STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT	IN THE COURT OF COMMON PLEAS FOR THE FOURTEENTH JUDICIAL CIRCUIT
Margaret R. Tribble, individually and as the Personal Representative of the Estate of Jack L. Tribble, Heidi Tribble, and Matthew Tribble. Plaintiffs vs. National Healthcare Corporation, NHC/OP, L.P., NHC/Delaware, Inc., The Palmettos of Bluffton, LLC, The Palmettos of Bluffton, and Hendrick Contracting and Home Design, Inc., Defendants	CIVIL ACTION NO.: **SUMMONS**

TO THE ABOVE NAMED DEFENDANTS:

YOU ARE HEREBY SUMMONED and required to answer the Complaint herein, a copy of which is herewith served upon you, and to serve a copy of your Answer to this Complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the Complaint, judgment by default will be rendered against you for the relief demanded in the Complaint.

Respectfully submitted,

RIKARD & PROTOPAPAS, LLC

s/ Robert G. Rikard
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June 12, 2024

STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT	IN THE COURT OF COMMON PLEAS FOR THE FOURTEENTH JUDICIAL CIRCUIT
Margaret R. Tribble, individually and as the Personal Representative of the Estate of Jack L. Tribble, Heidi Tribble, and Matthew Tribble. Plaintiffs vs. National Healthcare Corporation, NHC/OP, L.P., NHC/Delaware, Inc., The Palmettos of Bluffton, LLC, The Palmettos of Bluffton, and Hendrick Contracting and Home Design, Inc., Defendants	CIVIL ACTION NO.: **COMPLAINT** **JURY TRIAL DEMANDED**

Margaret R. Tribble, individually, and as Personal Representative of the Estate of Jack L. Tribble, brings this action against these defendants and demands a jury trial for all claims.

PARTIES

1. Margaret Tribble is the wife of Jack L. Tribble and has been duly appointed as the Personal Representative of his Estate. Ms. Tribble is a citizen and resident of Barnstable County, Commonwealth of Massachusetts. Margaret and Jack were married for fifty-one years and had two children, Matthew Tribble and Heidi Tribble.

2. Heidi Tribble is a citizen and resident of The Commonwealth of Massachusetts. Matthew Tribble is a citizen and resident of the state of New York. Heidi Tribble, Matthew Tribble, and Margaret Tribble are all entitled to wrongful death damages

under South Carolina's wrongful death statutes and are all separate and individual claimants under the South Carolina Noneconomic Damage Awards Act of 2005.

3. The Defendant National Health Corporation is a business organized and existing under the laws of a state other than the State of South Carolina. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Beaufort County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of National Health Corporation acted on behalf of themselves and/or on behalf of National Health Corporation and The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton. Defendant National Health Corporation is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiary, The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton. National Health Corporation used its position to control the management, operation, funding, and staffing at The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton all of which directly affected resident care such as the care and treatment of Jack Tribble. Further National Health Corporation acted on behalf of itself and on behalf of The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton, and NHC/OP, LLP. National Health Corporation advertises itself as follows:

> National HealthCare Corporation (NHC) has been providing the best in senior care for 50 years. At NHC, we believe that care should respect the individual, promote recovery, well being and independence. NHC currently operates for themselves and third parties 68 skilled nursing facilities with 8,726 beds. NHC affiliates also operate 23 assisted living

> communities with 1,210 units, five independent living communities with 475 units, three behavioral health hospitals, 35 homecare agencies, and 29 hospice agencies. NHC's other services include Alzheimer's and memory care units, pharmacy services, a rehabilitation services company, and providing management and accounting services to third party post-acute operators.
>
> NHC is recognized nationwide as an innovator in the delivery of quality senior care. Our founder, Dr. Carl Adams had a vision in 1971 to provide higher quality healthcare services for seniors. His dream was to create a campus concept that offered in-house services for residents as they age with different needs much like the continuing care retirement community of today.

4. Upon information and belief, Defendant NHC/OP, LP (hereinafter "NHC/OP") is a business organized and existing under the laws of a state other than the State of South Carolina. Defendant NHC/OP, LP is a wholly owned subsidiary of NHC. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Beaufort County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of NHC/OP acted on behalf of themselves and/or on behalf of NHC/OP, National Healthcare Corporation and The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton. Defendant NHC/OP is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiaries, The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton. At all times relevant herein, NHC/OP used its position to control the management, operation, funding, and staffing at The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton all of which directly affected resident care such as Jack Tribble's care. Further NHC/OP acted on

behalf of itself and on behalf of The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton.

5. Upon information and belief, NHC/Delaware, Inc. is a corporation organized under the laws of the Delaware with its principal place of business in Murfreesboro, Tennessee. Further it acted on behalf of itself and on behalf of The Palmettos of Bluffton, LLC in the operation of an assisted living facility known as The Palmettos of Bluffton.

6. Upon information and belief, The Palmettos of Bluffton, LLC is a limited liability company organized under the laws of South Carolina with its principal place of business in Beaufort County, South Carolina. Further, it provided care and treatment to Jack Tribble as referenced herein. It is a citizen and resident of the state of South Carolina.

7. National Healthcare Corporation, NHC/OP, L.P., NHC/Delaware, Inc., and The Palmettos of Bluffton, LLC are hereinafter referred to as the "NHC Defendants".

8. The NHC Defendants collectively own, operate, and manage an assisted living facility located at 3035 Okatie Highway, Okatie, South Carolina 29209, which is known as "The Palmettos of Bluffton."

9. Upon information and belief, Hendrick Contracting and Home Design, Inc. (Hendrick Contracting) is a corporation organized under the laws of the State of Tennessee with its principle place of business located in Wilson County, Tennessee.

STATEMENT OF FACTS

10. Jack Tribble was born on September 28, 1942. He grew up in Idaho Springs, Colorado and graduated from Colorado State University, earning a B.S., M.S., Ph.D. in Microbiology. Additionally, he earned a law degree from Seton Hall University in New Jersey. While in law school, Jack began working in the Patent Department of Merck & Co., and later retired as Senior Patent Counsel after working there for twenty years.

11. Jack and Margaret were married for 51 years at the time of his death. Jack was a devoted family man who loved nothing more than spending time with his family. He adored his two children, Heidi and Matthew.

12. Jack and Margaret lived an active life. Jack loved to ski, play tennis, and hunt elk in Colorado. He also loved to travel with Margaret, and they took many trips together over the years visiting places in the United States and abroad. Jack retired in 2015, and he and Margaret spent their summers in Cape Cod, Massachusetts, and winters in Hilton Head, South Carolina.

13. Jack was devoted to his two dogs, Spot, and Ella. Spot was alleged to be his favorite, and had recently died.

14. Prior to his admission to The Palmettos of Bluffton, Mr. Tribble began to experience health problems. He was diagnosed with Lewy Body dementia, and Margaret was unable to take care of him by herself as the condition progressed.

15. Mr. Tribble had begun to wander significantly, and Margaret searched for an appropriate medical facility that could care for Mr. Tribble.

16. The Palmettos at Bluffton advertise themselves as follows:

> The **Palmettos Village Memory Care** provides for the unique needs of our memory-impaired residents while offering a safe and secure place to call home. Palmettos Village allows residents to receive specialized assistance that enables them to maintain their quality of life. Our open floor plan and secure, private courtyard allows them as much independence as possible. Our personalized approach to each resident's care ensures that he or she feels entirely comfortable and at home in a protected environment.
>
> Guided by the memory care coordinator, the Palmettos Village staff is specifically educated in dementia and Alzheimer's programming and leads and assists the residents in structured, individualized daily activities. Programming thoughtfully guided by our caregivers will center on meaningful and useful activities that are rewarding and successful for each resident.
>
> Our goal is to create pleasure, maintain dignity, provide meaningful tasks, restore roles, and enable friendships. It is important to emphasize individual strengths and to promote self-esteem. Our families are an integral part of the care process, providing a partnership in caring for their loved ones.

17. Based on this, and with assurances from the Defendants that they could provide the appropriate care for Mr. Tribble, he was admitted to The Palmettos of Bluffton primarily for Lewy Body Dementia on February 14, 2022, and to care for his wandering and elopement behaviors. Medical records maintained by Defendants indicate that Mr. Tribble's family reported that he had a significant history of wandering, and they were no longer able to care for him because of the strong desire to wander, and his confusion caused by his Lewy Body Dementia.

18. Upon admission, the nursing assessment completed by Defendant NHC employees specifically noted that Mr. Tribble exhibited confusion, required redirecting, and that he wandered frequently.

19. During the first 72 hours of Mr. Tribble's admission to the Palmettos of Bluffton, medical records document that there were behaviors observed that should have

served as additional alerts and notice to the Defendants of Mr. Tribble's high risk for wandering and elopement. NHC records document that Mr. Tribble required redirection and "wandered frequently." For example, the records note and document that Mr. Tribble was, **"At risk for elopement. Staff to provide supervision and reassurance to adjust to his new environment."**

20. An "Individual Care Plan (ICP) was composed for dressing, bathing, toileting, grooming, medications, nutrition, and other activities. The ICP notes that Mr. Tribble had issues with Behavior/Mental Status **"Elopement risk,** aggression, **confused/disoriented."** The ICP notes that the "Responsible Party" charged with ensuring that these interventions were initiated and completed, and to prevent Mr. Tribble from wandering or leaving the facility was the "Staff caregiver" of the NHC Defendants on duty and responsible for caring for Mr. Tribble.

21. Elopement assessments were completed by the NHC Defendants on February 22, 2022, and August 11, 2022, which confirmed the following:

a) Mr. Tribble was independently mobile;
b) Mr. Tribble wanders with a history of exiting behavior at home and the facility;
c) Mr. Tribble exhibited a desire to leave the facility;
d) Mr. Tribble exhibited exit seeking behavior; and,
e) Mr. Tribble was an elopement risk.

22. During his admission, Mr. Tribble's individual care plan notes and reflects that he was an elopement risk, had a history of wandering, needed supervision, and did not have competent decision-making capacity. The Tribble Family provided the NHC Defendants with a Gizmo 2 watch for Jack Tribble with cellular phone service that would enable the family to contact Mr. Tribble during his admission. More importantly, the Gizmo 2 watch enabled the family and the NHC Defendants to track the location of Mr. Tribble when he was wearing the Gizmo 2 watch.

23. On March 11, 2022, the treatment flow sheet of the physician's orders for Mr. Tribble were amended by the NHC Defendants to specifically require that all direct care providers involved in Jack's care be required to:

a) Charge Mr. Tribble's Gizmo watch every other day;
b) Encourage Mr. Tribble to have his Gizmo 2 watch on every day;
c) Keep Mr. Tribble's Gizmo 2 watch in the medication chart at bedtime;
d) Apply Mr. Tribble's Gizmo 2 watch every morning and ensure that he was wearing it.

24. Mr. Tribble's treatment administration records reflect that the NHC Defendants were required to complete the following:

a) Charge Mr. Tribble's Gizmo watch every other day
b) Encourage Mr. Tribble to have his Gizmo 2 watch on every day;
c) Keep Mr. Tribble's Gizmo 2 watch in the medication cart at bedtime;
d) Apply Mr. Tribble's Gizmo 2 watch every morning.

25. Between March of 2022 and August of 2022, the NHC Defendants failed to follow and comply with the physicians' orders, and failed to consistently complete the treatment administration records related to the Gizmo 2 watch.

26. Throughout Mr. Tribble's admission, the Defendants' staff observed and noted that his wandering, elopement, and exit seeking behaviors continued and increased, which included the following:

a) Banging on doors and exhibiting exit seeking behavior;
b) Demonstrating confusion, memory loss, and agitation;
c) Falling while unaccompanied;
d) Turning on hot water and plugging up sinks in several locations and causing flooding;
e) Reporting beliefs that he is in the army and at war;
f) Demonstrating increased agitation;
g) Reporting that he wanted to return home to his family; and,
h) Following direct care providers to entryways and exits in an effort to learn how to leave the facility by trying to observe staff entering the code for the keypads on locked doors.

27. On August 4, 2022, Margaret Tribble specifically requested the NHC Defendants ensure that Mr. Tribble wear his watch every day so she could monitor and speak with her husband.

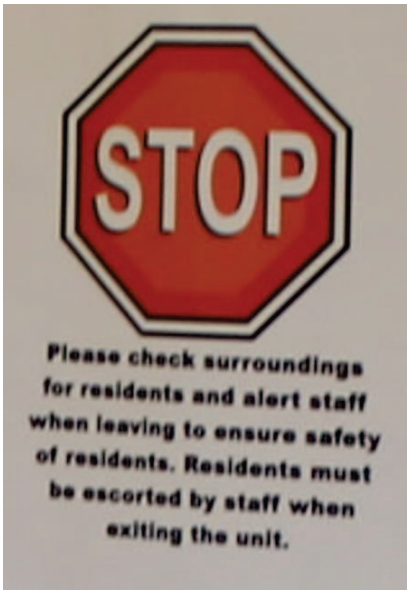
28. In August of 2022, the NHC Defendants hired and/or entered into a contract with Defendant Hendrick Contracting to perform construction and/or repair work at The Palmettos of Bluffton.

29. Upon information and belief, the NHC Defendants would have instructed Hendrick Contracting of the nature of the facility, its patients, and the heightened need to keep them safe and secure. Further it would have instructed Hendrick Contracting of the need to keep the facility secured at all times to prevent residents from wandering away from the facility.

30. The doors on the unit that Mr. Tribble resided in were supposed to remain locked at all times, and could only be opened through the use of an electronic keypad that only NHC Defendants' staff knew the passcode to.

31. Upon information and belief, the NHC Defendants gave this passcode to Hendrick Contracting and its employees working at The Palmettos of Bluffton.

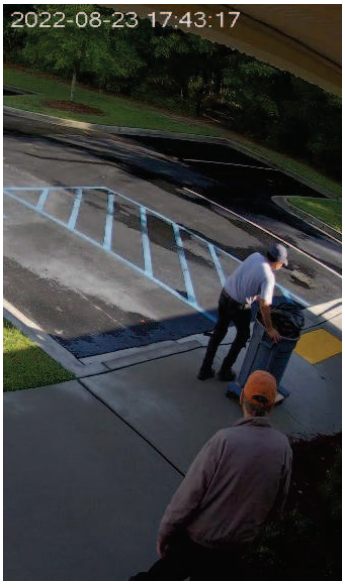
32. The doors at the facility have a sign affixed to them that states as follows, “Please check surroundings for residents and alert staff when leaving to ensure safety of residents. Residents must be escorted by staff when exiting the unit.”



33. On August 23, 2022, Mr. Tribble was in his dedicated, secured area of the Palmettos of Bluffton when an employee of Defendant Hendrick Contracting was exiting the facility. The employee of Defendant Hendrick Contracting used the secure passcode that had been provided by the NHC Defendants to access the door and unlock it.

34. As the Hendrick Contracting employee exited the Palmettos of Bluffton, Mr. Tribble followed closely behind him through two doors into the parking lot. Mr. Tribble followed the Hendrick Contracting employee as he left the NHC Defendants' facility at 5:43 PM according to video surveillance footage from the facility obtained from the Bluffton Police Department ("BPD"). Mr. Tribble is seen on this video footage walking outside and across the NHC parking lot at this time. According to the BPD investigation, the Hendrick employee observed Mr. Tribble leaving the facility with him, and did nothing to ensure that Mr. Tribble was not a patient. Further, the Hendrick employee did not alert any Palmettos staff that an individual had exited the secure facility area with him.

35. Mr. Tribble can be seen leaving the facility at 5:43 PM:



The video can be seen here: https://tinyurl.com/yk4unemc .

36. According to the BPD investigation, as Mr. Tribble was walking away from the NHC Defendants' facility, two of the NHC Defendants' employees personally witnessed Mr. Tribble outside of the facility. Neither employee intervened to return Mr. Tribble to the facility or immediately report that he was wandering outside of the locked facility. No employees attempted to redirect Mr. Tribble back to the facility.

37. Additionally, NHC Defendants' employee Michael Spriggs returned to the NHC facility after his shift to retrieve his cell phone. In a witness interview to law enforcement, Mr. Spriggs stated that on his way home from the facility he believed that he saw Jack Tribble walking down Highway 170. Once he returned home, he texted his supervisor, Diane Morrow, and told her he thought he saw Jack walking down Highway 170.

38. Upon information and belief, none of the NHC Defendants or employees acted on this information from Mr. Spriggs, and significant time passed before the NHC Defendants even discovered that Mr. Tribble was missing from the facility.

39. Other NHC Defendants' employees did not discover that Mr. Tribble was missing until 8:36 PM, approximately 3 hours after he wandered away from the facility.

40. At 8:48 PM the NHC Defendants notified law enforcement that Mr. Tribble was missing from the facility.

41. At 8:48 p.m. Sgt. R. Riney and other BPD officers went to The Palmettos of Bluffton in response to the missing persons report. The administrator, Heather Wigand, reported to the officers that Mr. Tribble had gone missing, and potentially walked off the facility at 8:30 p.m. Based on the video surveillance evidence, Ms. Wingand's report of the time that Jack walked away was incorrect. He actually wandered away from the facility at 5:43 PM according to video surveillance footage.

42. According to the police investigation, two officers reviewed video footage and revealed that Mr. Tribble walked off the property towards SC 170 at 5:43 p.m.

43. Multiple Bluffton police officers, K-9 units, drones, fire department personnel, and members of the Beaufort County Sheriff's Office began a search for Mr. Tribble.

44. On 08/24/2022, a Command Post was initiated at BPD. The facility was searched again. DHEC and Regional Long-Term Care Ombudsman were notified. The Memory Care Unit was searched again by two officers who noted a construction crew working who appeared to be supervised by a facility member. In addition to the significant search underway, helicopters and a search and rescue team were also searching for Mr. Tribble.

45. At all times relevant to this matter, Mr. Tribble was not wearing the Gizmo 2 watch, which was a violation of the care plan, the physician's orders, and the treatment administration records of the NHC Defendants.

46. At all times relevant to this matter, the Gizmo 2 watch was enabled with GPS technology that would have been able to track and locate Mr. Tribble.

47. Because Mr. Tribble was not wearing his Gizmo 2 watch, he was unable to be located by the NHC Defendants, his family, first responders, or law enforcement.

48. Mr. Tribble was never seen alive again after August 23, 2022, and was found dead in a swampy area approximately half a mile from The Palmettos of Bluffton on September 6, 2022.

49. Mr. Tribble's death certificate identifies his cause of death as acute bronchopneumonia associated with environmental exposure. Notably, the death

certificate identifies September 4, 2022, as the date of death, some 12 days after Mr. Tribble wandered away from the NHC Defendants' facility.

50. The Defendants had a duty to comply with all state and federal laws, regulations, and codes and they breached those duties. The injuries and damages sustained by Jack Tribble and the Plaintiffs were foreseeable and preventable, which includes, but is not limited to his exit and elopement from the Palmettos of Bluffton. These damages are a direct and proximate cause of the Defendants' breach of their duties to Plaintiffs.

51. The negligent and substandard care provided by the Defendants directly and proximately caused the death of Jack Tribble as well as the conscious pain and suffering he endured in the days and weeks prior to his death, which includes the following negligent, grossly negligent, wanton, willful, and/or reckless acts and/or omissions:

a) Ensure Mr. Tribble's Gizmo GPS watch is applied every morning;
b) Ensure Mr. Tribble's Gizmo GPS watch is charged every other day;
c) Frequent monitoring of Mr. Tribble's location to ensure Mr. Tribble stays in the facility;
d) Every one-half hour checks;
e) Have individual activities for Mr. Tribble as needed during periods of restlessness and wandering;
f) Implement a wander bracelet such as Wander Guard or another electronic alert system to alert staff if Mr. Tribble is attempting to exit the building, or if he does exit the locked portion of the building;
g) Add Mr. Tribble to a Resident Elopement Risk Profile with photos and descriptions of Mr. Tribble for easy identification. Place the Profile on each unit desk and reception desk. Educate staff that his name has been added to the Resident Elopement Risk Profile;
h) Educate vendors and visitors about the Memory Care Unit security processes and elopement risks to be guarded against;
i) Ensure security codes are not given to vendors or visitors, and only trained staff be allowed to possess security codes for the Memory Care Unit;
j) Monitor areas where vendors and visitors are entering or exiting locked Memory Care Unit doors to ensure that residents do not wander or elope from the facility during that time;

k) In failing to properly treat, evaluate, and take diagnostic measures at the appropriate times to care for Mr. Tribble;
l) In failing to timely and properly communicate about the care, symptoms, and treatment of Mr. Tribble among the NHC staff and employees.
m) In negligently hiring, retaining, and supervising staff;
n) In failing to follow and comply with Defendants' own policies and procedures directed at the care and treatment of the patients; and,
o) In such other and further ways as Discovery and Trial shall prove.

52. The failures and breaches of the standard of care described herein, were the proximate cause of Jack Tribble's wrongful death and conscious pain and suffering. Additionally, his wife and children have all suffered damages pursuant to the South Carolina Wrongful Death Statute. Plaintiffs are informed and believe that they are entitled to judgment against the Defendants for actual and punitive damages in an amount to be determined by the jury in this action.

53. The required expert witness affidavit is attached as "**Exhibit A**." The parties have complied with the applicable requirements of S.C. Code 15-79-125.

FOR A FIRST CAUSE OF ACTION
(Negligence – Wrongful Death)

54. The foregoing allegations are realleged and reincorporated as if fully set forth herein verbatim to the extent not inconsistent herewith.

55. The Defendants had a duty to comply with all state and federal laws, regulations, industry standards of care, duties of care, and codes and they breached those duties. The injuries and damages sustained by Jack Tribble and the Plaintiffs were foreseeable and preventable, which includes, but is not limited to his exit and elopement from the Palmettos of Bluffton. These damages are a direct and proximate cause of the Defendants' breach of their duties to Plaintiffs.

56. The negligent and substandard care provided by the Defendants directly and proximately caused the death of Jack Tribble as well as the conscious pain and suffering he endured in the days and weeks prior to his death, which includes the following negligent, grossly negligent, wanton, willful, and/or reckless acts and/or omissions:

a) Ensure Mr. Tribble's Gizmo GPS watch is applied every morning;
b) Ensure Mr. Tribble's Gizmo GPS watch is charged every other day;
c) Frequent monitoring of Mr. Tribble's location to ensure Mr. Tribble stays in the facility;
d) Every one-half hour checks;
e) Have individual activities for Mr. Tribble as needed during periods of restlessness and wandering;
f) Implement a wander bracelet such as Wander Guard or another electronic alert system to alert staff if Mr. Tribble is attempting to exit the building, or if he does exit the locked portion of the building;
g) Add Mr. Tribble to a Resident Elopement Risk Profile with photos and descriptions of Mr. Tribble for easy identification. Place the Profile on each unit desk and reception desk. Educate staff that his name has been added to the Resident Elopement Risk Profile;
h) Educate vendors and visitors about the Memory Care Unit security processes and elopement risks to be guarded against;
i) Ensure security codes are not given to vendors or visitors, and only trained staff be allowed to possess security codes for the Memory Care Unit;
j) Monitor areas where vendors and visitors are entering or exiting locked Memory Care Unit doors to ensure that residents do not wander or elope from the facility during that time;
k) In failing to properly treat, evaluate, and take diagnostic measures at the appropriate times to care for Mr. Tribble;
l) In failing to timely and properly communicate about the care, symptoms, and treatment of Mr. Tribble among the NHC staff and employees.
m) In negligently hiring, retaining, and supervising staff;

n) In failing to follow and comply with Defendants' own policies and procedures directed at the care and treatment of the patients; and,
o) In such other and further ways as Discovery and Trial shall prove.

57. Defendant Hendrick was negligent in failing to properly train, educate, and supervise its employee regarding the nature of the facility, its patients, and the heightened need to keep them safe and secure. Further it failed to properly train, educate, supervise, and instruct its employee regarding the need to keep the facility secured at all times to prevent residents from wandering away from the facility.

58. Defendant Hendrick is vicariously liable for its employee's and agent's conduct in failing to ensure that residents of the facility did not exit the facility while opening the facility doors during the construction project.

59. Defendant Hendrick is vicariously liable for its employee and agent's conduct in failing to alert the NHC Defendants that Jack Tribble wandered away from the facility.

54. Upon information and belief, the NHC Defendants would have instructed Hendrick Contracting of the nature of the facility, its patients, and the heightened need to keep them safe and secure. Further it would have instructed Hendrick Contracting of the need to keep the facility secured at all times to prevent residents from wandering away from the facility.

60. The NHC Defendants were negligent in failing to ensure that Hendrick employees and/or agents did not allow residents to wander away from the facility via the locked doors.

61. The failures, negligence, and breaches of the standard of care described herein, were the proximate cause of Jack Tribble's wrongful death and conscious pain and suffering. Additionally, his wife and children have all suffered damages pursuant to the South Carolina Wrongful Death Statute. Plaintiffs are informed and believe that they are entitled to judgment against the Defendants for actual and punitive damages in an amount to be determined by the jury in this action.

62. Defendants are responsible and vicariously liable for the negligent, grossly negligent, and/or reckless acts or omissions of their employees or agents acting in the course and scope of their employment and/or agency relationship.

63. Defendants, through their doctors, nurses, employees and other agents, including those employees and other agents specifically referenced herein, breached the applicable standard of care in multiple separate and independent particulars as described herein.

64. As a direct and proximate result of these Defendants' negligence, Jack Tribble suffered fatal injuries and died.

65. As a further direct and proximate result of these Defendants' negligence, Plaintiffs and Jack Tribble's beneficiaries suffered deep and profound grief and sorrow, permanent mental shock and suffering, and severe emotional distress. Additionally, Plaintiffs and the beneficiaries have been forever deprived of Jack Tribble's love and affection, comfort, companionship and society.

66. Plaintiffs are entitled to recover compensatory damages, including, but not necessarily limited to, damages for pecuniary loss, mental shock and suffering,

wounded feelings, grief and sorrow, loss of companionship, and deprivation of Jack Tribble's love, affection and society.

67. Plaintiffs are informed and believe that Defendants' actions were grossly negligent, willful, wanton, or conducted with such reckless disregard for and conscious indifference to Plaintiffs' rights that Plaintiffs are entitled to recover punitive damages in addition to compensatory damages.

FOR A SECOND CAUSE OF ACTION
(Negligence – Survival)

61. The foregoing allegations are realleged and reincorporated as if fully set forth herein verbatim to the extent not inconsistent herewith.

62. As a direct and proximate result of the separate and independent negligent, grossly negligent, reckless, willful and/or wanton acts of Defendants as described herein, Jack Tribble endured continuing and excruciating pain and suffering and mental distress and suffered damages in an amount to be determined by a jury at the trial of this case.

63. Because Mr. Tribble was not wearing his Gizmo 2 watch, he was unable to be located by the NHC Defendants, his family, first responders, or law enforcement.

64. Mr. Tribble was never seen alive again after August 23, 2022, and was found dead in a swampy area approximately half a mile from The Palmettos of Bluffton on September 6, 2022.

65. Mr. Tribble's death certificate identifies his cause of death as acute bronchopneumonia associated with environmental exposure. Notably, the death certificate identifies September 4, 2022, as the date of death, some 12 days after Mr. Tribble wandered away from the NHC Defendants' facility.

68. Plaintiffs are informed and believe that Defendants' actions were grossly negligent, willful, wanton, or conducted with such reckless disregard for and conscious indifference to Jack Tribble's rights that Plaintiffs are entitled to recover punitive damages in addition to compensatory damages.

FOR A THIRD CAUSE OF ACTION
(Loss of Consortium)

69. The foregoing allegations are realleged and reincorporated as if fully set forth herein verbatim to the extent not inconsistent herewith.

70. The plaintiff, Margaret Tribble, was Jack Tribble's legal wife.

71. As a direct and proximate result of the negligence, carelessness, gross negligence and/or recklessness of Defendants as described herein, Margaret Tribble was forever deprived of the companionship, services, affection, and support of her husband, Jack.

72. Margaret Tribble is informed and believes that Defendants' actions were grossly negligent, willful, wanton, or conducted with such reckless disregard for and conscious indifference to Jack Tribble's rights that Margaret Tribble is entitled to recover punitive damages in addition to compensatory damages.

FOR A FOURTH CAUSE OF ACTION
(**Corporate Negligence**)

73. The foregoing allegations are realleged and reincorporated as though fully set forth herein verbatim to the extent not inconsistent herewith.

74. The NHC Defendants had a duty of care to Mr. Tribble to ensure the facility was properly funded and properly staffed, that staff who provided care to Mr. Tribble

were properly trained, and that adequate policies and rules were implemented to ensure quality care for residents like Mr. Tribble.

75. Defendants breached the duties they owed to Mr. Tribble in one or more of the following particulars:

a. failure to properly fund the facility;

b. failure to ensure the facility had sufficient staff available to care for Mr. Tribble and other residents;

c. failure to ensure staff who cared for Mr. Tribble were properly trained;

d. failure to implement proper rules, policies, and procedures to ensure quality care for Mr. Tribble; and

e. in such other and further particulars as may be revealed in discovery and proven at trial.

76. As a direct and proximate result of Defendants' negligent, grossly negligent, reckless, willful, and/or wanton acts, Mr. Tribble endured excruciating pain and suffering and mental distress, incurred medical expenses, died, and suffered damages in an amount to be determined by a jury at the trial of this case.

77. Plaintiff is informed and believes Defendants' actions were willful, wanton, or conducted with such reckless disregard for and conscious indifference to Mr. Tribble's rights that Plaintiff is entitled to recover punitive damages in addition to compensatory damages.

WHEREFORE, Plaintiffs pray for the Court to award judgment against Defendants for compensatory damages, actual damages, pain and suffering, loss of enjoyment of life, mental distress, pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, deprivation of Jack Tribble's love, affection and society,

loss of consortium, punitive damages, attorney's fees, the costs of this action, such other and further damages as may be revealed in discovery and proven at trial, and such other and further relief as the Court deems just and proper.

Respectfully submitted,

RIKARD & PROTOPAPAS, LLC

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June 12, 2024

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

RE: Jack L. Tribble
DOB: September 28, 1942

My name is Paige Swatman, and I am over the age of eighteen (18). I am a Registered Nurse with 30 years' experience in the long-term care field. My experience includes Director of Nursing Service, Regional Clinical consultant, Vice President of Clinical services, and Long-term care surveyor for the South Carolina Department of Health and Environmental Control.

I have reviewed the medical records and law enforcement records related to Jack L. Tribble for the time period of February 17, 2022, through August 23, 2022. These records include Mr. Tribble's medical records from The Palmettos of Bluffton and records from the Bluffton Police Department.

Based on my review, it is my professional opinion that The Palmettos of Bluffton, an affiliate of National HealthCare Corporation, and its staff deviated from the standard of care for resident safety resulting in the traumatic death of Jack L. Tribble.

My findings are based on review of the records as follows:

1. Jack L. Tribble was admitted to The Palmettos of Bluffton secured Memory Care Unit on February 17, 2022, primarily for Lewy Body Dementia and to care for his wandering and elopement behaviors.

2. The nursing admission assessment done on February 2, 2022, states, "Requires redirecting, wanders frequently."

3. On 02/22/2022, Mr. Tribble had an Elopement Risk Assessment, and the findings were that he was an **elopement risk**. He was noted to wander, was independently mobile, and had a history of wandering and exiting a home without the needed supervision. He was not cognitively intact and did not have competent decision-making capability.

4. On February 25, 2022, Corinne Ingle, Nurse Practitioner, documented, "Staff nurse reports he has been banging on doors exit seeking."

5. On March 25, 2022, the Nurse Practitioner documented, "Asked to see patient for depression/low moods. He is normally quite laid back per facility nurse, but sometimes becomes quite agitated/anxious and packs up his things."

6. On 08/11/2022, a six-month "Resident Care Plan Without Schedule" included the following "Category/Resident Needs":

- Orientation-Requires regular prompting due to confusion and disorientation. Staff will reorient as needed.
- Wandering Behavior-Wanders intrusively but is easily redirected. Be alert to the need to rest and encourage and or prompt as appropriate.

7. Mr. Tribble had a Gizmo 2 watch provided by his family so that they could stay in contact with him at all times. The Gizmo watch had a cellular phone service, and also a location tracker to allow facility staff to know his whereabouts at all times.

8. On 03/11/2022, new physician orders were entered and are documented in the treatment flow sheet which state:

   a) Charge Mr. Tribble's Gizmo watch every other day;
   b) Encourage Mr. Tribble to have his Gizmo 2 watch on every day;
   c) Keep Mr. Tribble's Gizmo 2 watch in the medication cart at bedtime;
   d) Apply Mr. Tribble's Gizmo 2 watch every morning.

9. Mr. Tribble was noted to be missing at 8:48 PM on August 23, 2022. His Gizmo watch was not charged, he was not wearing it, and it was found stored in the medicine cart.

10. At 8:48 p.m. Bluffton Police Department officers went to The Palmettos of Bluffton based upon the missing persons report by Palmettos staff. According to the police records, the administrator, Heather Wigand, reported to the officers that Mr. Tribble was missing and potentially walked off the facility at 8:30 p.m. Officers reviewed video footage and discovered that Mr. Tribble actually left the facility on foot through an unsecured door and exited the property through the main entrance. He walked off the property at 5:44 p.m.

11. On 08/25/2022, Detective D. Marciano with the Bluffton Police Department interviewed Hendrick Contracting employee Brayan Hernandez. Per the police report, Mr. Hernandez was taking the trash out of the Memory Care Unit at approximately 5:47 p.m. Mr. Hernandez unlocked the Memory Care Unit door by using a code that had been provided to him by Palmettos staff. He claimed that his hands were full, and that Mr. Tribble held the doors open for him. Mr. Hernandez walked to the dumpster, and Mr. Tribble followed him out of the door and walked away from the facility.

12. Mr. Tribble's body was found on September 6, 2022, in a swampy area approximately .5 miles from The Palmettos of Bluffton.

13. Mr. Tribble's death certificate identifies his cause of death as Acute Bronchopneumonia associated with environmental exposure. The death certificate indicates that the date of death was September 4, 2022, twelve days after he wandered away from The Palmettos of Bluffton Memory Care Unit.

Summary:

Mr. Tribble was admitted to the Memory Care Unit due to his cognitive status, behaviors, and elopement risk. The unit was supposed to be a secure and safe unit for him. The nursing staff failed to recognize and appreciate that Mr. Tribble was an elopement risk. Mr. Tribble had reports of exit-seeking behavior, and positive elopement risk evaluations, shortly after admission and throughout his six-month stay at The Palmettos of Bluffton.

The nursing staff at The Palmettos of Bluffton failed to supervise and keep Mr. Tribble safe pursuant to the applicable standards of care. The staff at Palmettos of Bluffton failed to monitor Mr. Tribble for location and safety. They failed to have him wear his monitoring bracelet (Gizmo watch) as ordered, and allowed him to exit the facility unsupervised. The staff failed to observe the cameras outside the facility which showed Mr. Tribble walking away. The staff also failed to be aware of his elopement and take appropriate action after an employee reported seeing him walking along the highway. The staff failed to ensure that invitees to the facility did not allow residents to exit the Memory Care Unit unsupervised.

Conclusion:

It is my opinion, to a reasonable degree of nursing certainty, that The Palmettos of Bluffton and its nursing staff did not provide appropriate care to Jack Tribble per the applicable standard of care, resulting in Jack Tribble eloping from the facility on August 23, 2022, and ultimately being found dead on September 6, 2022.

These breaches of the standard of care by the staff at The Palmettos of Bluffton contributed in a direct and proximate way to the pain, suffering and death of Jack L. Tribble.

I reserve the right to amend this report or issue a supplemental report should additional information become available. All my opinions are within a reasonable degree of nursing certainty.

Paige Swatman, RN

Sworn and subscribed before me

this 22 day of FEBRUARY, 2024

Notary Public
My Commission Expires: 10/6/27

SCOTT MOORE NOTARY PUBLIC SOUTH CAROLINA My Comm Exp 10-06-2027