain the condition of the pressure ulcers which resulted in severe pain and ultimately, the amputation of both legs. The Robinson Parties filed and served an expert report by Dr. Lige B. Rushing, Jr. on the defendants pursuant to section 74.351 of the Texas Civil Practice and Remedies Code.[2]

Dr. Rushing opined the standard of care required Courtyard to (1) provide the level of care, treatment, and supervision that a reasonably prudent similar facility would provide under the same or similar circumstances; (2) ensure a resident who enters the facility without pressure sores does not develop pressure sores unless unavoidable and provide necessary treatment and services to promote healing and prevent infection of existing pressure sores and prevent new sores from developing; (3) maintain clinical records in accordance with accepted professional standards; (4) neither accept nor retain a resident whose needs the facility could not meet; and (5) implement a pressure ulcer prevention program. Dr. Rushing further opined that Courtyard did not meet these standards of care by (1) failing to appropriately treat or increase or change treatment levels to combat the pressure ulcers; (2) failing to maintain complete, accurate, and systematically organized records; (3) retaining Otis Robinson as a patient even though it was abundantly clear that his pressure ulcers were getting progressively worse; and (4) failing to document Otis Robinson's wounds. Dr. Rushing concluded that if

[1] The Robinson Parties non-suited Teddy Lichtschein, Eliezer Scheiner, LQVC Management, Inc., Northland Surgical, P.A., and Huynh Nguyen Investments, LLC.

[2] Dr. Nguyen and Houston Family Physicians challenged the sufficiency of Dr. Rushing's original report and the trial court granted the Robinson Parties a 30-day extension to provide a supplemental expert report. The Robinson Parties served Dr. Rushing's supplemental report on the defendants. The supplemental report is the subject of Courtyard's motion to dismiss and appeal.

Courtyard and its medical personnel had not breached the standard of care, Otis Robinson would not have suffered the infection, gangrene, and eventual amputation of his legs.

Courtyard moved to dismiss the Robinson Parties' claims against it in the trial court under section 74.351(b).[3] The trial court denied the motion to dismiss.[4] This interlocutory appeal followed.

II. STANDARD OF REVIEW

When reviewing the trial court's ruling on a challenge to an expert report, we apply the abuse-of-discretion standard. *Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 875 (Tex. 2001). A trial court "'abuses its discretion when it acts in an arbitrary or unreasonable manner without reference to guiding rules or principles.'" *Jelinek v. Casas*, 328 S.W.3d 526, 539 (Tex. 2010) (quoting *Bowie Mem'l Hosp. v. Wright*, 79 S.W.3d 48, 52 (Tex. 2002) (per curiam)). When determining whether the trial court abused its discretion, we may not substitute our judgment for that of the trial court. *Wright*, 79 S.W.3d at 52.

III. ANALYSIS

Courtyard challenges the trial court's order in two issues. First, Courtyard contends the Robinson Parties did not provide an expert report that satisfies the statutory requirements of section 74.351(r)(6). Courtyard challenges the sufficiency of the expert report as to the (1) applicable standard of care, (2) manner

[3] Unless otherwise noted, all references to section pertain to the Texas Civil Practice and Remedies Code.

[4] The trial court granted the motion to dismiss of Advanced Healthcare Solutions (the management company) and 7499 Stanwick Drive, LLC (the property owner), entities affiliated with Courtyard, under section 74.351(b). The trial court also granted the motion to dismiss of Dr. Khoa Don Nguyen and Houston Family Physicians, PA, Otis Robinson's attending physician and his medical group, under section 74.351(b). Courtyard is the only remaining defendant in the litigation at the time of this appeal.

in which Courtyard failed to meet the standard of care, and (3) causal relationship between Courtyard's failure and the injury. Second, Courtyard requests that we render judgment dismissing the Robinson Parties' claims against it and remand this matter to the trial court for a determination of attorney's fees.

A. Dr. Rushing's report is deficient under section 74.351(r)(6)

A claimant under the Texas Medical Liability Act must serve each defendant health-care provider with one or more expert reports and with the curriculum vitae of each expert listed in the report. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(a) (West 2017). The expert report must provide a fair summary of the expert's opinions regarding the applicable standard of care, the manner in which the healthcare provider failed to meet that standard, and the causal relationship between that failure and the injury or harm alleged. *Id.* § 74.351(r)(6); *Wright*, 79 S.W.3d at 52; *Palacios*, 46 S.W.3d at 878–79. In setting forth the expert's opinions on each of these three elements, the report must (a) inform the defendant of the specific conduct the plaintiff has called into question, and (b) provide a basis for the trial court to conclude that the claims have merit. *Palacios*, 46 S.W.3d at 879. A report does not fulfill these requirements if it merely states the expert's conclusions about the standard of care, breach, and causation. *Id.* The expert instead "'must explain the basis of his statements to link his conclusions to the facts.'" *Jelinek*, 328 S.W.3d at 539 (quoting *Wright*, 79 S.W.3d at 52).

1. Dr. Rushing provides separate standards of care for Courtyard and Dr. Nguyen

Courtyard contends that Dr. Rushing's report contains a standard of care which is not individualized to any particular health care provider making it conclusory and inadequate. The Robinson Parties contend that Dr. Rushing's report includes discussion of the standard of care applicable to Courtyard separate

from Dr. Nguyen and Houston Family Physicians. We agree with the Robinson Parties that the report contains separate standards of care for Courtyard and Dr. Nguyen and Houston Family Physicians.

The standard of care is what an ordinarily prudent health care provider would have done under the same or similar circumstances. *Palacios*, 46 S.W.3d at 880; *Kingwood Pines Hosp., LLC v. Gomez*, 362 S.W.3d 740, 747 (Tex. App.—Houston [14th Dist.] 2011, no pet.). "Identifying the standard of care is critical: Whether a defendant breached his or her duty to a patient cannot be determined absent specific information about what the defendant should have done differently." *Palacios*, 46 S.W.3d at 880. The standard of care must explain what care was expected but not given. *Id*. When there is more than one defendant, the standard of care must be set out in the report for each defendant and explain the causal relationship between each defendant's acts and the injury. *Id.*

Courtyard asserts the standard of care established in Dr. Rushing's report requires all parties to "provide that level of care, treatment, and supervision that a reasonabl[y] prudent similar facility would provide under the same or similar circumstances." The Robinson Parties contend that standard of care as to Courtyard articulated by Dr. Rushing also requires:

> Each resident must receive [and] the facility must provide [the] necessary care and services to attain or maintain [the] highest practicable[] physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care.
>
> In order to meet the standard of care, based on the comprehensive assessment of the resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. A resident who has pressure sores on admission to a facility must receive the necessary treatment and services to promote

> healing, prevent infection, and prevent new sores from developing. Otis Robinson's clinical condition did not demonstrate that his pressure ulcers were unavoidable or untreatable. In fact, records from Courtyard show that their nurses had found some of his ulcers, including the one on his right heel, to have been resolved in his stay at Courtyard.

We also note the report includes other actions Dr. Rushing opines Courtyard is required to perform to meet the standard of care including maintaining clinical records on each resident, neither accepting nor retaining a resident whose needs cannot be met, and implementing a pressure ulcer prevention program as ordered.

As to Dr. Nguyen and Houston Family Physicians, the standard of care requires he "provide that level of care that a reasonabl[y] prudent physician and PA would provide under the same or similar circumstances." Specifically, the report states the standard of care required the attending physician or nurse practitioner to "order the implementation of a pressure ulcer prevention program and to direct and supervise the implementation of this program." Dr. Rushing does not opine that the standard of care requires Courtyard to order a pressure ulcer prevention program. Rather, Courtyard is to implement the program ordered by Dr. Nguyen. We conclude that Dr. Rushing's report contains a standard of care for Courtyard separate from Dr. Nguyen and Houston Family Physicians.

2. Dr. Rushing's discussion of the manner in which Courtyard failed to meet the standard of care is conclusory

Courtyard also contends Dr. Rushing's report does not specify how each defendant breached its purported standard of care making the report inadequate and conclusory. The Robinson Parties counter that Dr. Rushing's report includes specific breaches as to Courtyard alone. Dr. Rushing opines that Courtyard breached the standard of care by allowing Otis Robinson to continue to develop pressure ulcers, failing to appropriately treat the pressure ulcers, retaining Otis

Robinson as a patient, and failing to properly document the pressure ulcers. "Whether a defendant breached his or her duty to a patient cannot be determined absent specific information about what the defendant should have done differently." *Palacios*, 46 S.W.3d at 880. We agree with Courtyard that Dr. Rushing's report is conclusory as to the manner in which Courtyard did not meet the standard of care.

i. Order the implementation of a pressure ulcer prevention program

As discussed above, Dr. Rushing opines that Dr. Nguyen and Houston Family Physicians are required to order the implementation of a pressure ulcer prevention program. Dr. Rushing separates the standard of care related to the ordering the implementation of a pressure ulcer prevention program and implementation of a pressure ulcer prevention program as ordered and who is responsible for each. The standard of care applicable to Courtyard required implementation of a pressure ulcer prevention program ordered by Dr. Nguyen or Houston Family Physicians. Accordingly, any failure to order the implementation of a pressure ulcer prevention program is not a breach of the standard of care applicable to Courtyard.

ii. Implementation of a pressure ulcer prevention program as ordered and treatment of the pressure ulcers

As to treatment, Dr. Rushing opines the standard of care requires Courtyard to implement a pressure ulcer prevention program as ordered and appropriately treat the pressure ulcers. Notably, Dr. Rushing does not explain whether a pressure ulcer prevention program was actually ordered by Dr. Nguyen or Houston Family Physicians. Further, he does not explain what the pressure ulcer prevention program in the present case required. Dr. Rushing provides details as to what a general pressure ulcer prevention program would consist of including regular and

documented head to toe skin checks once a week, a regular and documented turning and repositioning schedule, a pressure reducing mattress surface for the bed and a pressure relieving cushion for the wheelchair/geriatric chair, and specially constructed pressure relieving devices to relieve the pressure on his sacrum, hips, and heels. However, the discussion of a general pressure ulcer prevention program, without more, does not inform Courtyard of the conduct at issue. Without a discussion of the specific pressure ulcer prevention program ordered for Otis Robinson and the steps Courtyard failed to take, Dr. Rushing's report does not adequately address the manner in which Courtyard failed to meet the standard of care. *Cf. Christus Spohn Health System Corp. v. Castro*, No. 13-13-00302-CV, 2013 WL 6576041, at *6 (Tex. App.—Corpus Christi Dec. 12, 2013, no pet.) (mem. op.) (the expert reports did not address the specific conditions present in patient's care, even though they went into detail about the procedures necessary to prevent pressure ulcers, and did not adequately address the causation element).

Additionally, Dr. Rushing opined the standard of care regarding treatment was not met "when Mr. Robinson was permitted to continue to develop pressure ulcers while a resident at Courtyard." As to the standard of care, Dr. Rushing opines that Courtyard was required to "treat those wounds, prevent the wounds from deteriorating, and consult with an appropriate medical provider should the wounds no longer respond to treatment within the facility." Dr. Rushing opines "[t]he records from Courtyard show that Courtyard did not meet the standard of care for Mr. Robinson by failing to appropriately treat or increase or change treatment levels to combat the pressure ulcers." Missing from Dr. Rushing's report is any indication of what Courtyard did or did not do with respect to its treatment of Otis Robinson's pressure ulcers. It cannot be determined whether a defendant

breached the standard of care without specific information as to what the defendant should have done differently. *Id.* Comparable cases finding the expert report sufficient detail the report's discussion of specific actions required to treat the pressure ulcers. *See generally Baker v. Regency Nursing & Rehabilitation Ctrs., Inc.*, No. 13-12-00331-CV, 2013 WL 3895438, at *5 (Tex. App.—Corpus Christi July 25, 2013, no pet.) (mem. op.) (standard of care required ensuring there was not pressure on the heels which is best achieved using a foam rubber pad under the patient's leg, regular scheduled skin checks, documented turning and repositioning every two hours); *Arboretum Nursing & Rehabilitation Ctr. of Winnie, Inc. v. Isaacks*, No. 14-07-00895-CV, 2008 WL 2130446, at *3 (Tex. App.—Houston [14th Dist.] May 22, 2008, no pet.) (mem. op.) (report indicated the standard of care required nursing home to perform skin assessments and treat the pressure ulcers which was breached by failing to perform regular skin assessments and properly treat the stage I and II ulcers by relieving pressure on the affected area and ensuring nothing touched the ulcer). Dr. Rushing's statements as to the standard of care imposed upon Courtyard regarding treatment are too general and do not include specific information about what Courtyard should have done differently.

Dr. Rushing's report is insufficient as to any breach of the standard of care regarding the implementation of a pressure ulcer prevention program as ordered and treatment. *See Palacios*, 46 S.W.3d at 880; *Gomez*, 362 S.W.3d at 750.

iii. Notification of the family and physician or transfer of Otis Robinson to another facility

Dr. Rushing also opines that "the defendant[s] should have notified both the family and Mr. Robinson's physician that they were unable to meet his needs" when the pressure ulcers were getting progressively worse and that he should be

transferred to another facility which could meet his needs. Dr. Rushing states the failure to do this was below the accepted standard of care. It is unclear from his report which defendant should have notified the family and physician. The Robinson Parties contend it is clear that Courtyard is the referenced defendant as Dr. Rushing states Otis Robinson's physician should have been notified and Dr. Nguyen was Otis Robinson's physician. However, the report does not eliminate the possibility that Otis Robinson had physicians other than Dr. Nguyen. The lack of specificity prevents the trial court and parties from ascertaining whose conduct is at issue. As a result, Dr. Rushing's report does not sufficiently describe the conduct related to retention of Otis Robinson as a patient. *See Rittmer v. Garza*, 65 S.W.3d 718, 722–23 (Tex. App.—Houston [14th Dist.] 2001, no pet.).

iv. Documentation of the pressure ulcers

Dr. Rushing opines the standard of care as to documentation required Courtyard to "maintain clinical records on each resident in accordance with the accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized." As to documentation of Otis Robinson's pressure ulcers, Dr. Rushing's report does not provide specific information as to what was done or not done by Courtyard. Specifically, Dr. Rushing opines Courtyard did not meet the standard of care as to documentation "because the records provided do not meet the accepted professional standards of care, the records are incomplete, not accurately documented and are not systematically organized."

We note that Dr. Rushing discusses what should have been documented regarding the progression of Otis Robinson's pressure ulcers. Dr. Rushing opines:

> [T]here should have been comprehensive documentation and description of the pressure ulcers that would include the specific

> location, and accurately measured size, stage, presence or absence of odor, or presence or absence of exudates condition of the surrounding tissues and the presence or absence of undermining . . . The standard of care requires that Courtyard and its medical personnel document the progression of the pressure ulcers to enable any other treating physician to track the status of the wound and assess the effectiveness of the course of treatment.

Dr. Rushing opines that "while there was some documentation, the documentation was woefully inadequate." Dr. Rushing also states some of the records are illegible and the records do not enable him to clearly track the progression of Otis Robinson's pressure ulcers. However, Dr. Rushing does not address what was documented by Courtyard regarding the pressure ulcers, or how that specific documentation fell below the standard of care.[5] Simply stating the opinion that Courtyard's documentation breached the standard of care is conclusory and does not inform Courtyard of the specific conduct called into question. *See Palacios*, 46 S.W.3d at 880. We conclude Dr. Rushing's report does not adequately describe the breach of the standard of care regarding documentation of Otis Robinson's pressure ulcers.

Dr. Rushing's report does not sufficiently explain what Courtyard should have done differently regarding the treatment of Otis Robinson's pressure ulcers, or what it failed to do regarding the documentation of the ulcers. This failure prevents the trial court and Courtyard from ascertaining the conduct at issue. Accordingly, we conclude Dr. Rushing's report is insufficient under section 74.351(r)(6) as to the manner in which Courtyard failed to meet the standard of care.

[5] Dr. Rushing's report contains excerpts from Otis Robinson's chart regarding his pressure ulcers. However, Dr. Rushing does not refer to these excerpts in his discussion of the standard of care, breach, or causation.

3. Dr. Rushing's discussion of causation is conclusory

Courtyard contends that Dr. Rushing failed to adequately state the causal relationship between any conduct and the alleged harm. The Robinson Parties argue that Dr. Rushing specifically outlines the causal connection between the breaches and the harm. Further, the Robinson Parties contend Dr. Rushing was not required to rule out all other causes. We agree with Courtyard that Dr. Rushing's report is conclusory as to causation.

We begin by noting that the Robinson Parties' reliance on two cases—*VHS San Antonio Partners LLC v. Garcia*, 2009 WL 3223178 (Tex. App.—San Antonio Oct. 7, 2009, pet. denied) (mem. op.) and *Baylor Medical Center at Waxahachie v. Wallace*, 278 S.W.3d 552 (Tex. App.—Dallas 2009, no pet.)—is misplaced. The Robinson Parties rely on *Garcia* and *Wallace* to support their contention that Dr. Rushing's report need not rule out all possible causes of harm. However, Courtyard does not contend Dr. Rushing's report is insufficient for failing to rule out all possible causes. Courtyard contends that Dr. Rushing's opinions as to causation are deficient because they are conclusory. Accordingly, the Robinson Parties' argument that Dr. Rushing's report need not rule out all possible causes is not responsive to the issue before us.

While Dr. Rushing opines that Courtyard's failure to treat and document Otis Robinson's pressure ulcers was a breach of the standard of care, he fails to adequately address any causal relationship between these failures and the harm. Dr. Rushing opines:

> If, in this case, Courtyard had not failed to appropriate[ly] treat and document Mr. Robinson's heel ulcers, there would have been no skin breakdown and tissue injury. If there had been no skin breakdown and tissue injury there would have been no portal of entry for bacteria. If there had been no portal of entry for bacteria there would have been

> no infection of Mr. Robinson's heels. If there had been no infection of Mr. Robinson's heels, his already compromised circulation would not have been further compromised. If his circulation had not been further compromised there would have been no gangrene. If there had been no gangrene then Mr. Robinson would not have had both legs amputated above the knees. In summary, if Courtyard and its medical personnel had not breached the standard of care as described more fully above, Mr. Robinson would not have suffered the infection, gangrene, and eventual amputation of his feet.

As discussed above, Dr. Rushing does not adequately describe how Courtyard breached the standard of care with respect to treatment and documentation of Otis Robinson's pressure ulcers. His statement on causation does not clarify what failure of appropriate treatment and documentation is being referenced. Such a conclusory statement does not sufficiently establish causation. *See Castro*, 2013 WL 6576041, at *6.

i. Treatment of the pressure ulcers

When compared to cases where causation was sufficiently addressed based on the inadequate treatment of pressure ulcers, Dr. Rushing's report is insufficient. In *Isaacks*, we evaluated whether an expert report was sufficient to show causation in a medical liability case where the patient suffered from pressure ulcers resulting in an amputated leg and ultimately died as a result of aspiration pneumonia. *Isaacks*, 2008 WL 2130446, at *1. The court summarized the relevant part of the report addressing the standard of care and breach related to the pressure ulcers as follows:

> [T]he standard of care for the nursing home and their nurses requires that they (1) inspect and assess the skin, head to toe, every day with particular attention to pressure points such as heels, toes, hip, and sacrum, (2) document new skin changes on the very day that they are noted, (3) perform a regular and detailed documented skin assessment once a week, and (4) treat the stage I and stage II pressure ulcers as soon as they are discovered. . . .

> [T]he standard of care required that once stage I and stage II pressure ulcers were discovered, they should be treated by relieving pressure on the affected area and ensuring that nothing touched the ulcer. . . . [B]y failing to perform regular skin assessments and properly treat the stage I and stage II ulcers, the nursing staff at [facility] breached the standard of care. . . . [M]ost stage I and II ulcers, when treated properly, heal well. Had the ulcers been diagnosed and treated in the earlier stages, they would have healed and not progressed to stage III ulcers and osteomyelitis, ultimately resulting in amputation of the leg.

Id. at *3. In analyzing the sufficiency of the report, causation was addressed in the following context:

> [The expert's] statements link the breach of the standard of care to the cause of [the deceased's] injury and death. He explains that if [the deceased's] skin had been properly monitored, he would not have developed pressure ulcers, and the ulcers would not have become infected. Further, [the expert] goes beyond reciting mere possibilities of a better outcome and opines that if the nursing home had followed the proper standard of skin detection and treatment at the early stages of the ulcers, more likely than not, [the deceased] would have recovered. Finally, [the expert's] report sufficiently describes how [the deceased's] pneumonia could have been caused by the inability to protect the tracheobroncihial [sic] tree due to his weakened state as a result of the infection and amputation.

Id. at *5.

Additionally, in *San Jacinto Methodist Hospital v. Bennett*, 256 S.W.3d 806 (Tex. App.—Houston [14th Dist.] 2008, no pet.), we held the expert report was sufficient, stating:

> [The expert's] report sets forth the mechanism of [the deceased's] injury, specifically (1) failure to provide adequate initial skin assessment, hydration, and nutrition led to the formation of ulcers, and (2) failure to provide skin care nursing and protocol interventions when decubitus ulcers were detected as well as failing to optimize [the deceased's] nutrition and hydration led to formation of new ulcers and prevented healing of existing ulcers.

Id. at 817. We concluded the report sufficient as to establish causation as the

report indicated "that if each hospital had followed the appropriate standard of care, [the deceased] would have maintained good nutrition and hydration, ulcer formation would have been prevented, and those ulcers already present would have healed." *Id.*

Additional cases also provide guidance as to what is considered sufficient information to establish causation related to the inadequate treatment of pressure ulcers. *See Select Specialty Hosp.-Houston Ltd. Partnership v. Simmons*, No. 01-12-00658-CV, 2013 WL 3877696, at *11 (Tex. App.—Houston [1st Dist.] 2013, no pet.) (mem. op.) (report specifically identified and linked each alleged breach of the standard of care to the development of bedsores); *Hillcrest Baptist Med. Ctr. v. Payne*, No. 10-11-00191-CV, 2011 WL 5830469, at *8–10 (Tex. App.—Waco Nov. 16, 2011, pet. denied) (mem. op.); *Gallardo v. Ugarte*, 145 S.W.3d 272 (Tex. App.—El Paso 2004, pet. denied) ("This statement explains the standard of care by listing the steps that could have been taken and explains how the standard of care was breached by noting that none of the steps were taken. Thus, the statement specifically addresses what care was expected by not given. The statement addresses causation by indicating that if the proper steps had been taken, the decubitus could have been prevented or at least could have been prevented from progressing to stage IV.").

Dr. Rushing's report as to causation is more analogous to the expert reports at issue in *Castro*. In *Castro*, the court agreed with the healthcare provider that the expert reports did not "'explain how taking any particular action would have prevented the development of a pressure ulcer given the complex medical issues involved in [the patient's] care.'" *Castro*, 2013 WL 6576041, at *6. The court noted that while the reports went into great detail about procedures necessary to prevent pressure ulcers in standard conditions, "they do not address the specific

conditions present in [the patient's] care." *Id.* Dr. Rushing's report does not specify what conduct of Courtyard is being called into question. As a result, the report does not provide an adequate description of the relationship between the alleged breaches and the amputation of Otis Robinson's legs. Without specifically addressing what care was expected, but not given, Dr. Rushing's report does not explain how that care would have prevented Otis Robinson's pressure ulcers or the amputation of his legs.

ii. Documentation of the pressure ulcers

Additionally, Dr. Rushing's opinions as to improper documentation causing the amputation of Otis Robinson's legs are insufficient. While Dr. Rushing opines that documentation was required to allow any other reviewing physician to track the progression of the wound, he does not link the documentation to any care that was provided or should have been provided. In cases where causation was sufficiently established regarding documentation, the expert reports specifically explained how the documentation of the wounds would have been utilized to develop a treatment plan or alter that plan accordingly. *See Pinecrest SNF, LLC v. Bailey*, No. 12-14-00357-CV, 2016 WL 3050669, at *6 (Tex. App.—Tyler May 27, 2016, no pet.) (mem. op.) (expert opined that nursing staff's failure to assess, document, and report the progression of the pressure ulcer directly caused patient harm because interventions were not timely provided); *Payne*, 2011 WL 5830469, *10 ("If the nurses had documented and discussed Ms. Payne's pressure ulcer in the chart using the parameters of size, color, depth, drainage, odor[,] and progression, the worsening of the ulcer would have been tracked in the record and become apparent to the physicians who then would have been alerted. The physicians would then have implemented a treatment plan, including off loading, wound care[,] and a specialty mattress. Within a reasonable degree of medical

probability these interventions would have prevented the pressure ulcer from progressing to a Stage IV ulcer."). Dr. Rushing's report limits documentation to tracking the wounds, and does not link it to treatment. The report does not explain how proper documentation would have prevented Otis Robinson's pressure ulcers or the amputation of his legs. As such Dr. Rushing does not link his statements to the specific facts at issue in this case. *Cf. Taylor v. Christus Spohn Health System Corp.*, 169 S.W.3d 241, 245 (Tex. App.—Corpus Christi 2004, no pet.) (expert report did not explain how information would have altered the outcome of assessment or how it relates to the cause of death).

We conclude Dr. Rushing's report is insufficient under section 74.351(r)(6) as it does not link his conclusions to the facts such that his discussion of causation is conclusory. *See Jelinek*, 328 S.W.3d at 539. Because we conclude that Dr. Rushing's report is deficient under the statutory standard as to breach and causation, we sustain Courtyard's first issue.

B. Courtyard is entitled to recover reasonable attorney's fees and costs in an amount to be determined by the trial court

Courtyard requests that if we determine the Robinson Parties failed to produce an expert report meeting the statutory requirements we reverse and render judgment dismissing the Robinson Parties' claims and remand the case to the trial court for a determination of attorney's fees and costs. Courtyard contends the Robinson Parties are not entitled to an additional 30-day extension to cure Dr. Rushing's report as the trial court previously permitted an extension. The Robinson Parties do not address this point in their briefing or request a 30-day extension in the event we find the report insufficient under section 74.351. Accordingly, we do not address whether the Robinson Parties are entitled to an additional extension under the statutory language. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(c).

As the Robinson Parties failed to produce an expert report that satisfies statutory requirements, Courtyard is entitled to recover its reasonable attorney's fees and costs incurred. *See Lewis v. Funderburk*, 253 S.W.3d 204, 207–08 (Tex. 2008) (citing Tex. Civ. Prac. & Rem. Code Ann. § 74.351); *Hightower v. Baylor Univ. Med. Ctr.*, 348 S.W.3d 512, 521–22 (Tex. App.—Dallas 2011, pet. denied). We conclude the appropriate remedy is to reverse the trial court's order denying Courtyard's motion to dismiss, render judgment dismissing the Robinson Parties' claims against Courtyard, and remand the case to the trial court with instructions to conduct further proceedings to determine the amount of reasonable attorney's fees and costs which should be awarded to Courtyard under section 74.351.

IV. CONCLUSION

Dr. Rushing's opinion as to Courtyard's breach of the standard of care and causation is conclusory, rendering his report insufficient under section 74.351. Accordingly, we conclude the trial court abused its discretion in denying Courtyard's motion to dismiss and failing to assess attorney's fees and costs. We therefore reverse the trial court's order denying the motion to dismiss, render judgment dismissing the Robinson Parties' claims against Courtyard, and remand this case to the trial court with instructions to assess and award Courtyard its reasonable attorney's fees and costs incurred.

/s/ Tracy Christopher
Justice

Panel consists of Justices Christopher, Busby, and Jewell.