2014 IL App (2d) 131032-U
No. 2-13-1032
Order filed August 18, 2014

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

DIANE THOMPSON,	)	Appeal from the Circuit Court
	)	of Lee County.
Plaintiff-Appellant,	)	
	)	
v.	)	No. 10-L-21
	)	
KATHERINE SHAW BETHEA HOSPITAL,	)	Honorable
	)	Daniel A. Fish,
Defendant-Appellee.	)	Judge, Presiding.

JUSTICE SPENCE delivered the judgment of the court.
Justices McLaren and Zenoff concurred in the judgment.

ORDER

¶ 1 *Held*: Defendant's alleged violation of Rule 213 was harmless, in light of the lack of evidence that defendant's alleged negligence proximately caused plaintiff's injury.

¶ 2 Plaintiff, Diane Thompson, appeals a judgment, after a jury trial, for defendant, Katherine Shaw Bethea Hospital, on her negligence complaint. Plaintiff contends that the trial court erred in allowing defendant to introduce expert testimony from a witness who had not been properly disclosed under Illinois Supreme Court Rule 213(f) (eff. Jan. 1, 2008). We affirm.

¶ 3 Plaintiff's original complaint, filed July 29, 2010, named both defendant and Elizabeth Collins as defendants. It alleged the following facts. On April 28, 2009, plaintiff was discharged

from defendant's facility. Collins, a certified nursing assistant (CNA), attempted to escort her from a wheelchair to a waiting vehicle. Collins was negligent in that she did not use adequate assistive devices to transfer plaintiff and did not safely transfer plaintiff to the vehicle. As a result of Collins' negligence, plaintiff fell and was injured. Defendant was liable (1) under a theory of *respondeat superior*; and (2) for institutional negligence, in that it did not use multiple staff members to transfer plaintiff and did not use adequate assistive devices.

¶ 4 Discovery proceeded. On December 5, 2011, defendant and Collins disclosed their controlled expert witnesses (see Ill. S. Ct. R. 213(f)(3)). They included Collins; Martha Dailey, a registered nurse with defendant; and Eric K. Bartel, M.D. The disclosure also stated, "Defendants adopt any and all opinions and bases of Plaintiff's expert witnesses, if any, which are consistent with and supportive of the defense theories. Defendants may supplement or disclose further Rule 213(f)(3) witnesses pursuant to the Court's Order scheduling expert discovery."

¶ 5 On May 15, 2012, plaintiff filed an amended complaint, against defendant only. It alleged that defendant initially failed to assess plaintiff's fall risk; failed to alter the fall risk assessment after a physical therapist had examined plaintiff; failed to use more than one staff member to transfer plaintiff safely upon discharge; and failed to require the use of assistive devices, including but not limited to a gait belt, while transferring plaintiff to the vehicle.

¶ 6 Defendant answered the amended complaint. On June 25, 2012, plaintiff served notice of a discovery deposition on Rose Moss, a registered nurse (RN) whom defendant employed. On June 26, 2012, Moss was deposed. On February 22, 2013, plaintiff filed her witness list. Moss was listed as an adverse witness. Also on February 22, 2013, plaintiff moved *in limine* to bar "any evidence concerning opinions not raised by Defendant's experts in *timely* filed Answers to

Rule 213 Interrogatories and in deposition testimony, including, but not limited to any expert opinions of the defendant or her/its retained experts which either remain undisclosed or were disclosed [after the] witnesses' discovery depositions." (Emphasis in original.) On February 25, 2012, defendant filed its witness list, which included Moss, who was not listed as an expert. On March 8, 2013, the trial court granted plaintiff's motion *in limine*. The parties later filed updated witness lists, with plaintiff again listing Moss as an adverse witness and defendant listing her as a witness.

¶ 7 On May 29, 2013, the jury trial began. We summarize the considerable pertinent testimony. Plaintiff first called Sandra R. Ernat, who testified on direct examination as follows. Ernat, an RN, had reviewed records from defendant. When plaintiff was admitted to the hospital, on April 20, 2009, she was 69 years old, obese, and suffering from shortness of breath. She could not walk far and had a "waddling gait." About two years earlier, she had fallen and fractured her left leg. Upon her admission, defendant rated plaintiff a "very high risk" for falls. On the morning of April 28, 2009, when plaintiff was discharged, the physical therapy department recommended that she use a walker at home.

¶ 8 Asked how plaintiff should have been transferred upon discharge, including when she entered the car, Ernat testified that the standard of care required the use of wheelchair, a "gait belt *** [,] and two assists." A gait belt "give[s] us, the nursing staff, something to hang onto and to help the patient move." Also, two nurses or assistants should have been present when plaintiff was transferred from her wheelchair to the vehicle, "assisting her to stand up, moving that wheelchair back and assisting her to sit down, turn around, put her bottom down in the car and then swing her legs over." Other than the wheelchair, however, these measures were not used; there was no gait belt and only Collins to assist plaintiff. Ernat demonstrated the use of a

gait belt and explained that it gives the nurse "something to hold onto, something to grab if they start to go down." A gait belt would help the patient stand up, turn, and, in plaintiff's case, "put her bottom into the seat of the car and then move her legs in for her. She'd be safely in the car."

¶ 9 Ernat testified on cross-examination as follows. She had reviewed plaintiff's hospital chart for April 20-28, 2009, plaintiff's affidavit, the depositions of plaintiff and Collins, the records of Dr. Mark Carlson, an orthopedic surgeon who had treated plaintiff for her injury, and other documents. Ernat was aware that there were several versions of how plaintiff had fallen. One was that, without standing, she had put her left foot into the car, then had attempted to use the grip bar inside the car to put her right leg into the car, but got her right foot lodged under the car, in the doorway. According to this version, plaintiff told Collins that she had caught her foot; Collins pulled the wheelchair backward; and plaintiff slid out of the wheelchair and onto the ground, with her right leg under her, fracturing her ankle. In her deposition, Ernat had stated that the foregoing was her understanding of how the accident had occurred.

¶ 10 Ernat conceded that, in her affidavit, plaintiff had described the accident differently. In this version, plaintiff stated that she put her left leg into the car, then raised herself up on the arms of the wheelchair, whereupon her leg got caught in the door jamb. Collins then pulled the wheelchair back and out from under plaintiff. Finally, according to Dr. Carlson's records, plaintiff had told him that, when Collins pulled away the wheelchair, plaintiff's foot was "caught in the wheelchair," causing her injury. This description made no reference to the door or door jamb. Ernat believed, however, that, in any of the three situations described, the use of the gait belt and two assists could have prevented the injury. The use of the gait belt could have enabled the nurse(s) to restrain plaintiff and keep her in the wheelchair.

¶ 11 Ernat recounted Collins' deposition testimony that the wheelchair was brought up next to the car; Collins put the wheelchair's brakes on; plaintiff stood up; and the parking valet told her to stand, pivot, and sit in the car. Ernat did not recall plaintiff having testified in her deposition that, in every prior discharge situation, she had stood, pivoted, and sat in the car. Ernat agreed that directing plaintiff to do so would have been reasonable. Collins, however, had testified and documented that, instead of pivoting and sitting down, plaintiff attempted to step into the car, lost her balance, and fell. Asked whether, had plaintiff stood, pivoted, and sat, she would not have fallen, Ernat testified, "Oh, I don't know that."

¶ 12 Ernat conceded that hospital records showed that, while hospitalized, including on April 27 and 28, 2009, plaintiff had gotten out of bed or used the bedside commode with the "minimal assist" of only one person. However, on redirect examination, she noted that a document from defendant's nursing department entitled "Safety for the Patient Med/Surg" included the instruction, "Two staff will be in attendance when all patients are transferred to and from carts/beds."

¶ 13 Plaintiff next called Collins. She testified on direct examination as follows. She had been a certified nursing assistant (CNA) for defendant since 2007. On April 28, 2009, when plaintiff was to be discharged, Collins obtained a wheelchair, spoke to Moss, plaintiff's nurse, then went to plaintiff's room and helped her into the wheelchair. Plaintiff weighed more than 300 pounds. Collins wheeled plaintiff outside and placed the wheelchair "between the car and the door parallel with the car facing kind of like the door hinge." The car door was opened, and the wheelchair was "within pivot transfer distance" of the car, "maybe a step or two." The valet, who was not a medical professional, was there. Before the wheelchair was removed, the valet told plaintiff to "do a pivot and sit," *i.e.*, "turn and sit in the chair, then swing [her] legs in."

However, plaintiff stood up and tried to pick up her left foot. Her foot "hit the bottom of the car and at that point she lost her balance and kind of twisted back." Collins caught her by the back of her stretch pants and eased her to the ground. Plaintiff was not wearing a gait belt. Gait belts were available that day, but nobody had told Collins to use one for plaintiff.

¶ 14 Collins testified on cross-examination that, since she began working at the hospital in 2007, she had been assigned to the medical/surgical unit. Her shift began by receiving reports of the outgoing CNA and the nurse about her patients. She had access to the nurse's documentation for the patients. Collins took care of plaintiff several times in April 2009. She knew that plaintiff was a high fall risk, as signified by the sticker on her wristband. On the morning of April 28, 2009, Collins assisted plaintiff with using the commode; Collins recorded that plaintiff was "full weight bearing with assist of one, minimal assist." "Minimal assist" meant "[s]tandby assist *** no hands on" with no need for a gait belt or a second attendant.

¶ 15 Collins testified that, when she wheeled plaintiff out to the car, she put the brakes on and plaintiff stood up. Plaintiff's daughter was in the car. The valet told plaintiff to stand, pivot, and sit. Collins would have told plaintiff the same thing, but the valet "beat [her] to it." Once plaintiff was standing, the valet removed the wheelchair. Collins was behind plaintiff, well within arm's reach. When plaintiff stood up, she was "[s]tanding there, just fine" in front of the car, with the open door to her right and the seat to her left. She was not unstable. She refused to turn around and sit, but instead picked her leg up in order to put it into the car. She hit her foot on the bottom of the car, lost her balance, and twisted back to her left. Collins caught her instantly and eased her to the ground. Plaintiff was on the ground, with her legs under the car. She was taken to the emergency room.

¶ 16 On redirect examination, Collins testified that she did not document that plaintiff refused to stand, pivot, and sit. However, her incident report stated that plaintiff was trying to get into the car and caught her right foot on the bottom of it. The report continued that, when plaintiff attempted to put her right foot back onto the ground, she twisted it underneath the car and started to fall backward. This description was not consistent with "stand, pivot, and sit."

¶ 17 On examination by plaintiff as an adverse witness, Moss testified as follows. She was an RN and had worked as a staff nurse for defendant for 37 years. Staff nurses are in charge of CNAs. CNAs report their findings to the assigned staff nurse. The staff nurse is charged with determining whether a patient is a fall risk and the level of risk. The staff nurse also determines whether the patient needs help ambulating and needs assistive devices such as gait belts. On April 27 and 28, 2009, Moss was assigned to plaintiff. On April 28, 2009, Dr. Myers prepared discharge instructions for plaintiff. Moss prepared a discharge and care plan for her.

¶ 18 We recount Moss's examination by defendant. We note that, unless otherwise specified, all of plaintiff's objections were on Illinois Supreme Court Rule 213 (eff. Jan. 1, 2007) grounds.

¶ 19 Moss testified as follows. When a staff nurse comes on duty, she takes a report from the outgoing nurse and examines the patient's "Kardex," or chart. The Kardex indicates whether the patient is a fall risk. Physical therapists and CNAs have access to the Kardex. The patient's doctor writes orders relating to the patient, describing "what he feels that the patient can do," and the nurse decides from this information whether the patient needs assists, multiple assists, or assistive devices. The staff nurse also consults the nursing notes and physical therapy findings.

¶ 20 Moss testified further that a CNA starting a shift learns about a patient's needs from the CNA coming off the previous shift and from the staff nurse. The CNA will also tell the staff nurse about the patient's condition. The following colloquy ensued:

"Q. Now, one of the things we have been talking about is moving patients. Is there a word or term that's used for that process, moving patients?

A. Transfer.

Q. Okay. And are there different types of transfers?

A. Yeah.

Q. Okay.

A. Yes. Sorry.

Q. Does it make a difference where you're going from, from what position to what position?"

¶ 21 At this point, plaintiff objected that defendant was "asking for an opinion [that had] not been disclosed." The trial court overruled the objection. Moss described a variety of transfers. Defendant asked whether "the process [was] basically the same" for all of these movements. Plaintiff objected. The court overruled the objection. Moss then testified further as follows. The basic concept of "stand, pivot, and sit" is the same for everyone. Defendant asked whether "walking in the hallways or some distance [is] the same as the transfers we talked about"; plaintiff objected; and the trial court overruled the objection. Moss answered that walking in a hallway is "more of an activity than a transfer" because it involves going a longer distance. She also testified that devices that nurses and CNAs use to help transfer patients include gait belts.

¶ 22 Defendant then asked Moss, "[H]ow do you decide whether to use a gait belt?" Plaintiff objected that defendant was "leading up to a standard of care opinion." The trial court allowed the question as a proper inquiry into Moss's job duties. Moss then testified that "[y]ou take a lot of factors into consideration," such as the nurse's assessment of the patient.

¶ 23 Defendant next asked Moss whether the hospital had policies relating to transferring patients. Moss said that there were and that she was familiar with them. Defendant asked Moss whether her duties included following the policies; plaintiff objected; the trial court overruled the objection; and Moss answered yes. Moss was familiar with plaintiff's exhibit No. 2, defendant's nursing department's standards for "Safety for the Patient Med/Surg" (Safety Standards). Over plaintiff's objection, she read paragraph 7, which stated, "Assistance will be given to all patients ambulating until staff feels gait is stable." The assistance could mean a gait belt, other devices, or just walking along with the patient. While Moss was caring for plaintiff, she did not believe that plaintiff's gait was unstable.

¶ 24 Over plaintiff's objection, Moss read paragraph 8 of the Safety Standards, which stated, "Patients are identified for High Risk for Falls, following proper protocol. (See Policy Identification of Patients at High Risk for Falls)." Moss also identified defendant's exhibit No. 2 as the policy to which this paragraph referred. Defendant asked Moss, "Was a fall policy followed in regards to the care and treatment that you were involved in for [plaintiff]?" Plaintiff objected that defendant was attempting to introduce a standard-of-care opinion from a witness who had not been disclosed as an expert on the standard of care. Defendant's attorney argued that he was asking Moss only about her job duties and what, in fact, she had done in treating plaintiff. The trial court overruled the objection. Moss then answered the question, "Yes."

¶ 25 Moss testified that, upon being admitted, plaintiff was identified as a fall risk, based solely on her previous fall. Moss provided care for plaintiff on April 27 and 28, 2009, and assessed her condition each day. Defendant asked Moss, "[W]hen you assessed [plaintiff], and based upon what you had learned about [plaintiff] from the other documentation in the reports, what was her level of assistance for mobility purposes?" Over plaintiff's objection, Moss

answered, "She was minimal assist," requiring one person. Moss testified that she had seen the physical therapist's reports on plaintiff. Defendant's attorney asked Moss, "What did you understand her level of assistance was based upon the assessment of the therapist?" Over plaintiff's objection, Moss answered, "That she needed [an] assist of one."

¶ 26 Defendant directed Moss to the physical therapist's care plan for plaintiff. The plan stated in part, "REG (A) for AMB." Moss explained that this meant, "Requires assist for ambulation" and that it meant assistance by "[j]ust one" person. Defendant asked Moss, "How do you know it's not two or three or four?" Over plaintiff's objection, Moss testified, "They would write if they needed more than one assist." Moss testified that the plan contained a similar notation for transfer (assistance by one person). On April 27, 2009, Moss would have told the oncoming shift nurse that plaintiff needed a "stand by [*sic*] assist or assist of one" for transfer. Defendant asked why Moss would have so stated. Over plaintiff's objection, Moss testified, "Because she could stand and pivot on her own."

¶ 27 Moss testified that plaintiff was discharged at 10:30 a.m. on April 28, 2009. Plaintiff's condition and her need for assistance had not changed from the previous day. Defendant asked Moss, "So what was her level of assistance as of the morning of April 28th?" Over plaintiff's objection, Moss testified, "She could be up with one assist, stand by [*sic*]."

¶ 28 Moss testified that, on the morning of April 28, 2009, for the 8 a.m. and 9 a.m. hours respectively, she and Collins assessed plaintiff as "full weight bearing with assist of one, minimal assist." Defendant asked Moss, "Based on your assessment and the care that was provided[,] did [plaintiff] require any assistive devices for her transfers?" Over plaintiff's objection, Moss answered, "No."

¶ 29 Moss testified that she signed Dr. Myer's discharge instructions for plaintiff. Defendant directed her to plaintiff's exhibit No. 1, defendant's "Standards of Practice/Standards of Care Medical Surgical." Defendant asked, "Does that policy require you to prepare any additional documentation for [plaintiff] as part of her discharge?" Over plaintiff's objection, Moss answered, "No, she has discharge instructions and there was nothing else ordered." Defendant asked Moss, "So when that document makes reference to a discharge plan[,] what specific documentation is that policy referencing?" Over plaintiff's objection on Rule 213 and foundation grounds, Moss testified, "The discharge instruction." Defendant asked Moss, "And collectively the balance of what you have documented in the nursing notes and the other information *** is that consistent with what that policy, Plaintiff's Exhibit I, required you to do?" Over plaintiff's objection, Moss answered, "Yes."

¶ 30 The examination continued:

"Q. And at the time that you were aware [plaintiff] was going to be discharged what—level of assistance based upon your involvement in her care did [plaintiff] require for transfer?

A. Minimal assistance. Just stand by.

Q. One person, two people, three?

A. One person.

MR. MELTON [plaintiff's attorney]: I didn't want to interrupt. My 213 objection stands.

THE COURT: Understood. Overruled.

Q. And again based upon your evaluation, care, your involvement in her assessments that morning, did [plaintiff] require the use of any device, any assistive device for her transfer?

MR. MELTON: Same objection.

THE COURT: Understood. Overruled.

A. No.

Q. Specifically a gait belt, was that required for a transfer for [plaintiff] on the morning of the 28th?

A. No.

MR. MELTON: Same objection.

THE COURT: So noted. Overruled.

A. No."

¶ 31 The trial court admitted the deposition of Cheryl Vajdik, RN, an expert witness. She testified as follows. Defendant did not prepare a discharge plan for plaintiff and, therefore, did not provide a plan to ensure a "safe transfer to the next step." The transfer plan would have included, among other things, having plaintiff "discharged per wheelchair to a car with a gait belt and the assistance of two people or more." The lack of a discharge plan deviated from the standard of care. Further, an evaluation by Brandi Miller, plaintiff's physical therapist, on April 27, 2009, stated that plaintiff required assistance for ambulation and transfers. Vajdik could find no evidence that either Moss or Collins was ever made aware of this evaluation, and this failure also deviated from the standard of care.

¶ 32 Vajdik testified further that, even with the use of a gait belt and two assists, plaintiff might still have fallen; but "more likely than not she would not have had such a severe injury."

With a gait belt and multiple assists, she could have been caught and stabilized even if she fell. The failure to use a gait belt and multiple assists deviated from the standard of care. Vajdik was aware that there were several versions of how plaintiff fell, and she did not have an opinion on how plaintiff was injured. Her opinions did not depend on how plaintiff's injury was caused.

¶ 33 Vajdik testified that Dr. Myers's discharge instructions said nothing about the level of assistance to be given plaintiff for the transfer. Dr. Myers did approve Miller's recommendations.

¶ 34 The trial recessed. Plaintiff moved for a mistrial, based on Moss's alleged expert opinion testimony. The trial court denied plaintiff's motion.

¶ 35 The trial resumed. On direct examination, plaintiff admitted that there were several versions of how her accident happened. Asked to explain again, she testified, "I—I really can't remember anything but going down to the car and going—going to the cement."

¶ 36 On cross-examination, plaintiff testified that, before April 2009, she had been hospitalized at defendant's facility on several occasions, perhaps as many as nine. Every time that she had been discharged, except for April 28, 2009, she had stood up from her wheelchair, pivoted, and sat down in the car. She did not recall being told to stand, pivot, and sit on April 28, 2009, but, from experience, she already knew what to do. However, she was unable to stand, pivot, and sit on April 28, 2009, because the wheelchair was too close to the car. She did not recall the wheelchair being two feet or more from the car. Defendant read from her deposition of July 6, 2011, in which she had stated that her feet had been "maybe two feet" from the open car door; plaintiff did not remember giving that testimony.

¶ 37 Plaintiff denied having told Collins that there was not enough room to stand up, and she denied that Collins told her to try to put her legs into the car or slide into the car. Defendant

showed plaintiff her affidavit, in which she stated that she had raised herself up from the wheelchair seat using her arm and had put her left leg into the car, then gotten her right toe stuck in the door hinge or jamb. Plaintiff admitted that, in her deposition, she had testified that she grabbed the grip inside the car, stuck her left leg into the car, and, when she went to put her right leg into the car to swing herself into the car, her right leg got stuck in the door hinge. Plaintiff denied having told Dr. Carlson that she had caught her foot in the wheel of the wheelchair. On redirect examination, plaintiff stated that she had been wearing jeans with an elastic waistband.

¶ 38 Plaintiff rested. Defendant first called Miller. On direct examination, she testified as follows. As a physical therapist for defendant, she was responsible for determining the safest way to transfer or ambulate patients. Per an order from plaintiff's doctor, Miller examined plaintiff on the morning and afternoon of April 27, 2009, with plaintiff's possible discharge the next day in mind. She wrote up an evaluation that day. The doctor's notes, which Miller reviewed before examining plaintiff, stated that plaintiff wanted physical therapy "for walking" and did not indicate that there were any problems with transfers.

¶ 39 Miller's evaluation, defendant's exhibit No. 1, summarized plaintiff's pertinent medical history and the results of various tests that Miller performed on her. Plaintiff told Miller that she had not previously used assistive devices, such as canes or walkers, for walking. Plaintiff was independent with all of her "activities of daily living," such as getting dressed, bathing, driving, and, in particular, transfers and ambulation, including getting in and out of cars. Miller's testing showed that plaintiff was "full weight bearing [*sic*]," *i.e.*, "able to put full weight on both feet." Plaintiff was able to stand up from her chair and sit down while Miller had one hand on her.

¶ 40 Based on the information that plaintiff provided and the testing, Miller's report concluded that plaintiff needed one person's assistance for ambulation and one person's assistance for

transfers. For walking, plaintiff needed a pick-up walker, but she did not need it for transfers. In her report, Miller did not recommend that the nursing staff use a gait belt while transferring plaintiff. Miller could not recall whether she had communicated her findings directly to the nursing staff, but she explained that such information "[is] in the charts and they know how to access my findings." Miller's testimony continued:

"Q. Did you make a recommendation *** that someone, nursing staff or others, use an assistive device for [plaintiff]?

A. For walking.

Q. Pick-up walker?

A. Correct.

Q. Did you recommend the use of assistive devices for [plaintiff] in any other setting? Other than walking?

A. Just—no, just walking."

¶ 41 After other questioning, the examination continued:

"Q. Do you have an opinion about whether you acted as a reasonably careful physical *** therapist in all aspects of your evaluation, care, and treatment of [plaintiff]?

A. I feel I did.

Q. *** Does the standard of care require that you recommended the use of a gait belt for others in providing assistance to [plaintiff]?

A. No.

Q. Did the standard of care require that you recommend more than one assist for any of her transfer [*sic*] or ambulation?

A. No."

¶ 42 Miller testified on cross-examination that she entered her evaluation onto plaintiff's paper chart, but that she had been unaware at that time that the hospital was in the process of switching to electronic charts. She could not say whether the nurses had looked at the paper chart. On redirect examination, Miller testified that the paper chart had been kept at the nurses' station in the same binder as the doctor's progress notes, which the nurses were required to read.

¶ 43 Defendant next called Dr. Eric Bartel, an orthopedic surgeon. He testified as follows. He had examined plaintiff's records and X-rays and other pertinent documents in this case. Dr. Bartel opined, to a reasonable degree of medical certainty, that plaintiff's injury, a spiral fracture of her right ankle, was "a planted injury to the foot with a twisting of the leg above the foot." This was a "low energy [*sic*]" injury. The ankle was not displaced and the fracture was "essentially a hairline." It was "very consistent" with plaintiff having her weight on her right foot and losing her balance with an inward rotation. It was not consistent with plaintiff having caught her foot in the door jamb or hinge and then being pulled out and falling. The type of twisting injury that occurred to plaintiff's ankle could not have resulted from her having caught her foot in the jamb, being sent straight back, and falling.

¶ 44 In her short closing argument, plaintiff noted that both Ernat and Vajdik had testified that, in their opinion, the failure to use a gait belt and multiple assists deviated from the standard of care. Defendant had recognized that plaintiff was at a high risk for falling. Whatever way plaintiff's fall had occurred, it was the predictable result of being requested to transfer herself without any assistance and without the use of a gait belt.

¶ 45 In its closing argument, defendant noted that, although plaintiff had been recognized as at a high risk for falling, based solely on her prior fall. Miller had opined that she did not need more than one person's minimal assistance for ambulating or transfers. Before she was

hospitalized, plaintiff had undertaken her daily activities without assistive devices. On the morning of April 27, 2009, Moss assessed plaintiff, based on the information provided by various people. This information included Miller's report, which was in the binder with the doctor's progress notes.

¶ 46 Defendant argued further that plaintiff was transferred in accordance with Miller's recommendations, which did not include the use of the gait belt or multiple assists. Even had Moss and Collins not read that recommendation, they followed it. Miller had found that plaintiff could get up out of a chair with only moderate assistance from one person, and there was no evidence that getting out of the wheelchair was any different.

¶ 47 Defendant turned to the causation of plaintiff's injury and the multiple versions of how she fell. Defendant argued as follows. Plaintiff had testified that she did not recall how her injury occurred. However, in her affidavit, deposition, and consultation with Dr. Carlson, she had given varying accounts of the injury. None of these versions fit the facts: Dr. Bartel had explained that the injury, a spiral fracture, was not caused by a fall to the ground but by plaintiff losing her balance and rotating inward toward the car while all of her weight was on her right foot. This discrepancy went to plaintiff's credibility as a witness.

¶ 48 Moreover, defendant continued, the evidence showed that plaintiff's injury was not proximately caused by the absence of a gait belt and multiple assists. Plaintiff was told to stand, pivot, and sit, and she had always followed this procedure in previous discharges from the hospital. But this time, she attempted to step into the car and lost her balance, causing the twisting motion that "caused the fracture while she was still standing on the leg." Collins eased her to the ground.

¶ 49 Defendant returned to the standard of care, arguing as follows. There was no merit to the assertion that defendant had deviated from the standard of care by failing to develop a discharge plan. The discharge instructions provided all of the information required under defendant's written policies, and every pertinent actor was aware of them. Nobody had recommended the use of a gait belt or multiple assists, and no such assistance had been provided or needed for plaintiff in any of her ambulation or transfers during her stay. Miller had testified that the assistance provided comported with the standard of care; nobody had testified that Miller had not properly assessed plaintiff; and Moss and Collins had complied with her recommendations.

¶ 50 Defendant then returned to proximate cause, arguing as follows. Plaintiff had injured herself not by falling, but by disobeying the instructions to stand, pivot, and sit and, as a result, rotating her left leg inward so as to cause the ankle fracture while she was standing on her right foot. Dr. Bartel had provided "uncontroverted evidence" that the fracture had occurred while plaintiff was still standing and that the injury was low-impact, so that it could not have been caused by a fall. Thus, all the evidence showed that the fall did not cause the fracture. The lack of the gait belt and multiple assists had nothing to do with plaintiff's injury. Plaintiff's failure to follow the directions to stand, pivot, and sit had everything to do with the injury.

¶ 51 In rebuttal closing argument, plaintiff contended that the evidence did not show that Moss had ever communicated the substance of any discharge plan to Collins. On the matter of the injury itself, and the causation, plaintiff's entire rebuttal argument follows:

> "Doctor Bartel this morning said that it was a self transfer, he used those words. Brandi Miller used a gait belt. Of course she used the gait belt, it's part of the uniform. It's what should have been done here and it wasn't. You have a valet giving, giving instructions on how to transfer from a wheelchair to the car. [Collins was] not six feet

tall and two hundred pounds. You have to believe Elizabeth Collins when she says that she could only ease a 320[-]pound woman who's fallen to the ground without a gait belt."

¶ 52 The jury returned a verdict for defendant. Plaintiff moved for a judgment *n.o.v.* or a new trial, arguing in part that Moss had improperly given expert opinions without having been disclosed as one of defendant's expert witnesses. The trial court denied the motion, reasoning that Moss had not provided expert opinions but had only explained what she had done in the course of caring for plaintiff. Plaintiff timely appealed.

¶ 53 On appeal, plaintiff raises one claim of error: that the trial court erred in allowing Moss to testify as an expert witness and provide opinions even though defendant had never disclosed her as an expert witness. Plaintiff argues that she is entitled to a judgment *n.o.v.* or, at the least, a new trial. We hold that any error did not prejudice plaintiff, and we affirm.

¶ 54 Plaintiff relies on Rule 213, which, as pertinent here, provides:

> "**(f) Identity and Testimony of Witnesses.** Upon written interrogatory, a party must furnish the identities and addresses of witnesses who will testify at trial and must provide the following information:
>
> * * *
>
> (3) *Controlled Expert Witnesses.* A 'controlled expert witness' is a person giving expert testimony who is the party, the party's current employee, or the party's retained expert. For each controlled expert witness, the party must identify: (i) the subject matter on which the witness will testify; (ii) the conclusions and opinions of the witness and the bases therefor; (iii) the qualifications of the witness; and (iv) any reports prepared by the witness about the case.

> **(g) Limitation in Testimony and Freedom to Cross-Examine.** The information disclosed in answer to a Rule 213(f) interrogatory, or in a discovery deposition, limits the testimony that can be given by a witness on direct examination at trial. ***
>
> Without making disclosure under this rule, however, a cross-examining party can elicit information, including opinions, from the witness ***." Ill. S. Ct. R. 213(f)(3), (g) (eff. Jan. 1, 2007).

¶ 55 Plaintiff argues that Rule 213 required the trial court to exclude various opinions that, she asserts, Moss provided on examination by defendant. Specifically, she contends, Moss testified on the standard of care, and on whether defendant met the standard of care, even though defendant had never disclosed her as a standard-of-care witness. She also argues that, without Moss's improper opinions, the jury would have had no basis to find for defendant. Therefore, she requests that we enter a judgment *n.o.v.* for her or at least remand for a new trial.

¶ 56 Plaintiff's appellate briefing is seriously deficient. Under Illinois Supreme Court Rule 341(h)(6) (eff. July 1, 2008), an appellant's brief must contain a statement of facts, "which shall contain the facts necessary to an understanding of the case, stated accurately and fairly without argument or comment ***." See *Doe v. Boy Scouts of America*, 2014 IL App (2d) 130121, ¶ 60. Plaintiff's statement of facts is not only incomplete but highly selective, slighting much of the important evidence in this complex case, favoring the evidence that supported her over that which supported defendant, and engaging in commentary that should have been reserved for the argument portion. As for the argument portion, it takes up slightly under two pages (about half of which quotes or paraphrases Rule 213), contains no citations to the record (see Ill. S. Ct. R. 341(h)(7) (eff. July 1, 2008)), and does not address the trial court's reasoning on the issue raised.

¶ 57 A court of review is entitled to have issues clearly defined; it is not a depository into which the appellant may dump the burden of argument and research. *In re Marriage of Baumgartner*, 237 Ill. 2d 468, 474-75 (2010); *People v. Ramirez*, 2013 IL App (4th) 121153, ¶ 74. Owing to the severe deficiencies of plaintiff's appellate presentation, we hold that she has forfeited review of her claim of error. See *Doe*, 2014 IL App (2d) 130121, ¶ 60 (insufficient factual presentation); *Ramirez*, 2013 IL App (2d) 121153, ¶ 74; *Holmstrom v. Kunis*, 221 Ill. App. 3d 317, 325 (1991) (inadequate presentation of argument). Plaintiff's brief not only fails to cite appropriate pages of the record or pertinent case authority, but also contains no argument on why Moss's testimony was expert opinion testimony, as opposed to lay opinion testimony. Plaintiff omits any citation to Illinois Rule of Evidence 701 or 702 (eff. Jan. 1, 2011) or any case authority on the standards for determining whether Moss was providing expert opinion testimony or lay opinion testimony. Although the central issue is whether Moss improperly gave expert opinion testimony, plaintiff slights this issue and concentrates on the failure to disclose Moss as an expert under Rule 213(f), a matter not really in dispute. In sum, plaintiff has not sufficiently supported her argument for reversal, and therefore that argument is forfeited.

¶ 58 We also hold that any error was harmless in light of the evidence. Plaintiff was required to prove not only that defendant violated the standard of care but also that defendant's negligence proximately caused plaintiff's injury. The evidence on the issue of proximate cause was not closely balanced. Plaintiff's theory of the case was that defendant's failure to use a gait belt and multiple assists caused plaintiff to fall and that, in turn, her fall caused her injury. Even if the evidence allowed the jury reasonably to accept the first part of this theory, it gave the jury no reason to accept the second part.

¶ 59 Plaintiff, at various times, offered varying and inconsistent accounts of her accident. At trial, she offered essentially no account at all. But, in any event, her theory that the fall caused her to fracture her ankle was not supported by the evidence. The evidence was overwhelming that plaintiff was told, and already knew, that she was to stand, pivot, and sit in the car but that she did not do so and, instead, stood and placed all of her weight on her right foot. Dr. Bartel testified without contradiction or impeachment that plaintiff's injury was a low-energy, hairline-type fracture that occurred *before* she fell and that *could not have been caused* by her fall.

¶ 60 Thus, the jury could not reasonably have found that the lack of the gait belt and multiple assists proximately caused the injury. Notably, defendant stressed this point in closing argument, and plaintiff responded with essentially nothing. The jury could not have found for plaintiff without ignoring the uncontradicted expert testimony that the fall did not cause plaintiff's injury. Thus, any error in the admission of Moss's testimony was harmless and does not entitle plaintiff to a new trial, much less a judgment *n.o.v.*

¶ 61 For the foregoing reasons, the judgment of the circuit court of Lee County is affirmed.

¶ 62 Affirmed.