

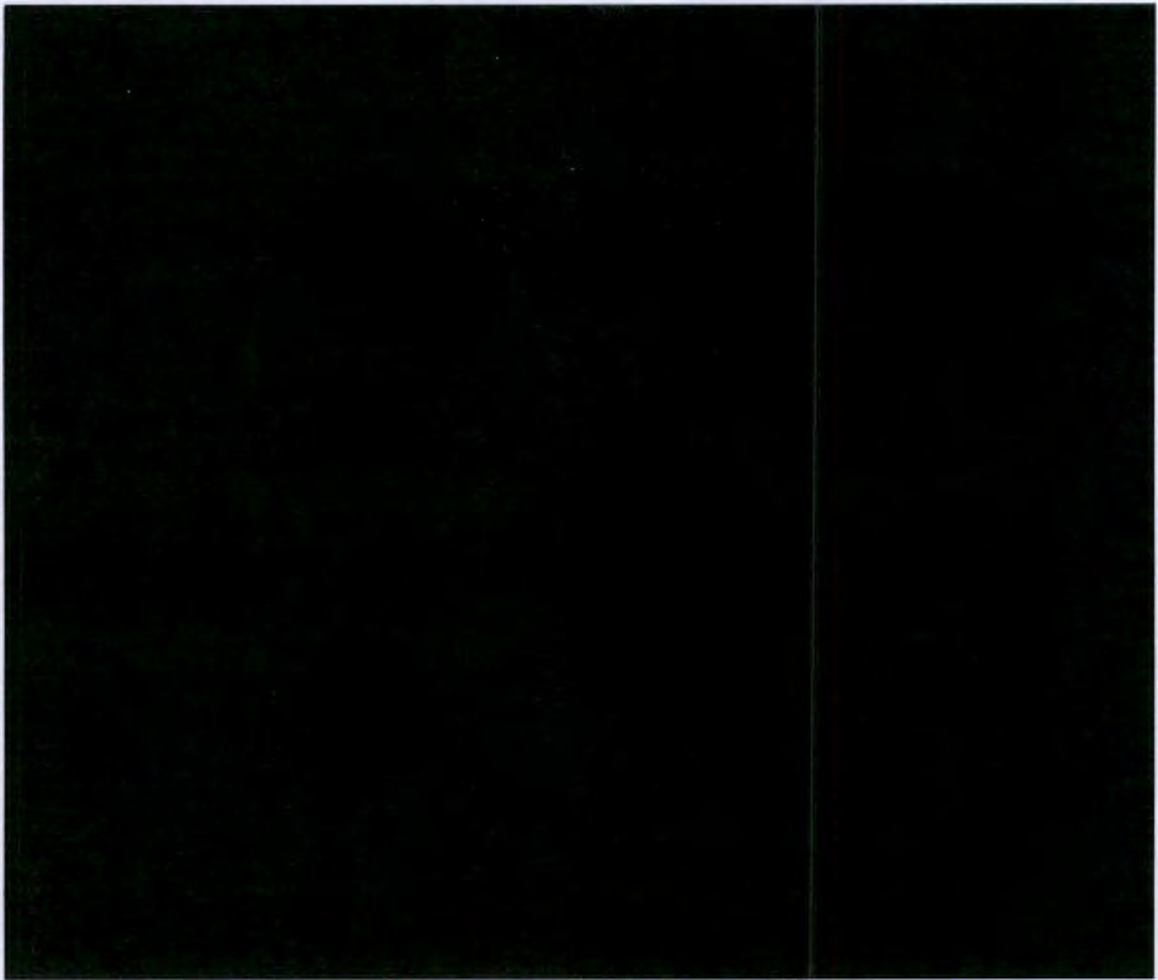
**Patient: RW**  
[REDACTED]

**6/12/14** - 2300 - RN and MD met with patient to discuss plan and medication regime. At this time the plan is for RN to assess patient twice a day and to give him his medication every morning to self-administer throughout the day. If patient needs to travel without RN he can have two days of medication at a time. RN will be in close contact with patient's assistants to arrange daily meetings. RN will report status of patient to MD via telephone on a daily basis.

During initial meeting patient was pleasant and cooperative. Patient agreed to the plan and appears motivated to make positive changes in his life. Patient was able to identify some negative consequences of current medication usage and looks forward to living a healthier lifestyle. Plan is for RN to monitor patient and current medication regime while patient finishes his work commitment in Boston through mid July. Once patient completes work commitment he will begin a medical detox in LA.

**6/13/14** - 1500 - Met with patient in his apartment. Patient continues to be pleasant and cooperative. He stated that he initially started taking opiates after some dental work and became dependant on them. Patient is fearful of coming off of opiates but knows it is what he needs to do. Patient also expressed some emotional trauma, which causes him depression and anxiety. Patient given positive reinforcement for reaching out for help at this time. Patient was given his daily medication. Each medication was discussed with patient and he expressed verbal understanding. When asked to turn over all medications that he had in his possession, assistant gave the following medications to RN:

PLT/ Def: 40  
Date: 04/11/2022  
Judge: PSA  
Case: CL-2019-0002911

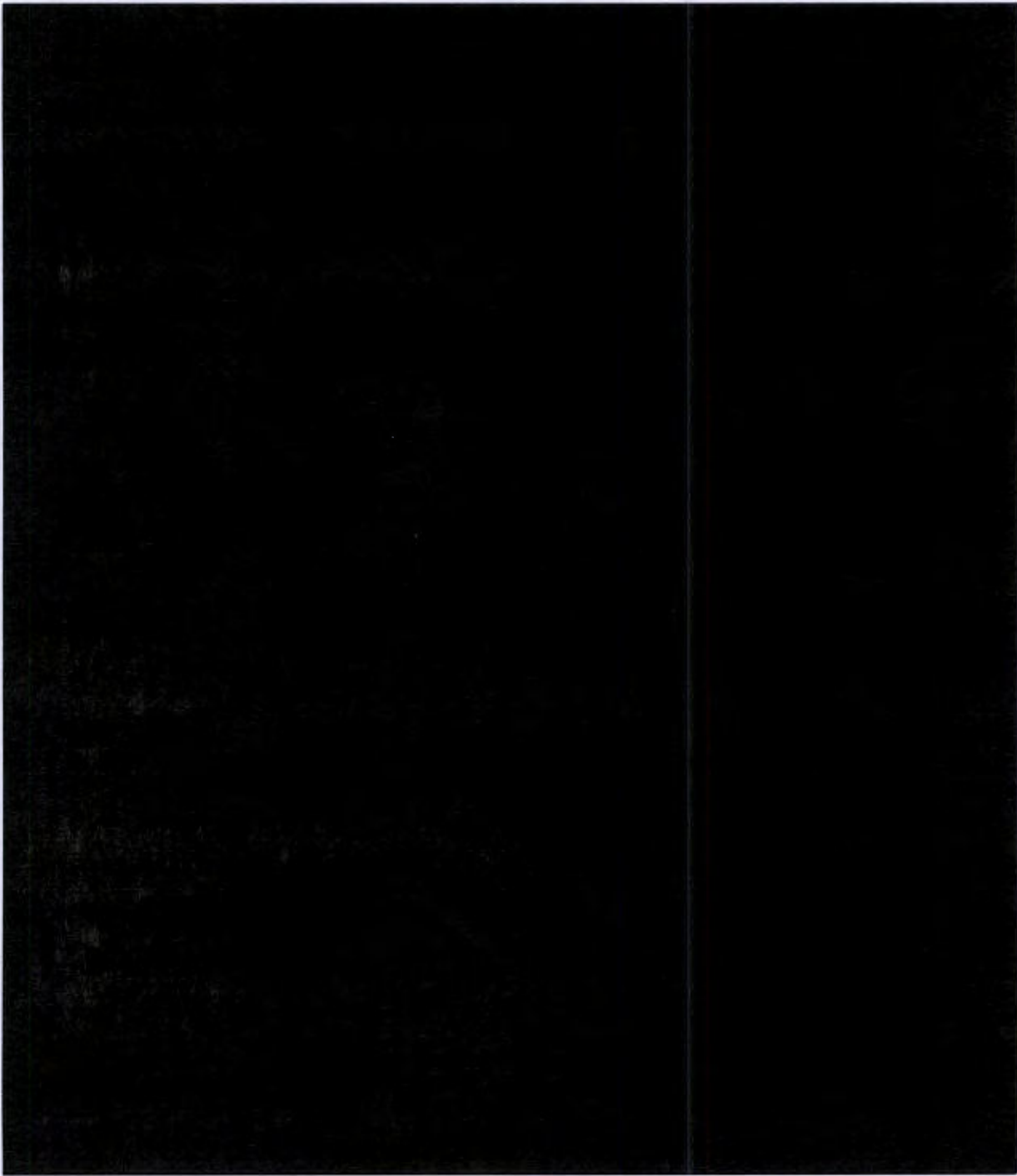


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6/16/14 -

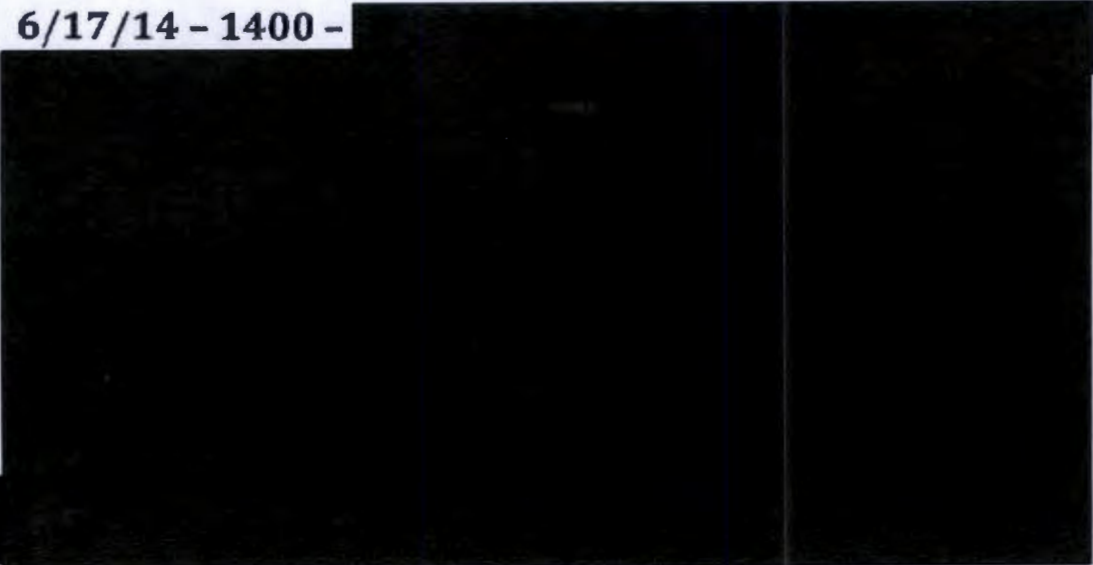


19STCP04763


PLAINTIFF'S TRIAL EXHIBIT 0040\_0004

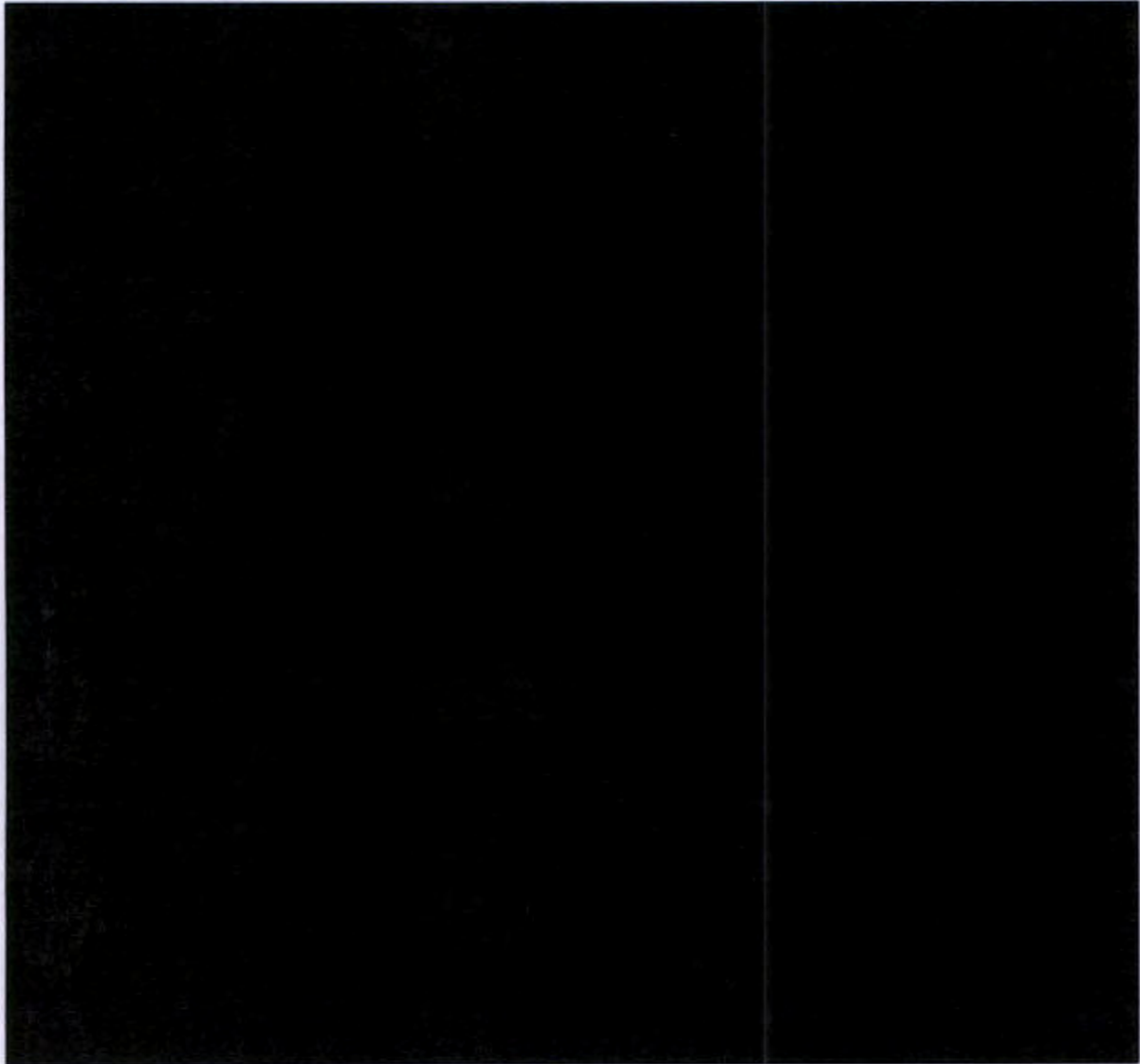
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6/17/14 - 1400 -



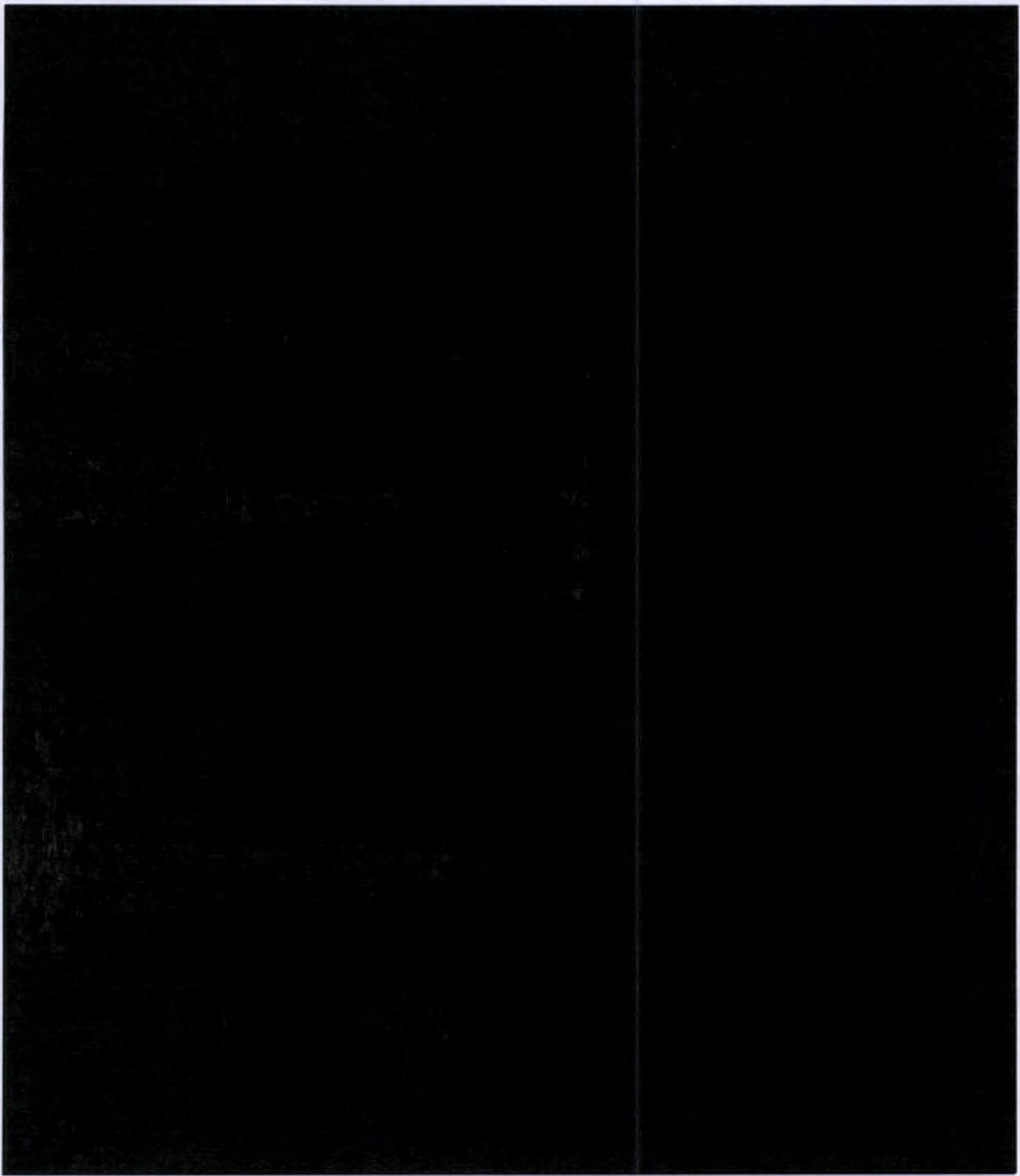
2330 - Accompanied patient, fiancé, assistants and security to concert. Patient was preoccupied as he was performing with other musicians during the concert. Patient appeared in good spirits but I was unable to spend any one on one time with patient to assess him or speak to him about how he is feeling. Daily routine medications were given to assistant for patient to self-administer tomorrow. Assistant informed me that patient took Adderall 5mg in am today rather than Adderall 10mg, which he had previously requested. Assistant was asked to please have patient call MD tomorrow, as he would like to check in with him. Assistant was also asked to pass on RN and MD's numbers to fiancé as we would both like to speak with her and to obtain her input towards patients treatment needs. Tomorrow patient is off from his current film but has to do some voiceover commitments for a previous film. Plan is for RN to check in with assistant in the afternoon to see when a good time to assess patient would be. Assistant was also asked to find a good time when we could get some blood drawn for lab work that MD is requesting.





6/19/14 -





6/20/14 -

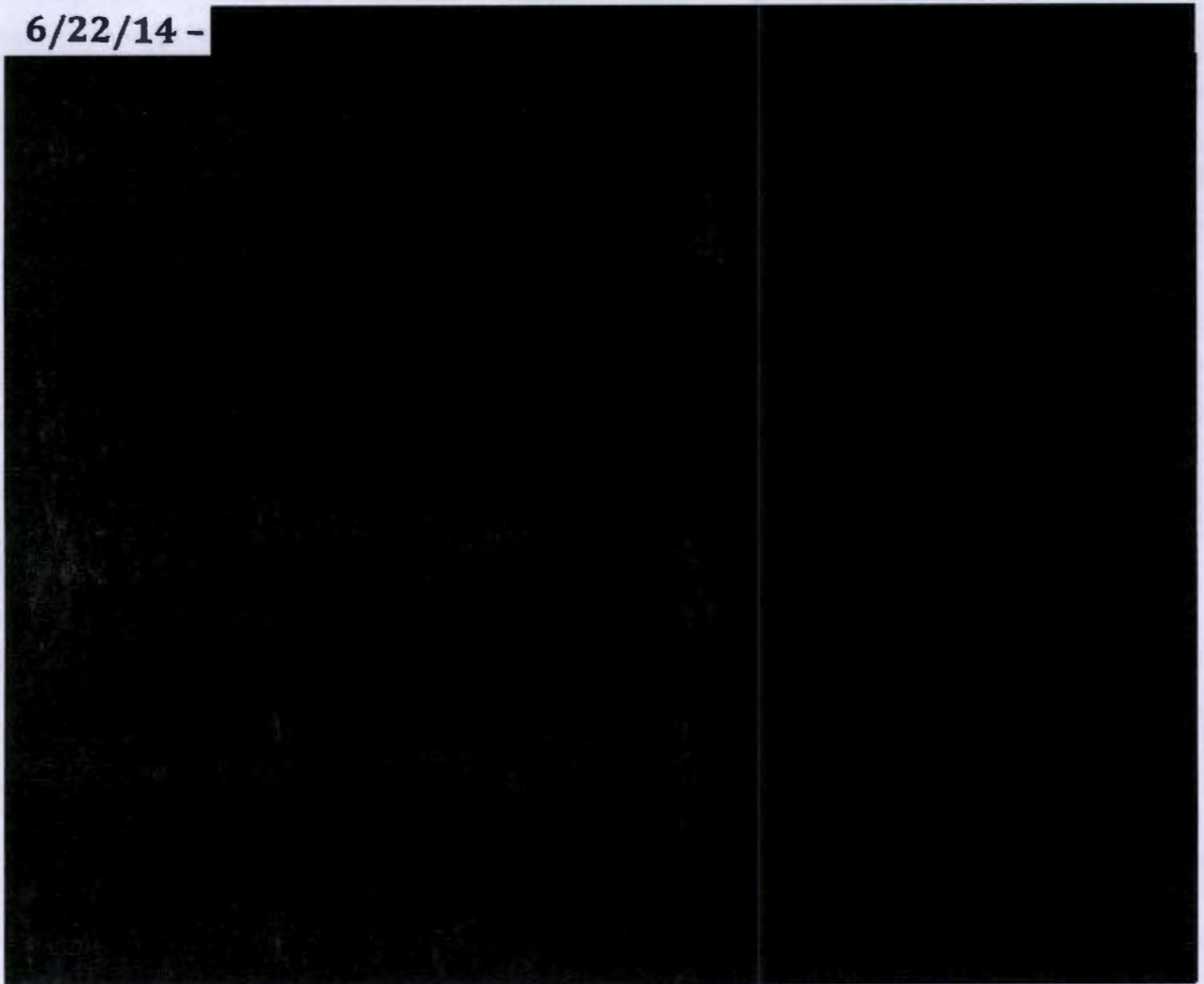




6/21/14 -



6/22/14 -



6/23/14 -

[REDACTED]

[REDACTED]

6/24/14 - 1200 - RN and MD met with patient's fiancé to inform her of treatment plan for patient. Fiancé voiced concerns of patient's behavior while using drugs and alcohol. She is in agreement of treatment plan and supportive of patient's decision to detox after he finishes filming. Fiancé was educated on patient's current medication regime and feels comfortable with treatment he is receiving. She was encouraged to call RN or MD with any questions or concerns that might arise.

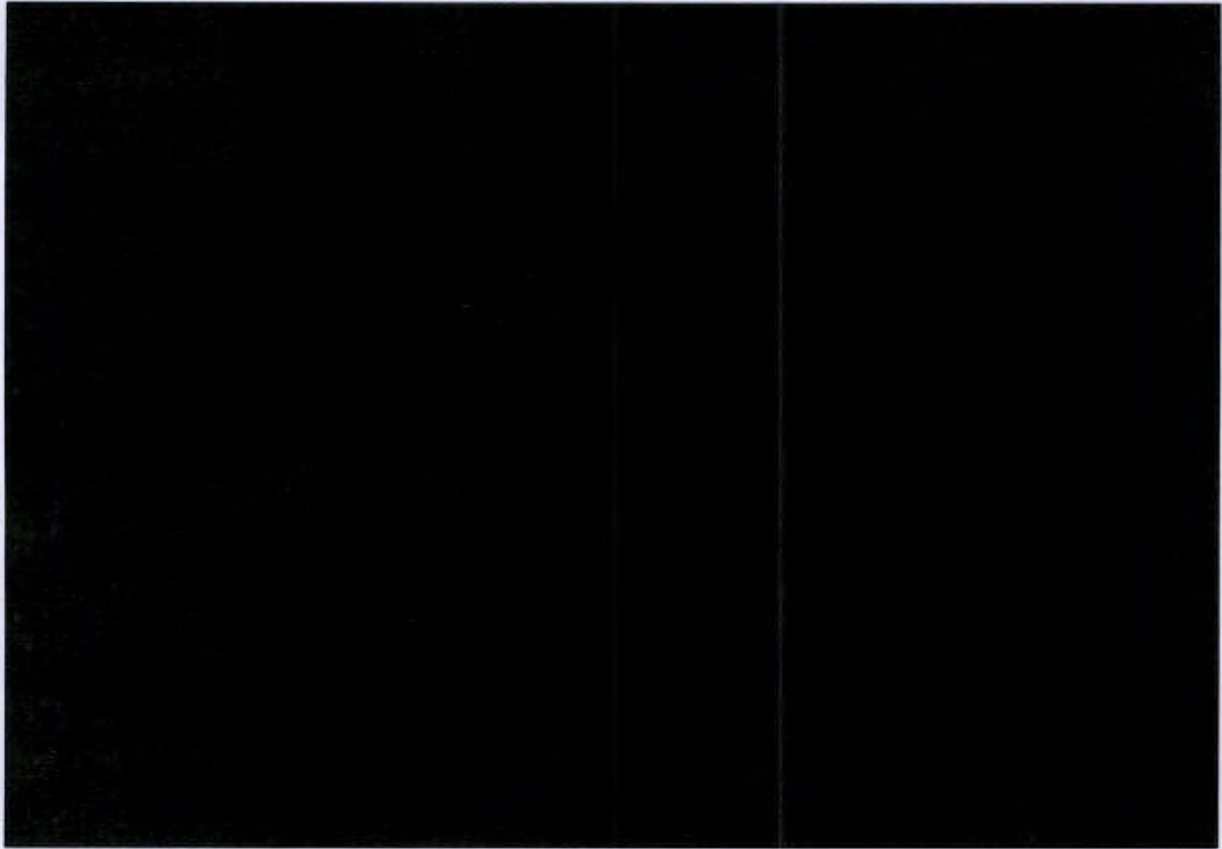
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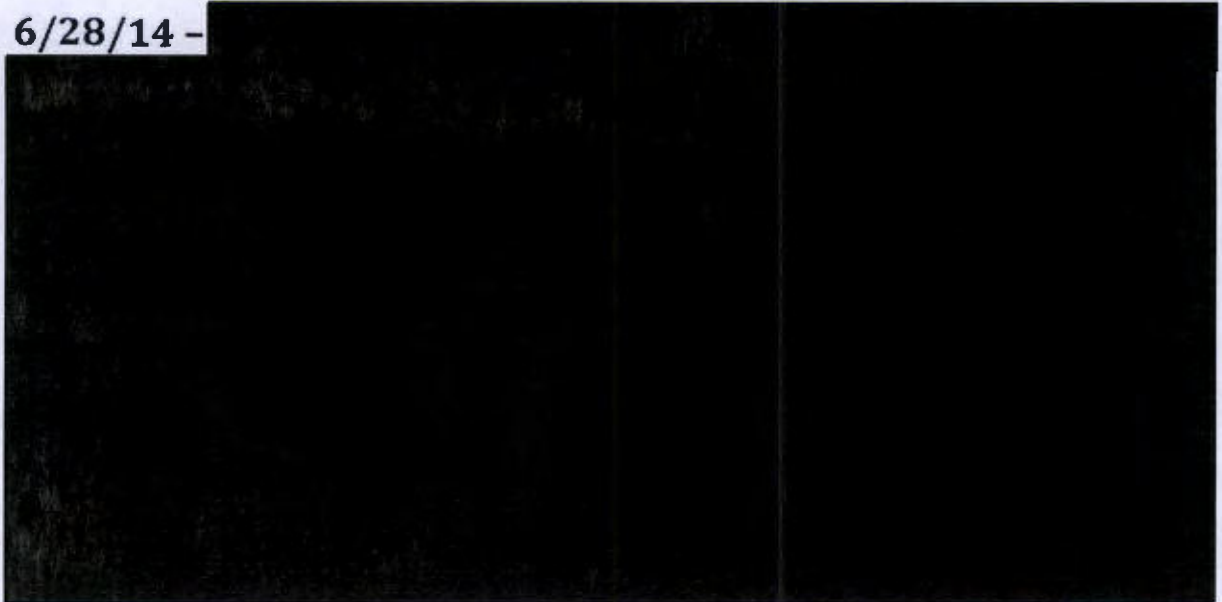




6/27/14 -



6/28/14 -



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6/30/14 -

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7/1/14 -

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7/2/14 -

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7/7/14 -



7/8/14 -



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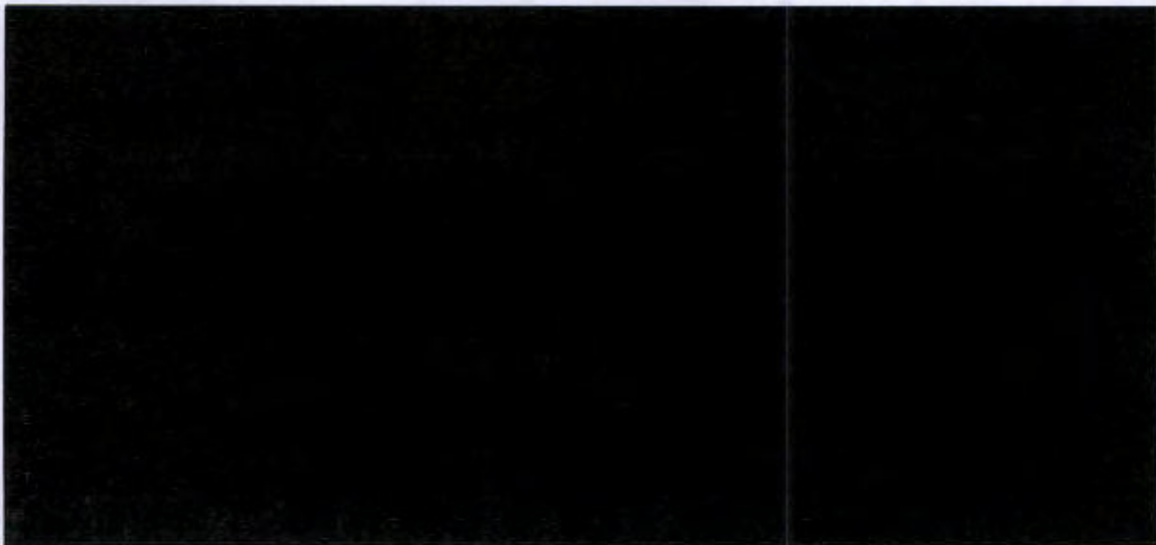
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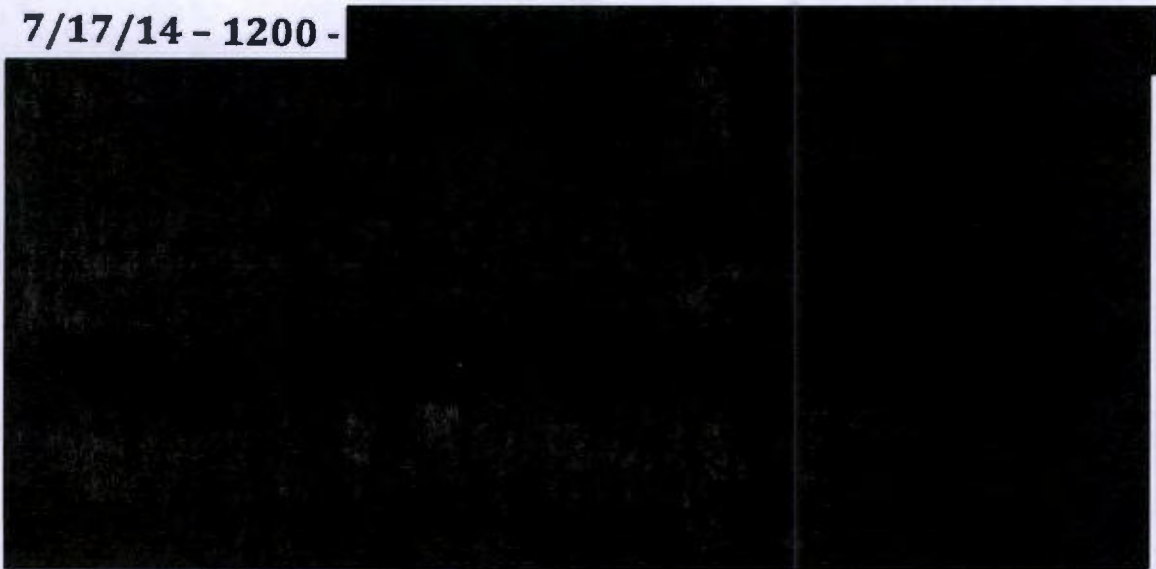
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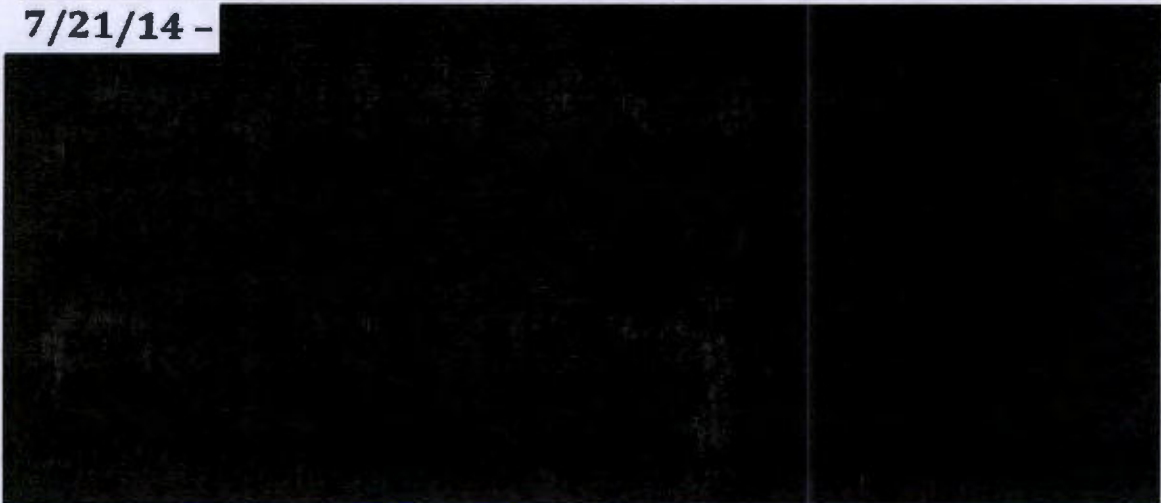
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7/17/14 - 1200 -



7/21/14 -



[REDACTED]

7/24/14 -

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7/27/14 -

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[REDACTED]

[REDACTED]

7/31/14 -

[REDACTED]

8/4/14 -

[REDACTED]

8/7/14 -

[REDACTED]

8/8/14 - Arrived on island today. Plan is for patient to continue to take routine meds through tomorrow at HS. At that time he will not take his Oxycodone and detox medications will be initiated.

8/9/14 - Patient expressed fears of never feeling normal without his drugs. Reassured him that this is a normal feeling and to just focus on one day at a time and see how he feels on a day-to-day basis. Patient encouraged to be open and honest with how he is feeling physically and emotionally throughout the detox process and assured we will keep his safe and




comfortable. Patient took his routine meds today. His HS dosage of Oxycodone was discontinued and replaced with phenobarb 64.8 mg and baclofen 20mg. Patient was also given his routine morning medications minus the discontinued Klonopin and Oxycodone. Patient was left Phenobarb 64.8mg and Baclofen 20mg in addition to morning meds. Patient will self-administer medications. Patient was left with written instructions of what meds he was taking. Patient was also left with an automatic BP cuff and shown how to use machine. Patient encouraged to check BP prior to administering meds and if he starts to feel any withdrawal s/s. Patient expressed verbal understanding and patient's fiancé demonstrated using the BP machine. Patient was instructed to call RN if he needs anything throughout the night. If patient does not need RN throughout the night he was instructed that RN needs to see him 1 hr after he takes his morning medications to assess how he is feeling. MD will arrive tomorrow evening.

New medications orders as of 8/9/14

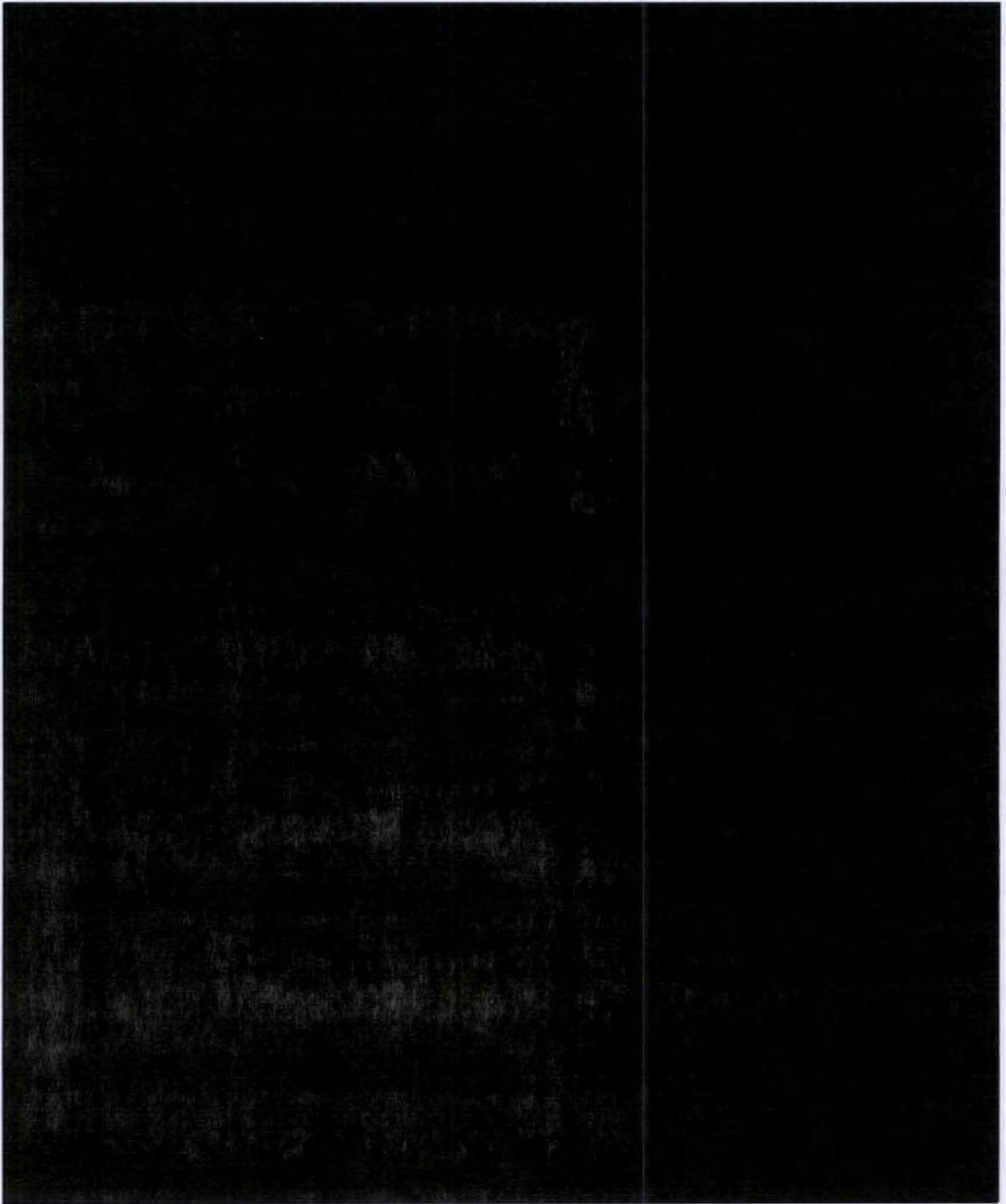
Discontinue Oxycodone 30 mg - ½ tab BID, 1 tab at HS  
Discontinue Klonopin 1mg - 2 tabs in am  
Start Phenobarb 64.8mg q6-8 hr while awake  
Start Baclofen 20 mg QID prn body aches

8/10/14 -



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1000 - MD's flight has been cancelled. Arrangements are being made for him to arrive on the island 8/12/14.



19STCP04763

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**8/11/14 -**

**0220** - Patient's fiancé contacted RN. Stated she had given patient his HS meds along with Phenobarb 81 mg and Baclofen 20 mg at 0100. Stated patient is complaining of being in a lot of discomfort - muscle spasms, chills and pains. Instructed to give patient a prn phenobarb 32.4 mg and neurontin 300 mg and to let RN know if it has an affect on patient.

**0335** - Patients fiancé contacted RN to inform that patient is still awake and continues to complain of discomfort. Instructed to give vistaril 25 mg.

**0445** - Patients fiancé contacted RN to inform that patient is still awake and complaining of muscle spasms and pain. Instructed to have him take a hot shower and take Neurontin 600 mg.

**0540** - Patient continues to be awake and complain of muscle spasms and pain. RN assessed patient - he had restless legs, muscle twitches, complained of feeling like skin was crawling. BP 124/83 P 63. Magnesium 1 tab and Toradol 30 mg IM administered. Patient encouraged to take a warm shower and did so with assistance from his fiancé. After show patient felt better and restless legs had calmed down. Patient was able to sit still in bed.

**0600** - Status reported to MD.

Increase pheno to 97.2mg Q4-6h

**0615** - AM dose of Phenobarb 97.2 mg and Baclofen 20 mg given to patient. Patient was relaxing in bed and felt as though he could finally go to sleep. RN instructed patient to call when he wakes up in the morning / afternoon. Encouraged him to wake and take his next dose of meds around noon.

**8/12/14** -

1030 - Per fiancé, patient slept till 1000. Meds given at 1010. VS 117/83 P68. Patient states he feels much better this morning. Medications will be increased today. MD arriving this morning and will assess patient.

New Medicaiton orders:

**Phenobarb 120 mg q4-6h**

Per fiancé - patient took meds at 1534 VS 112/65

1715 - Patient's fiancé text called and reported patient was c/o headache, deep chills, restlessness and body aches. VS 114/69 P 65. Went to see patient. MD ordered

Motrin 800 mg QID,  
Requip .5mg stat and at HS

Patient states he feels better after taking Motrin

2200 - Patient, Fiance, RN and MD had dinner together. Patient was in good spirits and expressed appreciation for RN and MD to treat him on the island. Patient continues to be fearful of who he will be off medications but continues to have a positive attitude toward detox process. Patient had no w/d complaints throughout dinner.

2250 - Patient's fiancé called to say that patient is "not feeling well" and his hands are "twitching bad" - Instructed to give him his HS meds and have him lie down. Fiance instructed to call RN if patient does not fall asleep within 30 min.

**8/13/14**



1340 - Patients fiancé text to say he wasn't feeling well. MD orders Pheno 64.8 mg, Neurontin 600 mg Stat. Patient and fiancé informed that today and tomorrow will be the most difficult days and to keep in close contact with us.



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**8/14/14**

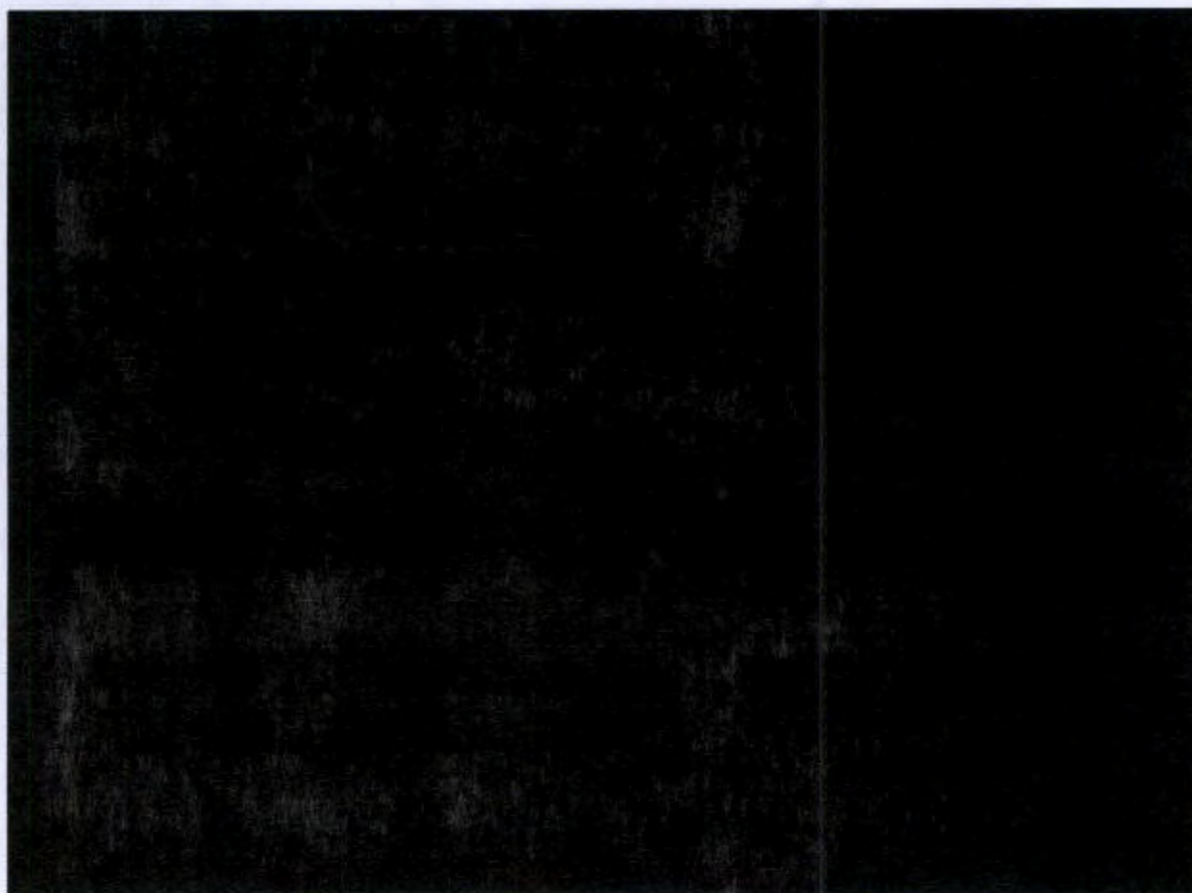
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8/15/14 -



8/16/14 -





**8/17/14**

**0830** - Patient awake VS 132/82 P 82. RN and MD assessed patient. Patient is social but appears guarded. Discussed med changes with patient and he is on board to continue taper.

**Phenobarb 64.2 TID**  
**Seroquel 25mg BID, 50mg HS**

**1400** - Patient called to ask if we were tapering him today. Reminded him that he got the same dose this am but we are spreading the dose out. Patient stated he was ok to wait till dose.

**1545** - Patients fiancé came to get MD and RN [REDACTED] RN and MD found patient sitting quietly on his porch. Patient was calm and stated he was frustrated with the process of detoxing. Stated he thought he should be feeling better by now. RN and MD sat with patient and listened to his express his frustrations with how he was feeling physically and emotionally. Patient reassured that what he is feeling is part of the process. Patient stated he wanted to speed the process up and it was agreed between patient and treatment team that we should go back to LA tomorrow and start the next stage of patient's treatment.

**8/18/14 - 0100** - [REDACTED] MD and RN went to assess patient. He states he had a fight with fiancé and is questioning whether or not he can emotionally and physically handle detox. Complains of



agitation and nausea. RN and MD gave patient emotional support. MD ordered:

Seroquel 100mg - STAT  
Phenergan 100 mg IM - STAT

Patient was escorted to bed. Plan is to leave the island tomorrow.

**8/19/14 - 0900** - RN and MD went to check in on patient. Patient is still agreeing that it is best to leave the island but is unsure if he wants to continue detox when he arrives back to LA. MD sat with patient and discussed all the benefits of continuing treatment. AM meds administered. Plan is to leave the island at 1800.

**1500** - Patient's fiancé administered afternoon dose of medications.

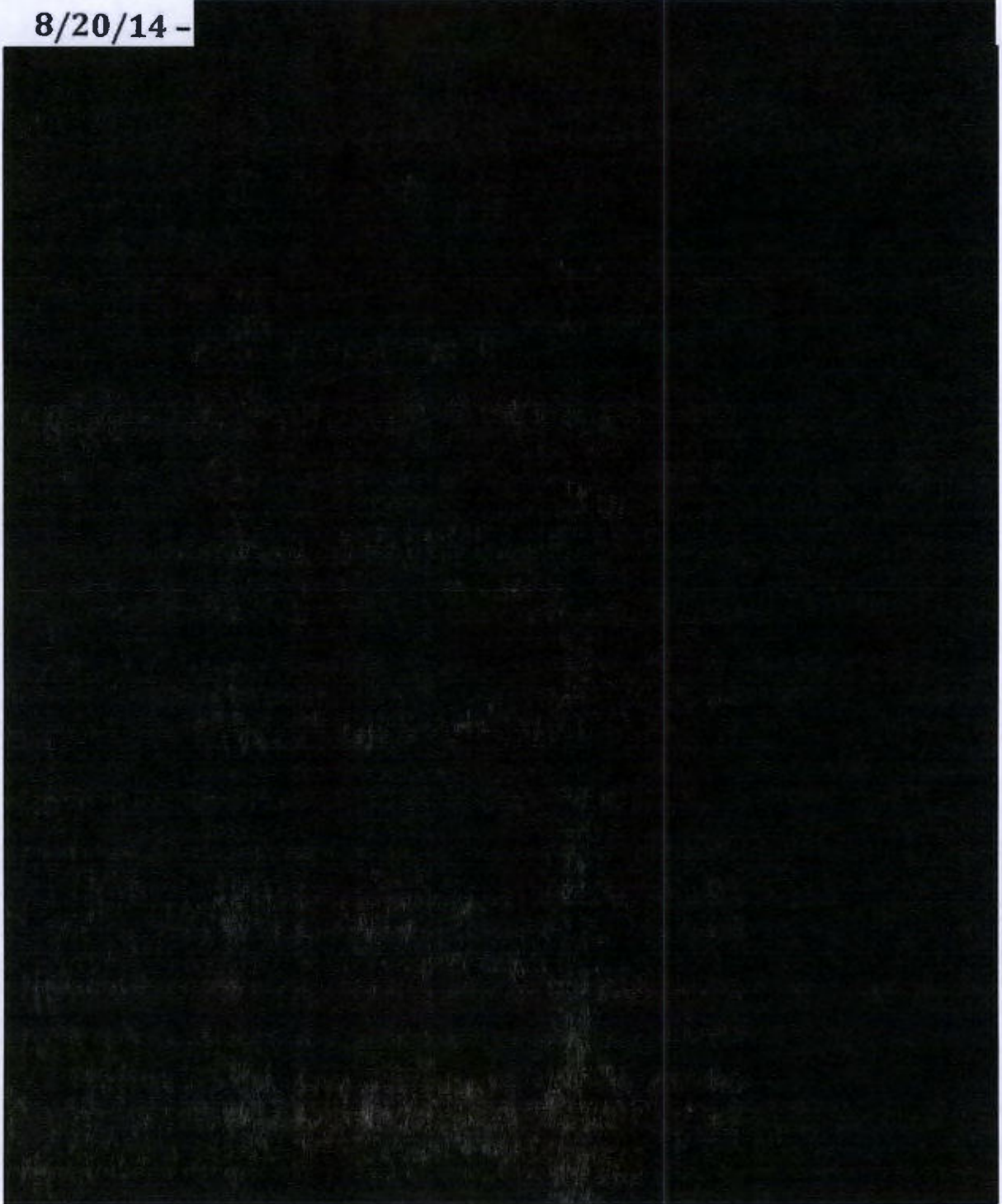
**1830** - Upon leaving the island patient appears to be in good spirits. He states that the med combination that he is on making him comfortable and he agrees to continue treatment once back to LA.

**2130** - Patient complains of body aches - evening dose of medications administered.

**2335** - Arrived back in LA. Patient was social for ½ the flight home and then rested for the last ½ flight home. Upon arrival at LAX patient and fiancé head back to house downtown. Fiancé was given patient's HS meds and AM meds for 8/20/21. Plan is for RN to see patient in the morning.

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8/20/14 -




8/20/14

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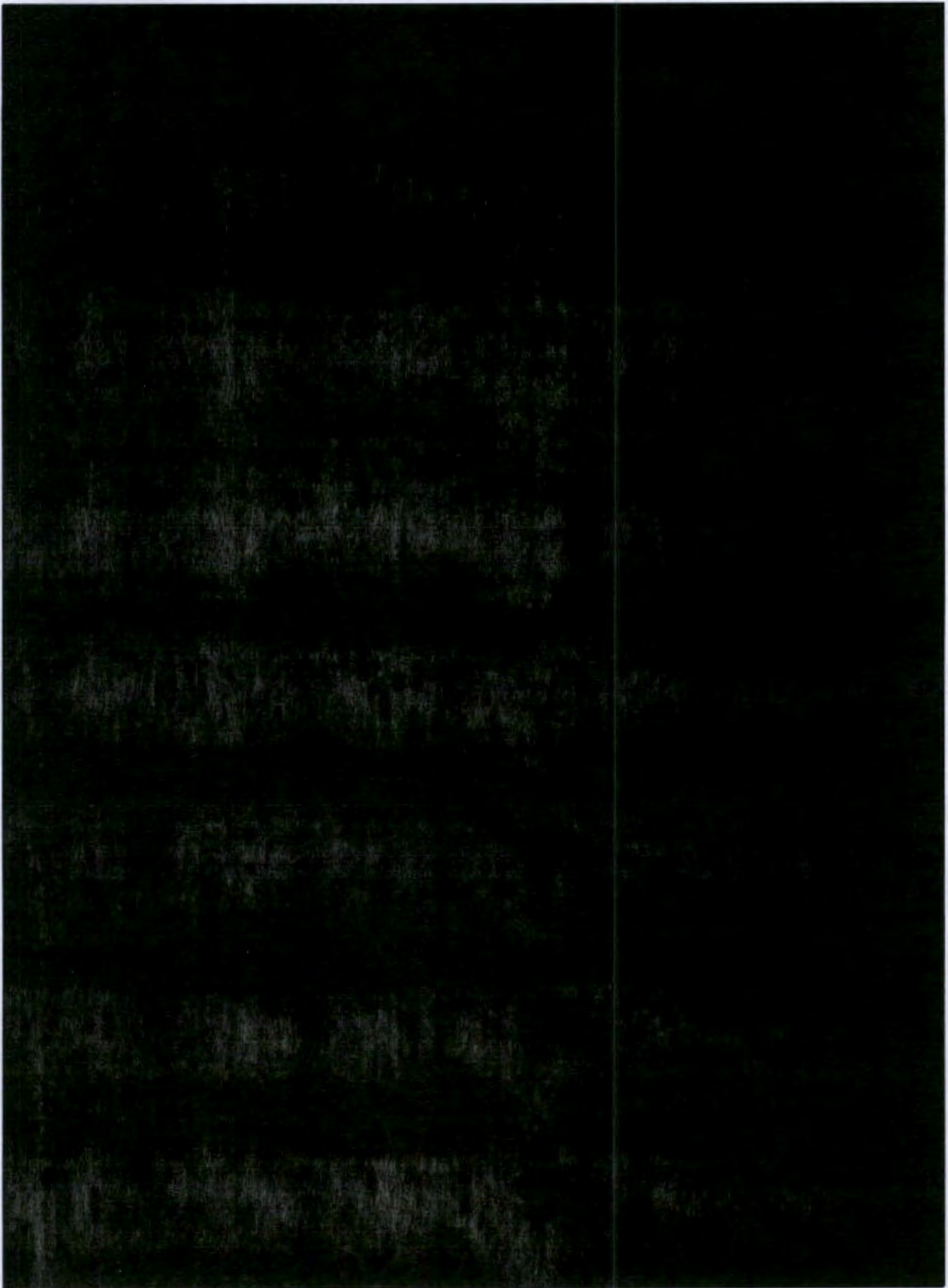
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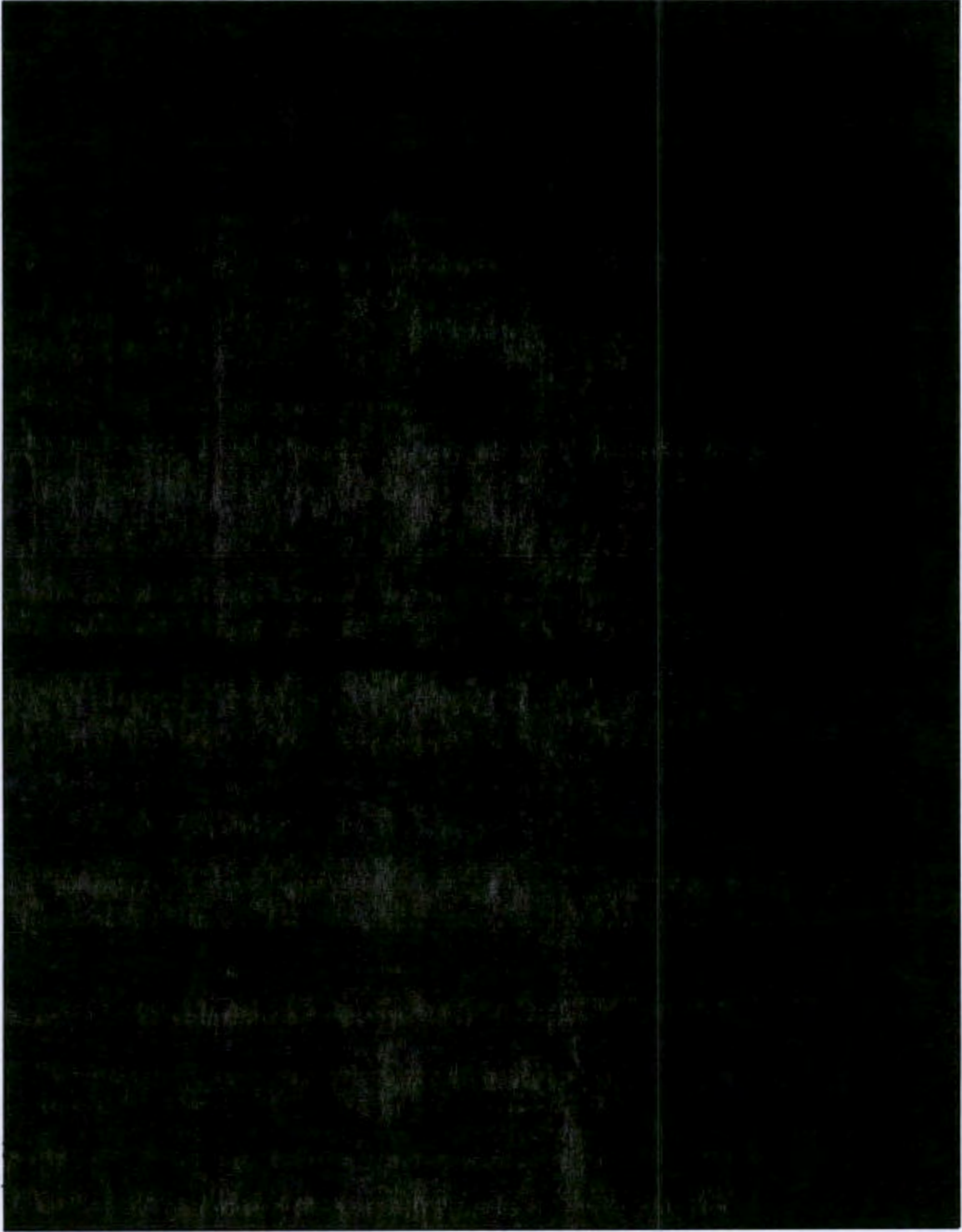
**1230** - RN and MD spend time talking with patient. Patient expressed frustration with the detox process and with not liking how the phenobarb was making him feel. Initially, he stated he was done with the process and no longer wanted MD and RN's services. After processing his feelings and realizing how far he had come and that part of his wanting to give up was due to tension between him and his fiancé. Patient, Fiancé, RN and MD came up with a plan for Fiancé to take a few days for herself and patient was willing to continue treatment but was going to refuse Phenobarbital from this point forward.

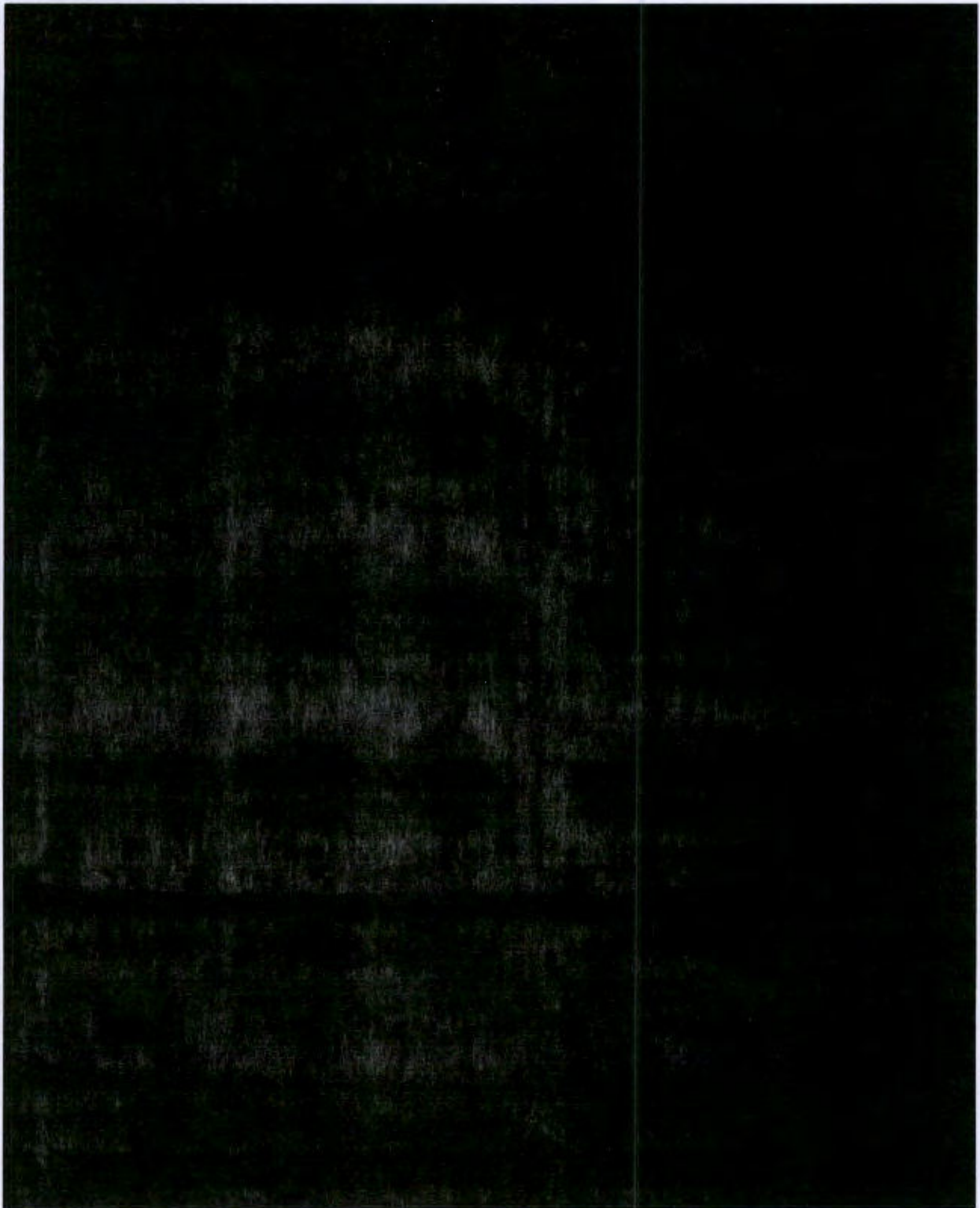
**Patient took AM medications except Phenobarbital at 1020** RN and MD informed patient of the dangers of stopping medication abruptly and offered to shorten the taper but patient refused to take pheno all together. Patient requested Xanax for breakthrough anxiety while going off pheno abruptly. MD agreed to prescribe Xanax 0.5 #15 and patient could keep in his possession as long as RN could randomly count meds to see how many he had taken.





8/21/14 -



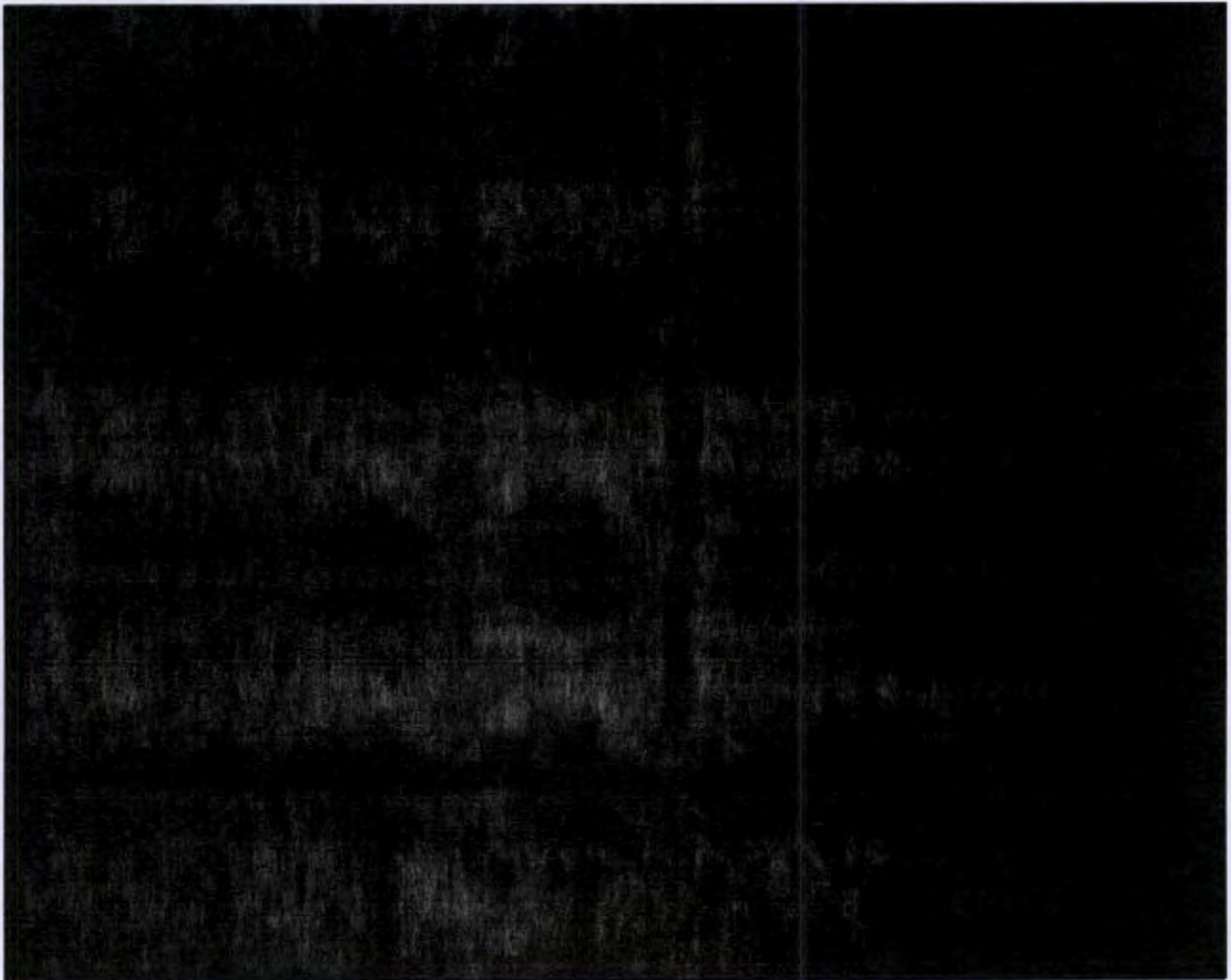


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8/24/14



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**8/25/14**

**1000** - Met patient at the house of his children and gave him Acyclovier Ointment. New Medication Order - Acyclovier Ointment 1% - Apply as needed up to 3x per day. Patient stated he was enjoying spending time with his children with a clear mind. He took his daughter shopping and the spa and took his son to a comedy show. Plan is for patient to visit his daughter on set today and then meet with RN, MD and fiancé at 1600. Patient given his routine meds for 8/25/14 and 8/26/14.

**1900** - Meeting at MD's house was quite stressful for patient. Him and his fiancé are having a hard time communicating and understanding each other's point of view and feelings. A few times during the meeting patient wanted to give up process and talked about going out and relapsing. Per MD stat order - patient was given prn dosage of Neurontin 600mg and Seroquel 50mg to help with his anxiety. Patient was able to talk through his feelings and agreed to stay working with treatment team. Plan is for fiancé to start therapy tomorrow, patient will continue with current treatment plan through movie shoot and start individual therapy as soon as he is back in LA. By end of meeting patient and fiancé were emotionally stable and agreed to go home and have a relaxing night and not to continue discussion while alone with each other. Patient will call MD or RN if needed throughout the evening.

**8/26/14**





[REDACTED]

**8/27/14 - 0900** - Received text from patient's sister that patient had been recording music with his friend till 0500 and did not go to sleep till 0700 and is currently still sleeping. Sister stated that patient and his fiancé has a disagreement last night and that patient was able to remain calm and handled situation appropriately.

**1330** - Patient awake and self-administered routine morning medications. Patient expressing feeling about argument with fiancé and feels relationship is putting unwanted stress on him right now. Patient given positive reinforcement for recognizing triggers and some healthy coping mechanisms for stress were discussed. RN counted patient's Xanax and he has taken #9 tabs since prescription was filled on 8/20/14. Patient reminded that the Xanax was only to be used when his anxiety reach 8/10 and he should use alternative methods of stress relief before taking medication. Patient expressed verbal understanding.

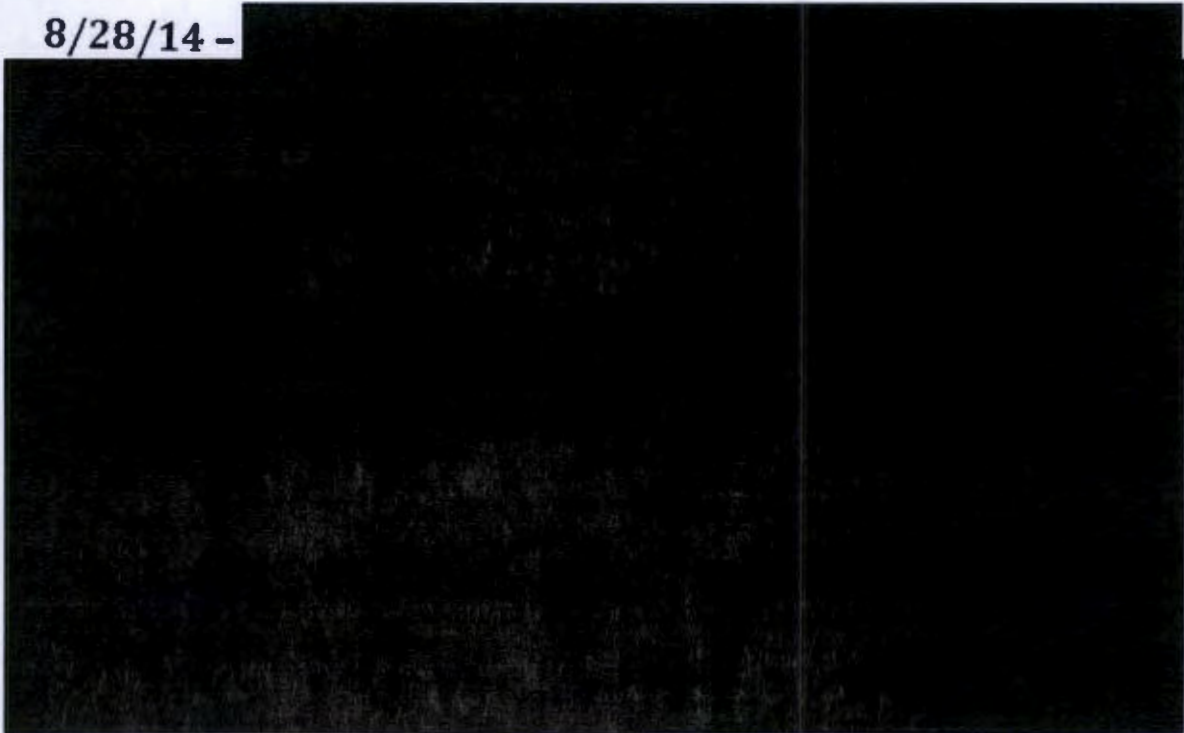
**1600** - Patient off to play music with friend and will self-administer routine afternoon medication.

**2130** - Patient back home. Per patient he had a long conversation with fiancé and they both understand that right now is a time to work on themselves as individuals. Patient's fiancé now has a RN to help her anxiety and to monitor her while starting a new mood stabilizer medication. Patient feels this will take some stress of their relationship and in return


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take some stress off of him. Patient is in good spirits. Plan is to leave for London this evening.

8/28/14 -



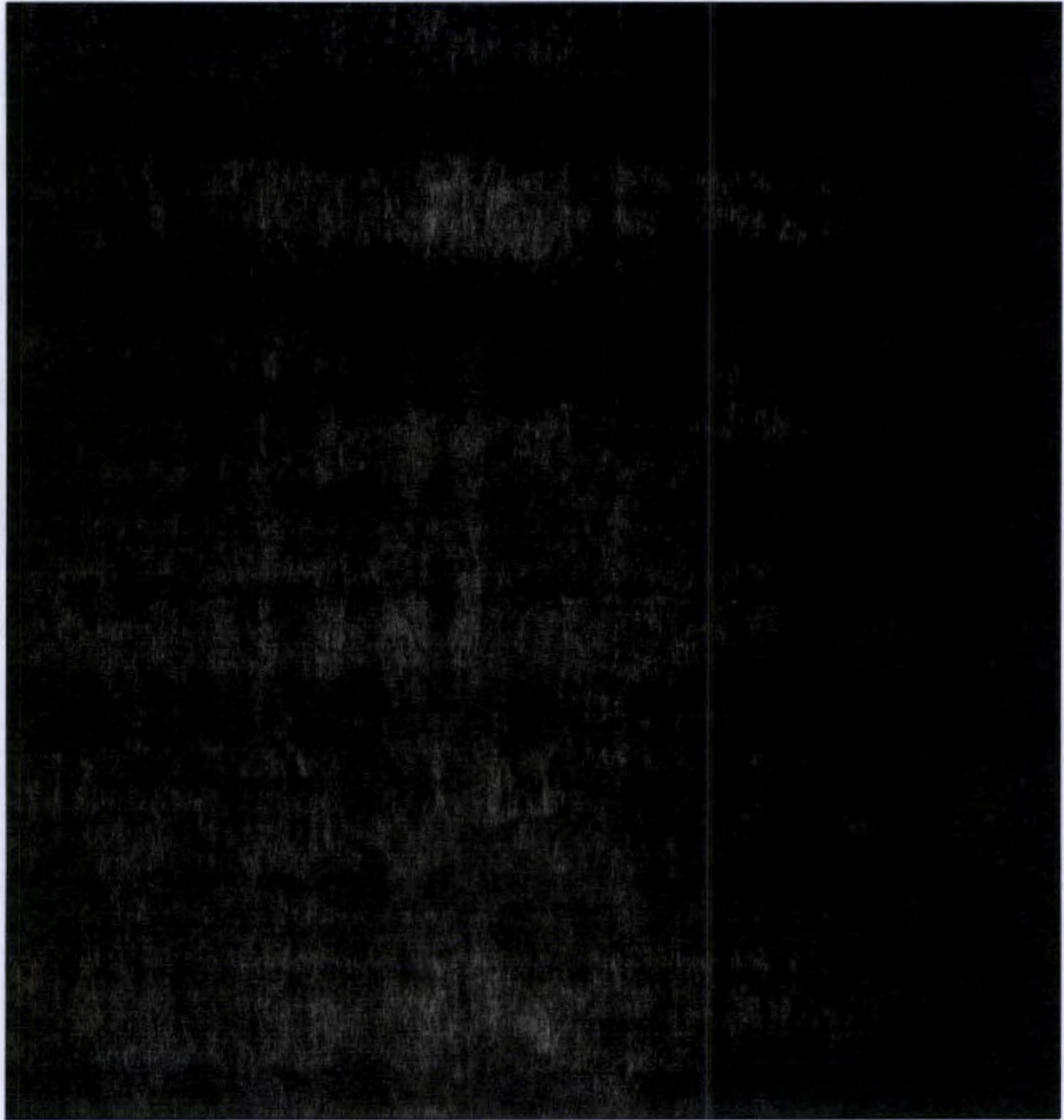
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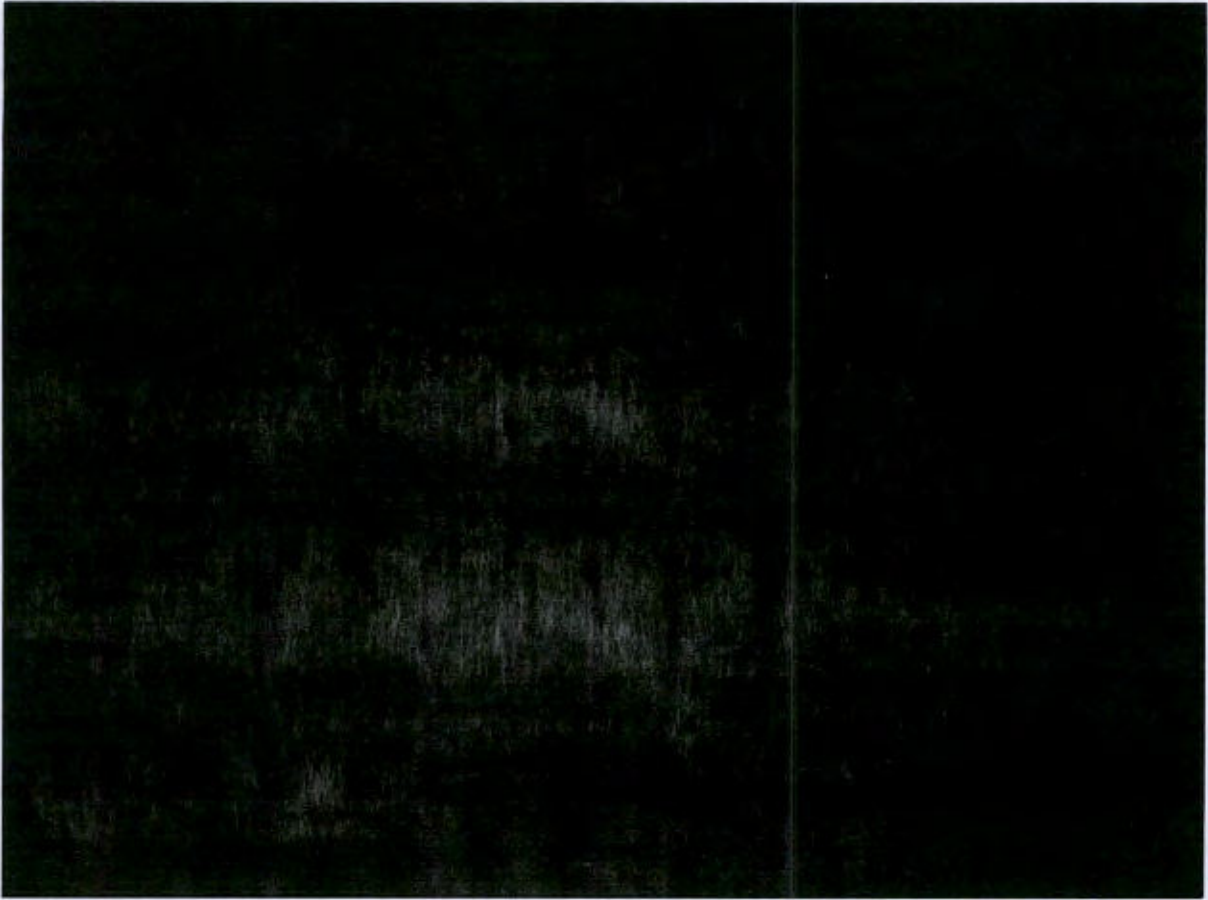


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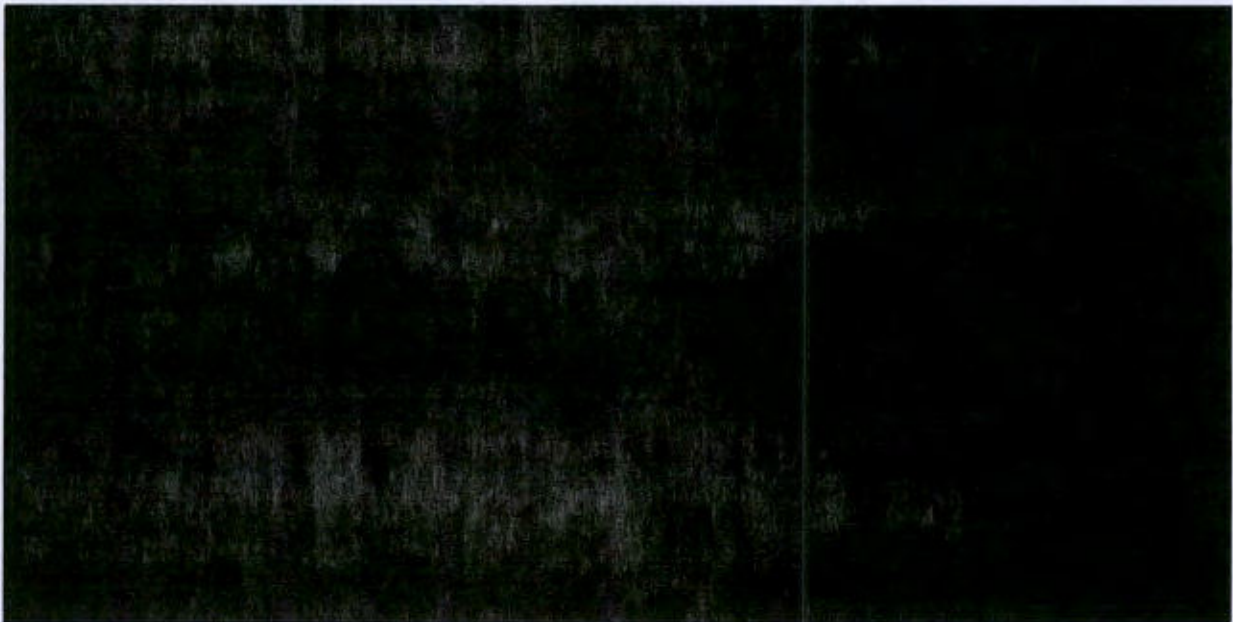


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9/1/14



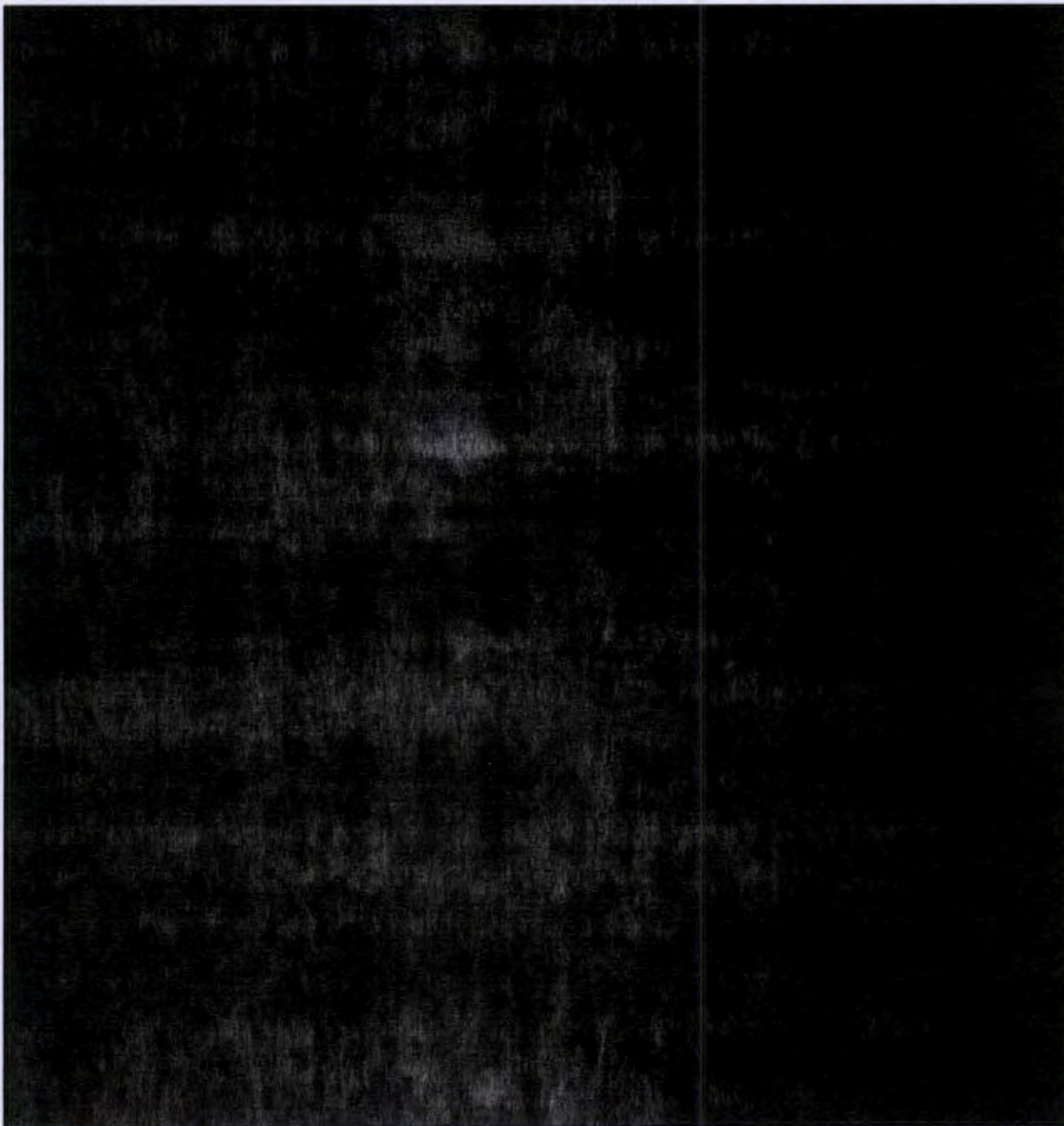
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PLAINTIFF'S TRIAL EXHIBIT 0040\_0037

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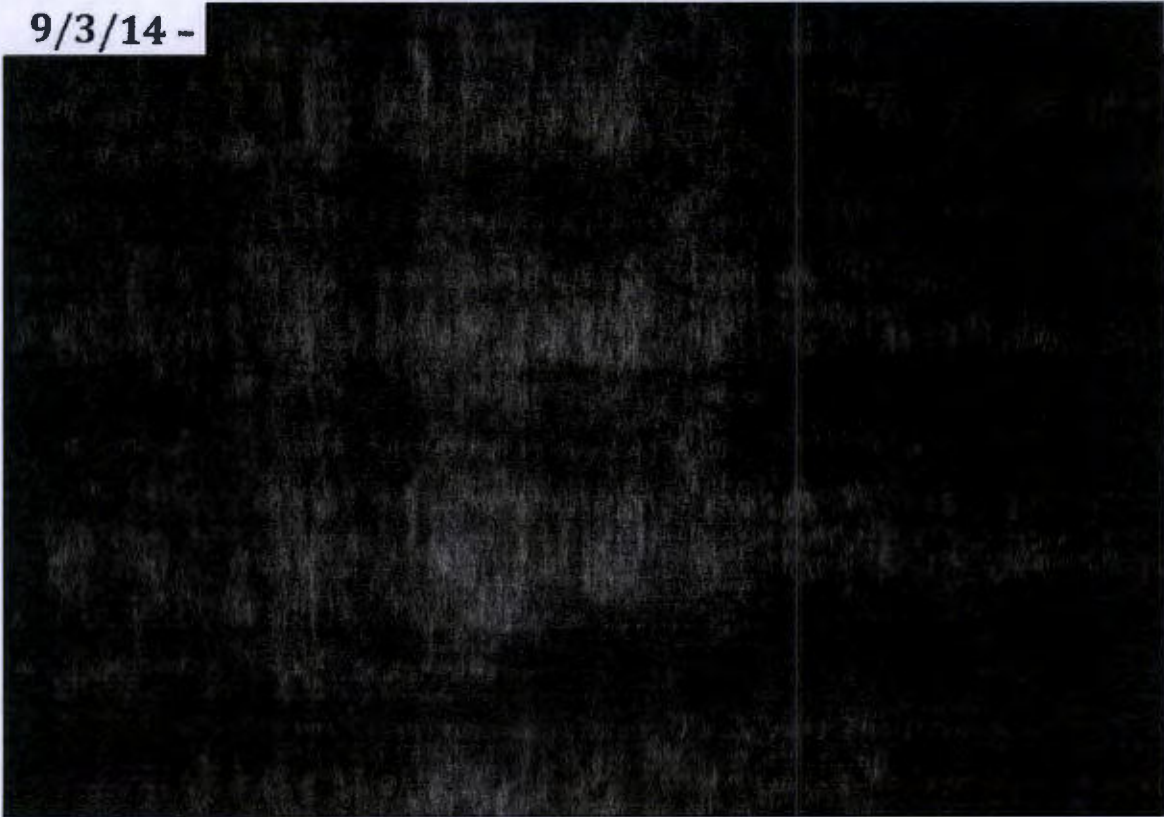


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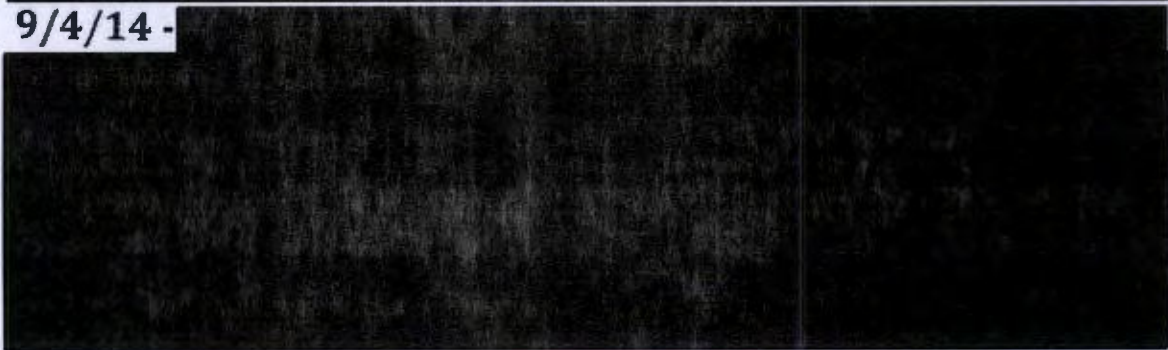




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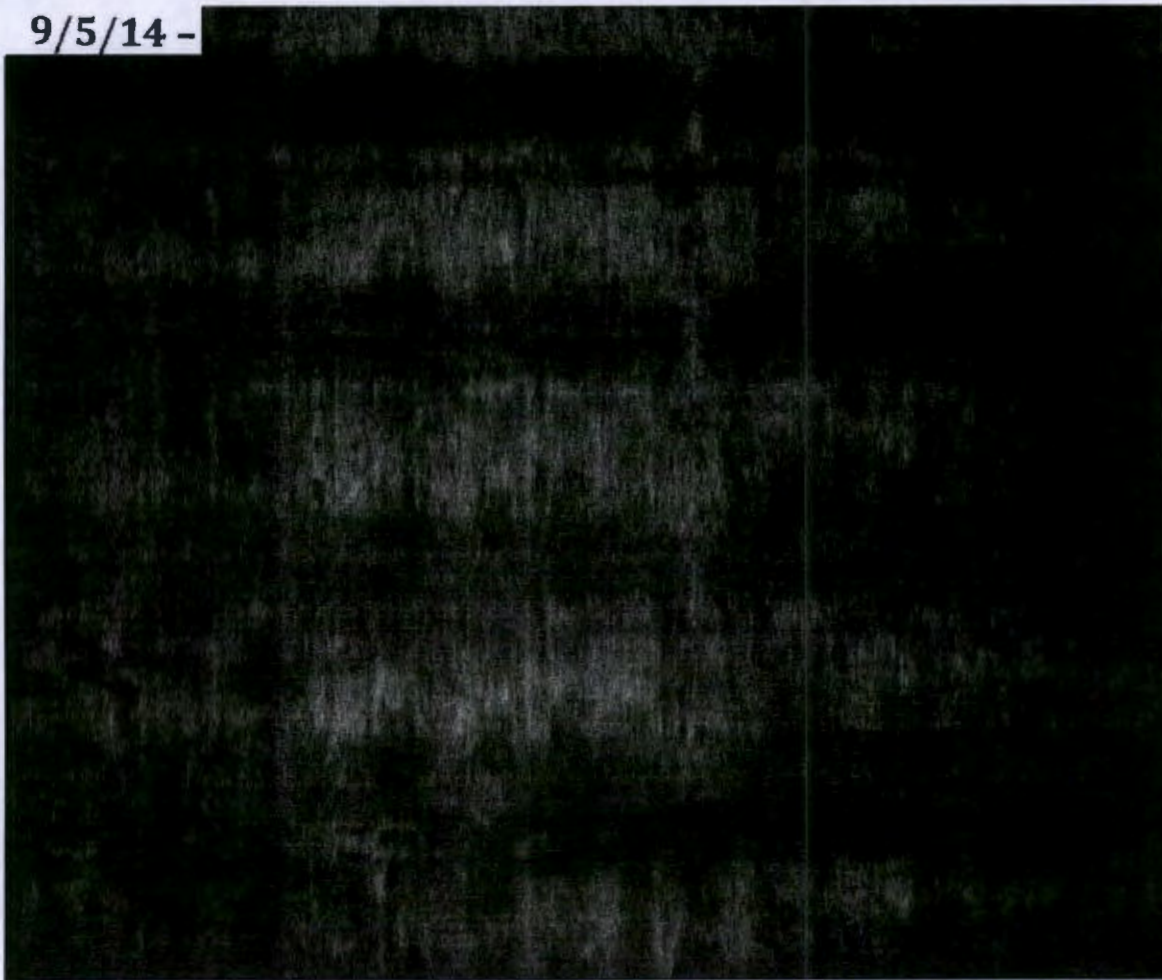
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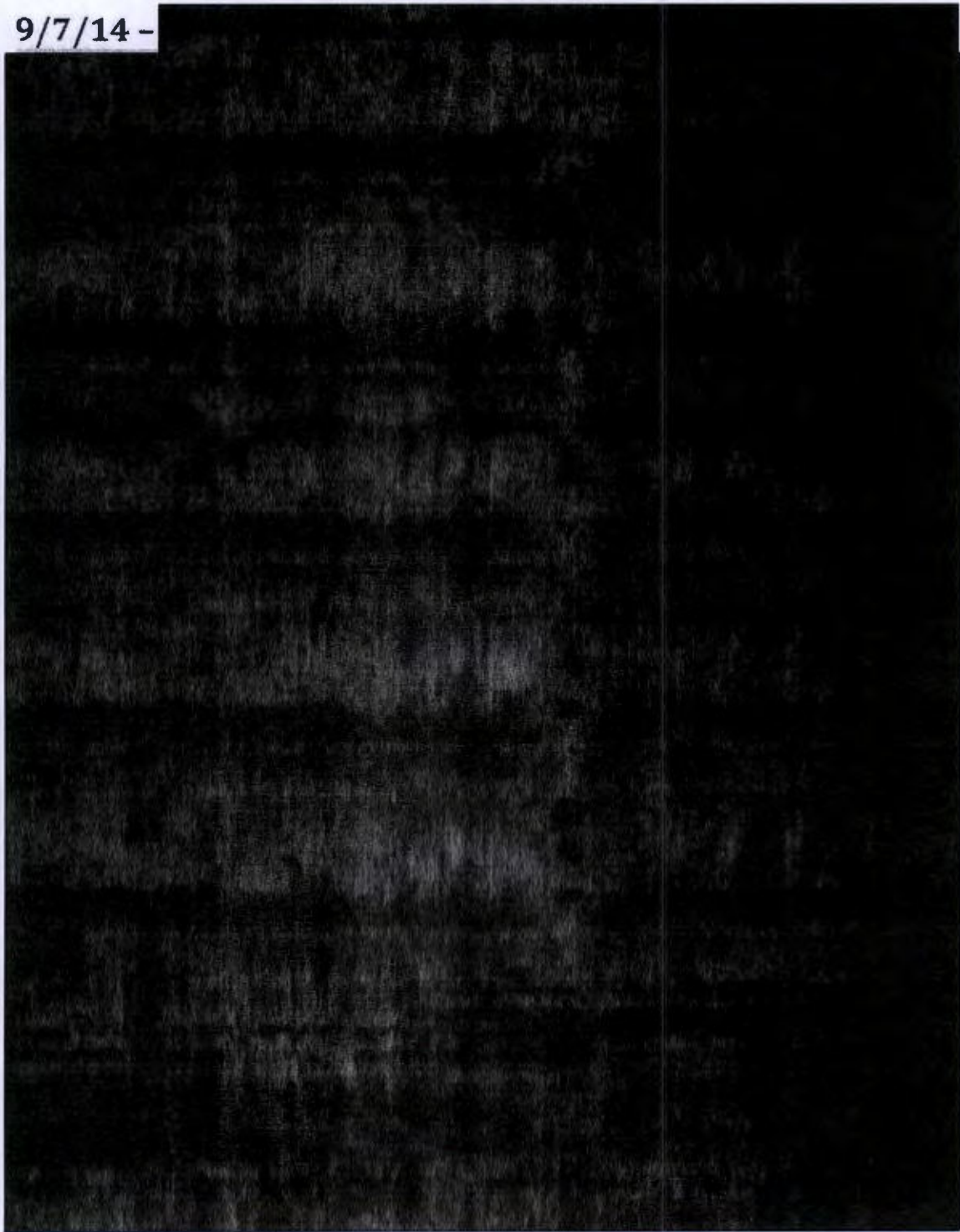


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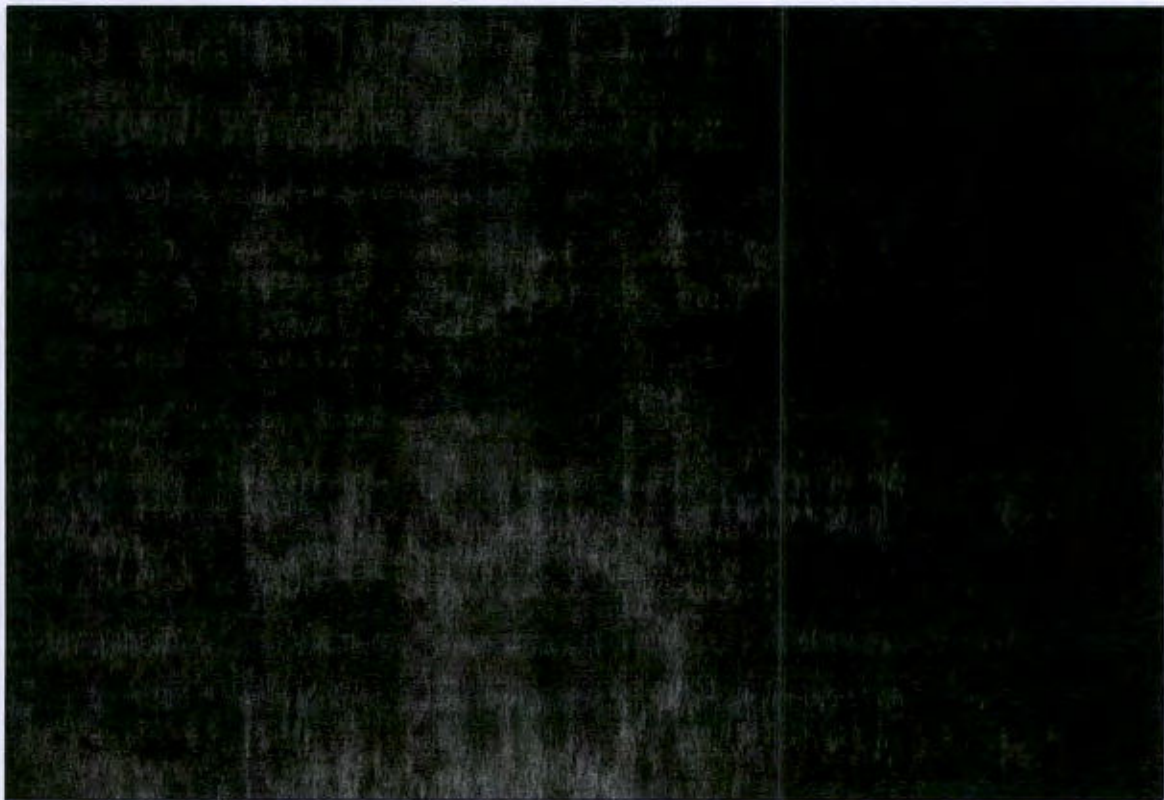
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**9/9/14**



**9/10/14**

**1300** – Per assistant, RN is unable to go to patient's work to see him due to transportation issues. Patient will be seen at his home when he is finished with work.

**2120** - RN received call from patient's assistant stating the patient was requesting an extra dose of Adderall and had asked assistant to take it from tomorrow's meds. Assistant instructed to tell patient that he could not do that and reminded assistant that patient is not allowed to self medicate and change his medications without speaking to MD and situations like this are why RN needs to see patient while he is at work.

**2215** - Received text from patient that he is on his way home, stating that "he feels a little weird. Trying to rule out possibilities..... No biggie, though! Promise though. Might be lack of sleep, or a lack of food???" Patient informed RN would be at house to see him when he got home.

**2330** - Met with patient. He complained of body aches and nausea. Phenergan 100ml IM RUOQ administered with good effect. Patient reminded the importance of eating small portions throughout the day. While RN was visiting patient, fiancé came in and tried to start an argument with him. Patient was able to stay calm and talk his fiancé down. Patient given positive reinforcement for his reaction. RN encourage patient to take his HS meds within the next 30 minutes and to get some rest. Patient was exhausted but in good spirits when RN left home. Plan is for RN to visit patient at work tomorrow.

**9/11/14**





**9/12/14 - 1700** - RN and MD visited patient at work. Patient continues to be satisfied with his "clarity" progress and expresses appreciation for medical team. Patient expressed some concerns with fiancé's behavior and how it is adding stress to his life. Patient given positive reinforcement on how he is working through his emotions and redirected to continuing to work on himself as his fiancé is continuing to work with her treatment team. MD gave patient some communication techniques to use with his fiancé when confrontation situations arise. MD also suggested it was time for patient to begin working with a psychiatrist and patient agreed. Patient informed MD and RN that he will be traveling to France with his fiancé this weekend. MD and patient decided it would be best for patient and fiancé to travel without treatment team so they could be alone and focus on one another for the weekend. RN gave patient all routine medications for 9/14, 9/14, 9/15 for self-administration. Per MD orders patient was given Xanax 1mg #5 and Adderall 10mg #5 as prn medications for his trip. Plan is for RN to check in with patient via text msgs throughout the weekend and will see him back at work on Monday.

**9/13/14 -**

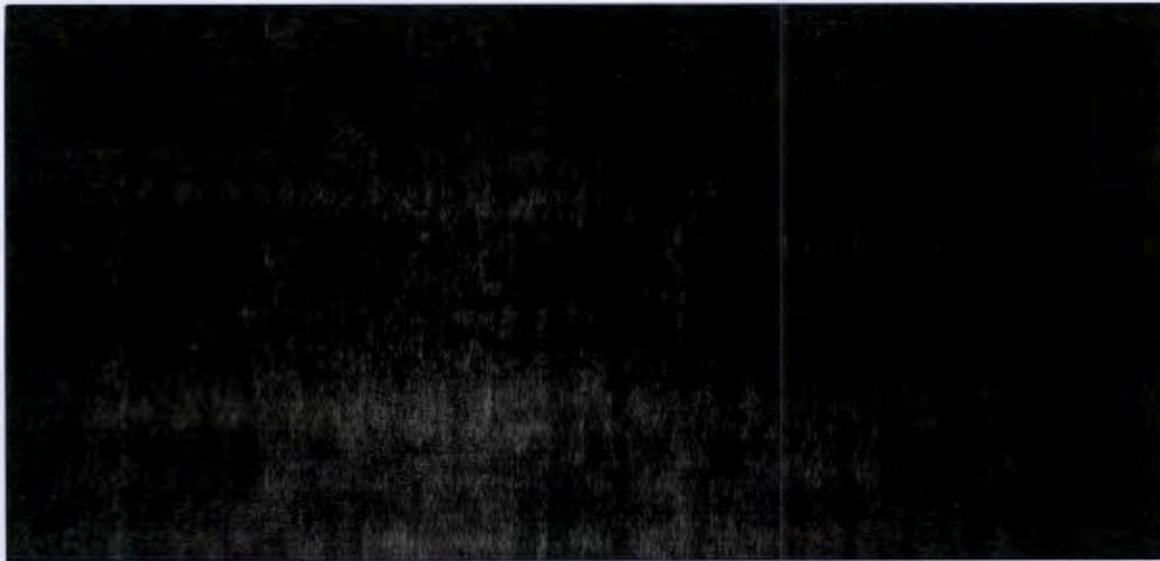


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9/18/14 -

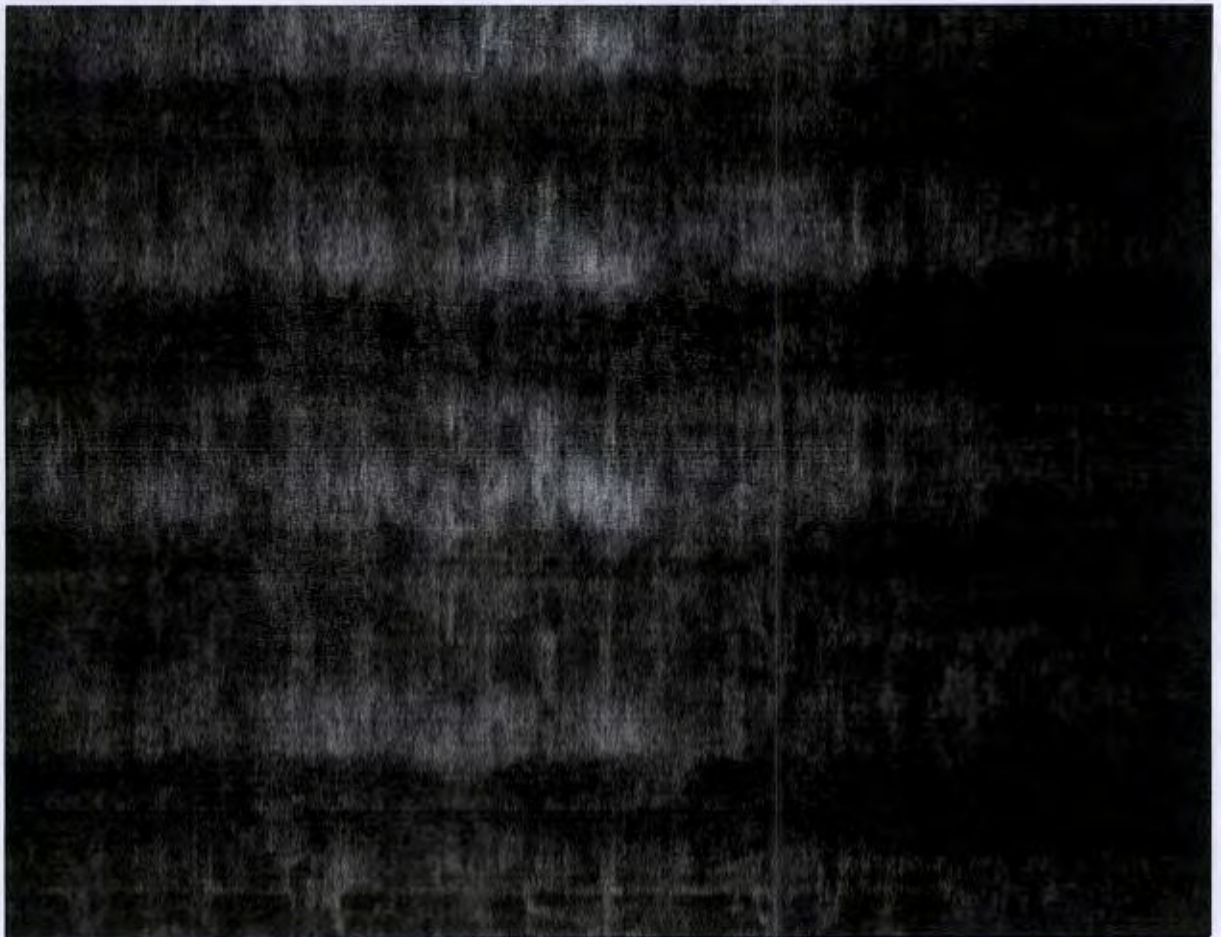


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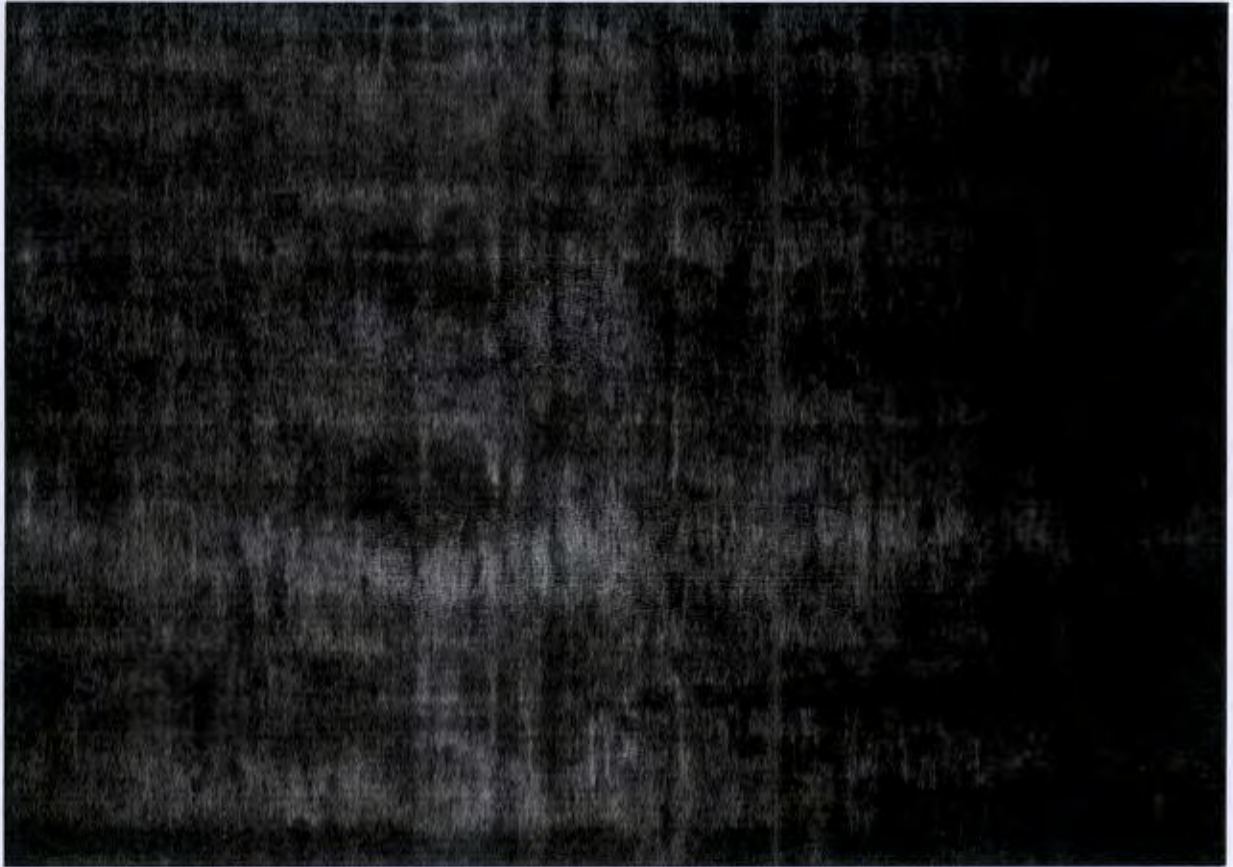


9/20/14 -





9/21/14





**9/22/14**

**0125-** RN received text from patient stating that he had been in an argument with fiancé and she "had a nasty freakout" and he would like RN to come give him "some fuckin' knockout yum, yum. RN instructed patient to take prn Neurontin 300mg prn and Seroquel 50mg and that RN was on her way over.

**0330 -** Upon arriving at the home patient was sitting in kitchen with scraped and bloody knuckles on R hand. Patient stated he had punched white board in kitchen after fight. Patient stated he had been texting his friend explaining why he didn't show up to play music and fiancé got upset that he was not giving her enough support and the fight escalated from there. Call to MD at 0145 and instructed to given a Stat order of Ambien 10mg to help patient get to sleep as he has an early work day. After taking medication - patient refused to lie down as he didn't want fiancé to think he didn't care by falling asleep. Patient was able to talk through his feelings and realized that he had not caused this argument. At 0300 fiancé came downstairs (she had been talking with Erin, RN) and asked fiancé to come to back. RN asked fiancé and patient to not discuss argument anymore tonight as patient needed to get to sleep. They both agreed. RN let patient know she would stay at house to make sure things remained calm for the rest of the night.

**0630 -** Patient up for work. Stated he slept about an hr. Patient informed RN that he would be taking extra adderall throughout the day as he could not get through work without

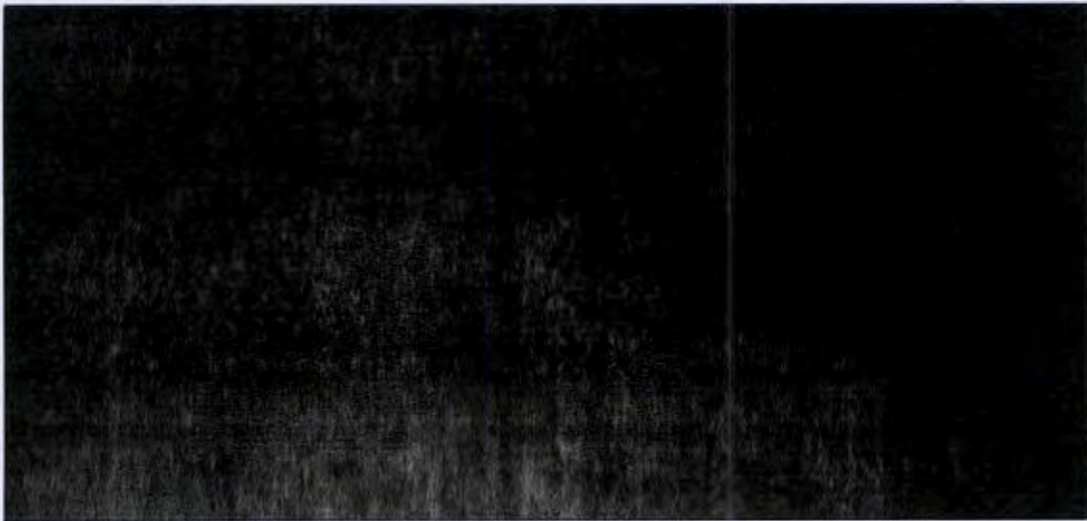


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it. Report given to MD via email. RN will visit patient at work in a few hrs.

**1930** - Patient stated he took an additional Adderall 5mg with his routine morning medications and took an additional Adderall 10 mg in the afternoon. Report given to MD. MD is ok with patient taking additional Adderall at this time but does not want to increase his routine dosage until we see how he feels after fiancé leaves for NY tomorrow and patient will get more sleep. Patient and fiancé texted throughout the day and appear to be in a better place. Patient instructed to go to bed early tonight and to not stay up late discussing relationship. RN is now living in house with patient and informed patient to text if he needs anything throughout the night.

9/23/14

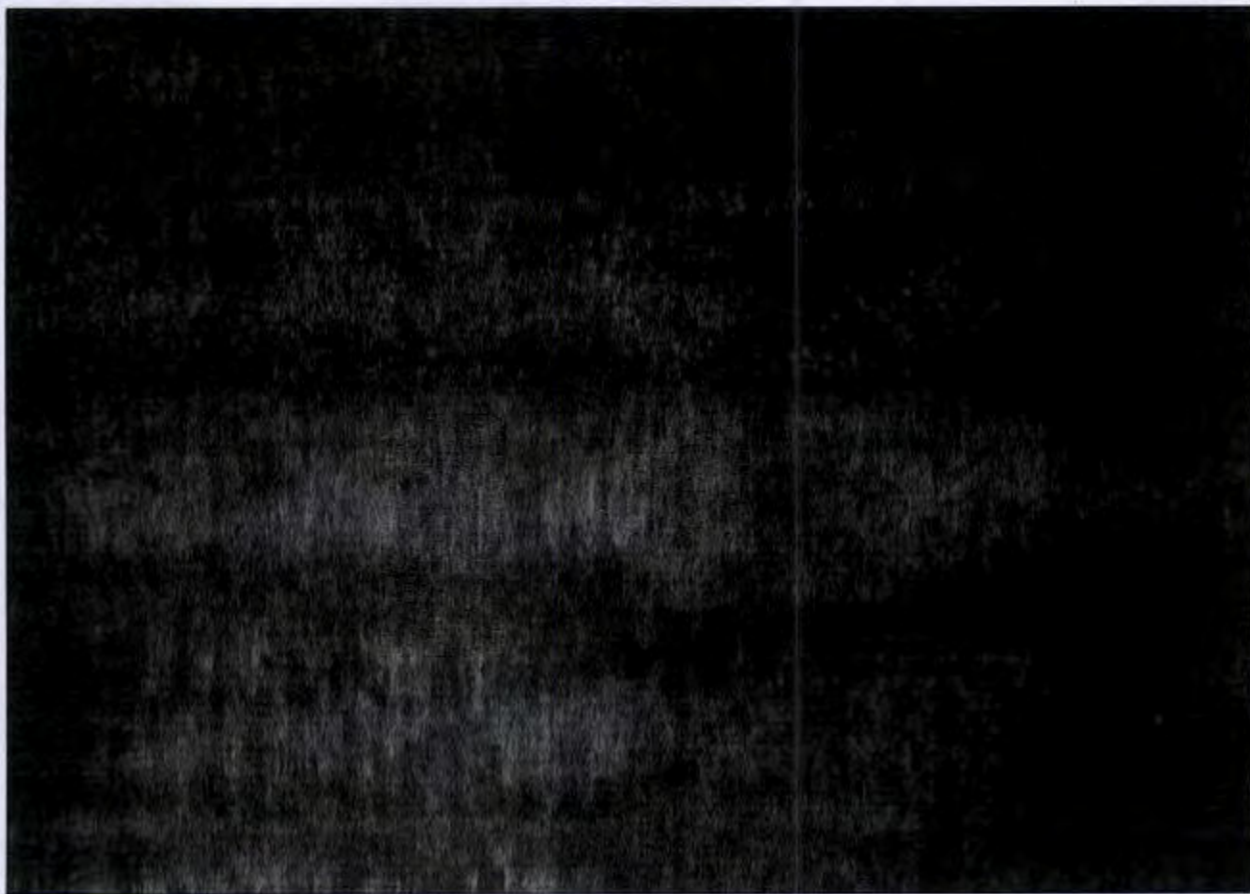


9/24/14



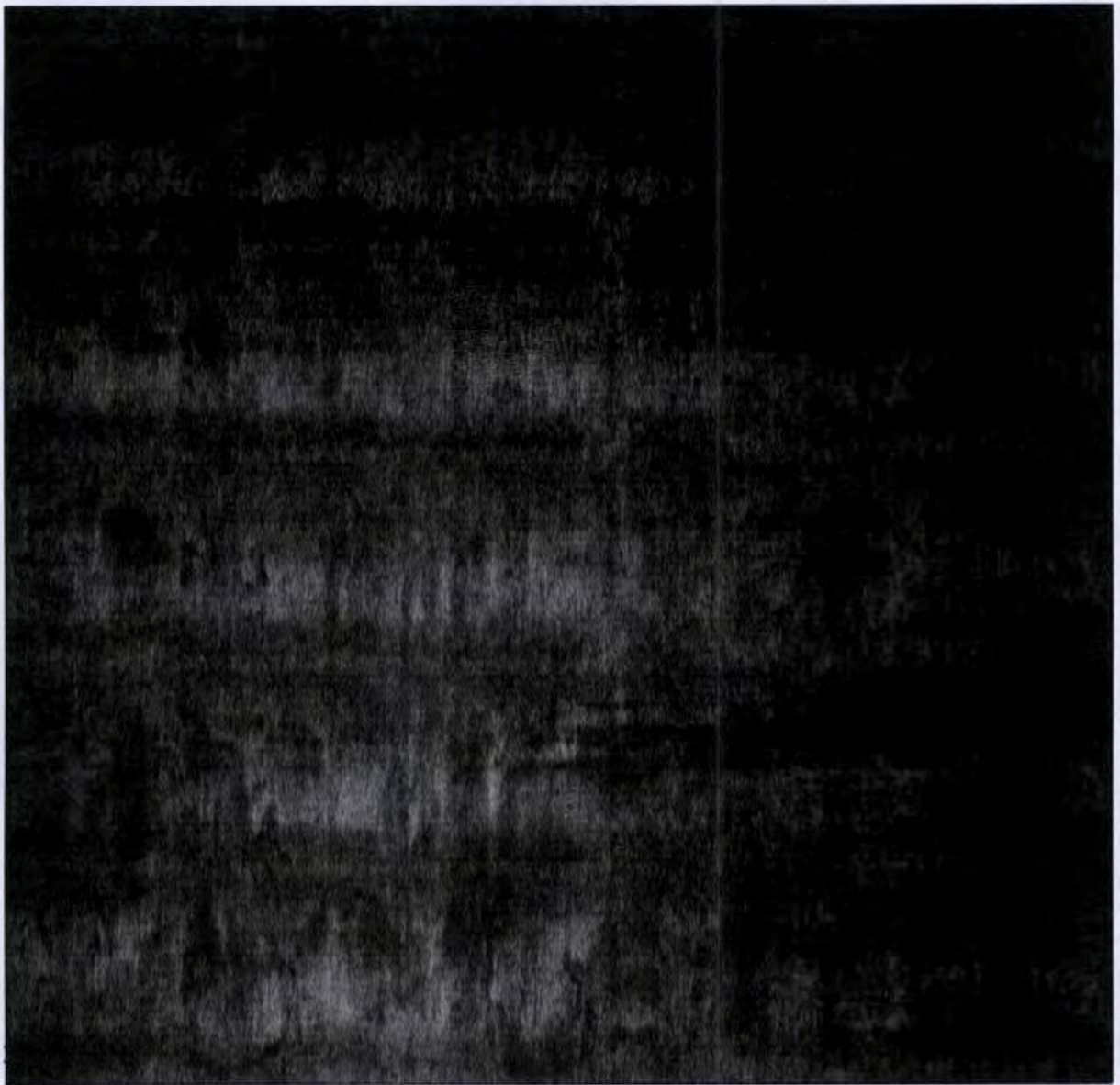
19STCP04763

Kipper 0102

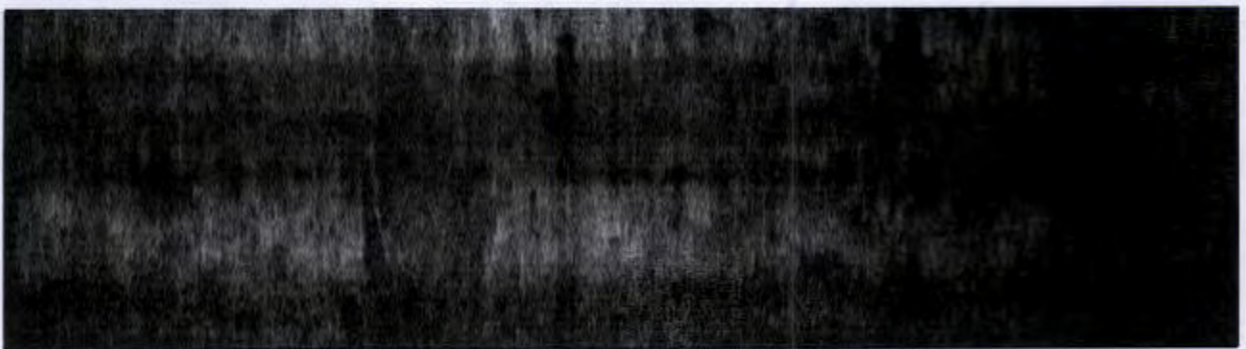


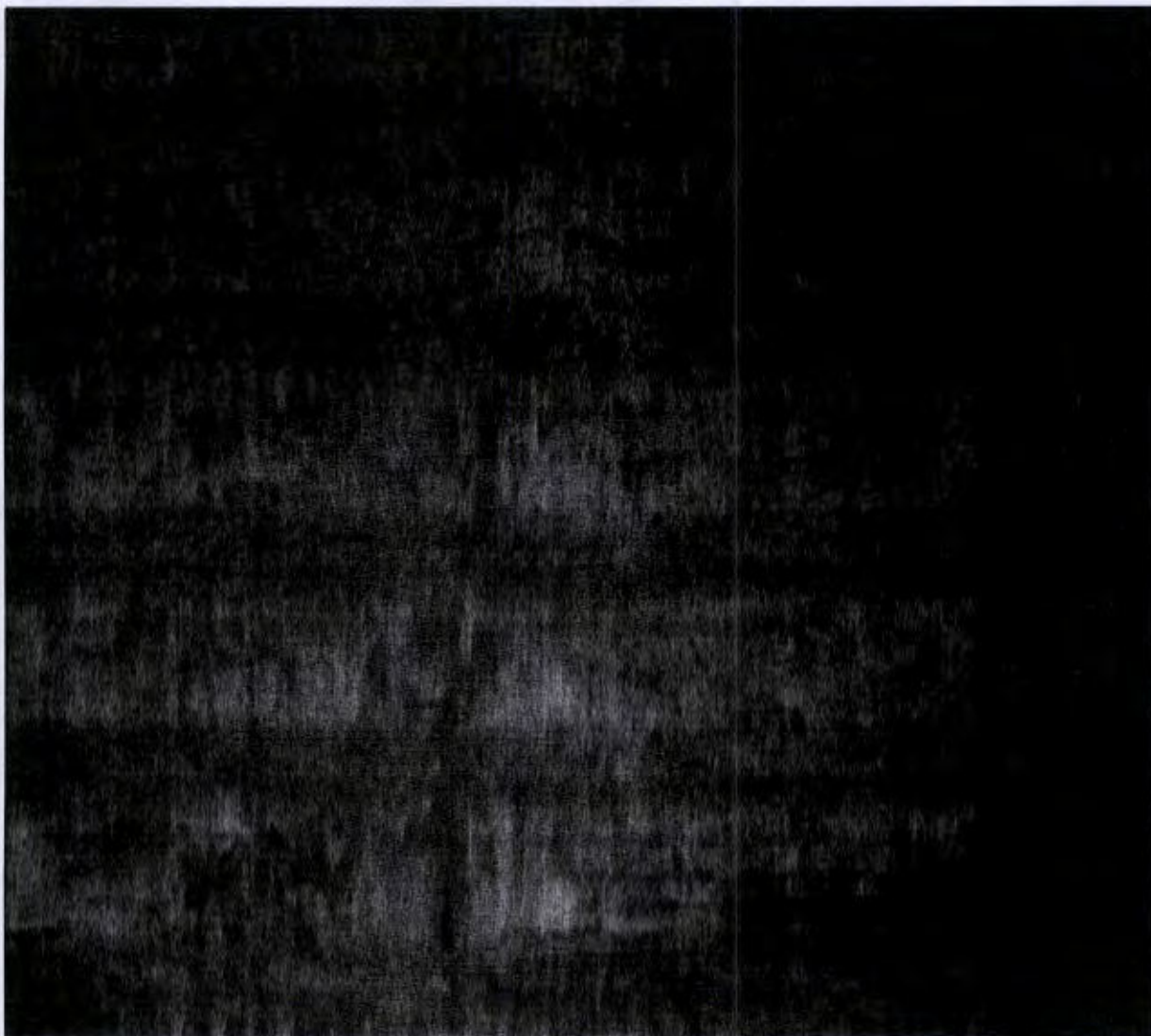
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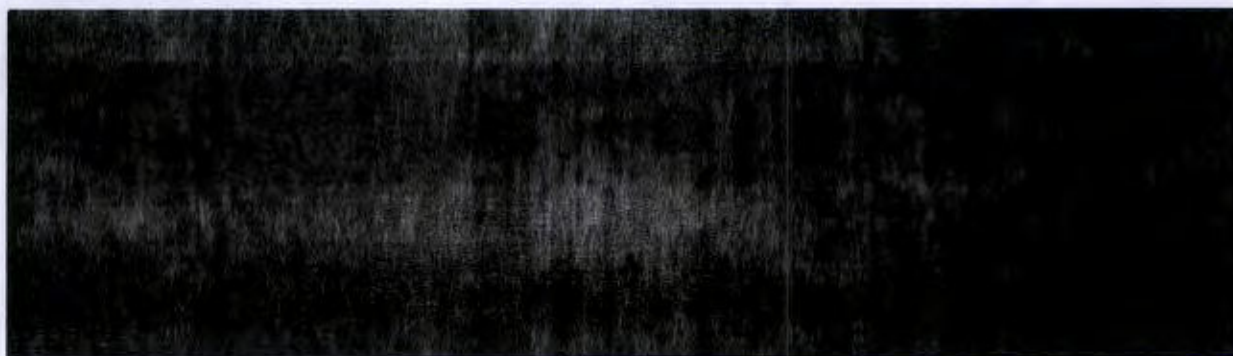


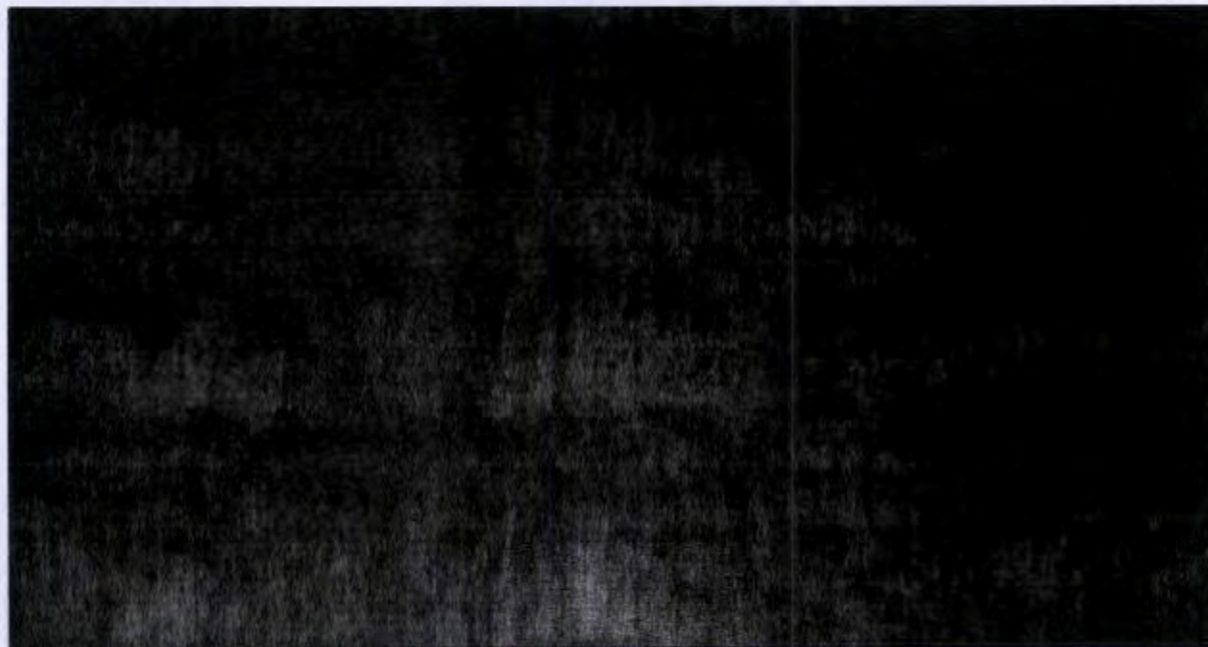
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9/27/14





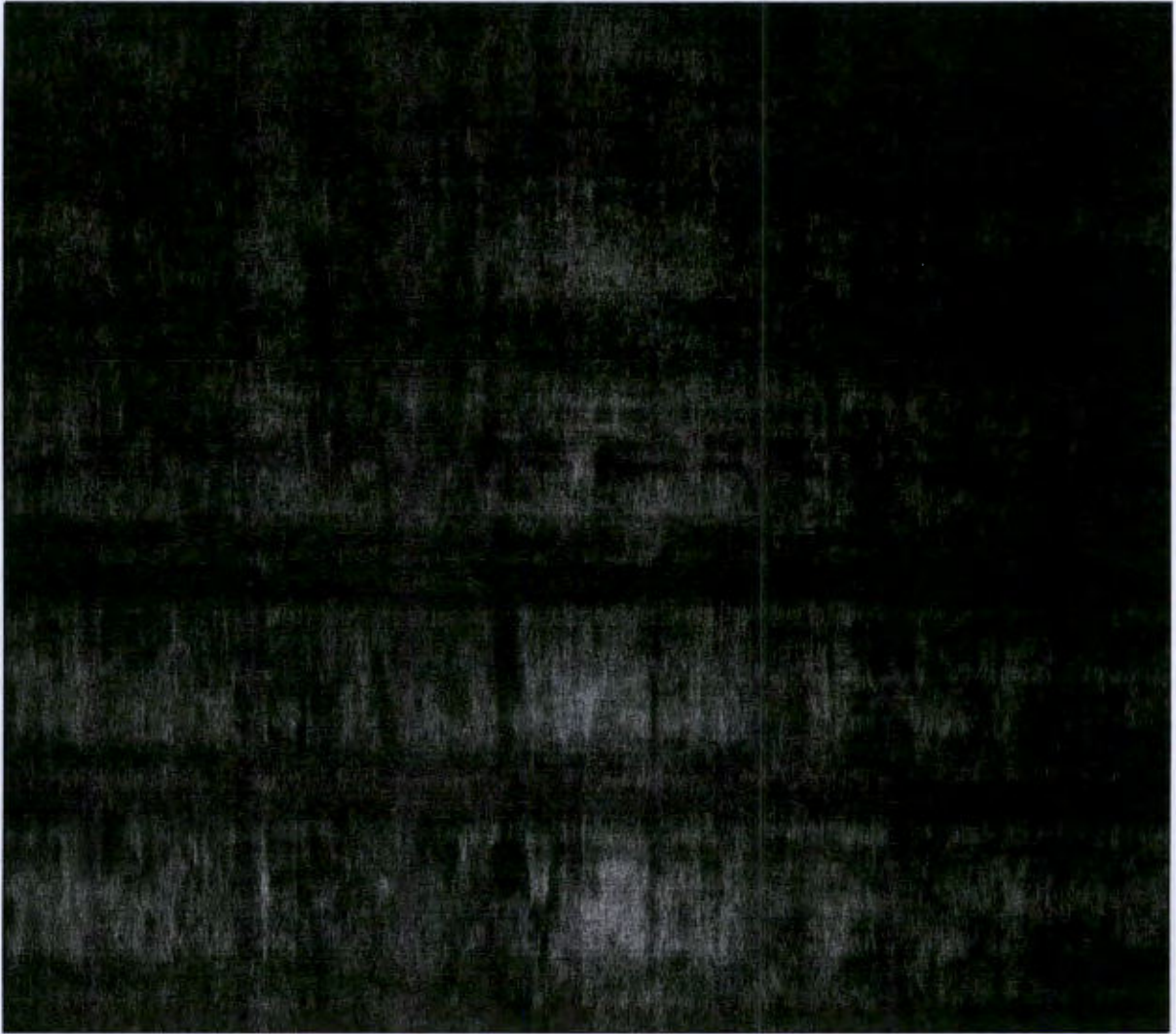
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9/29/14



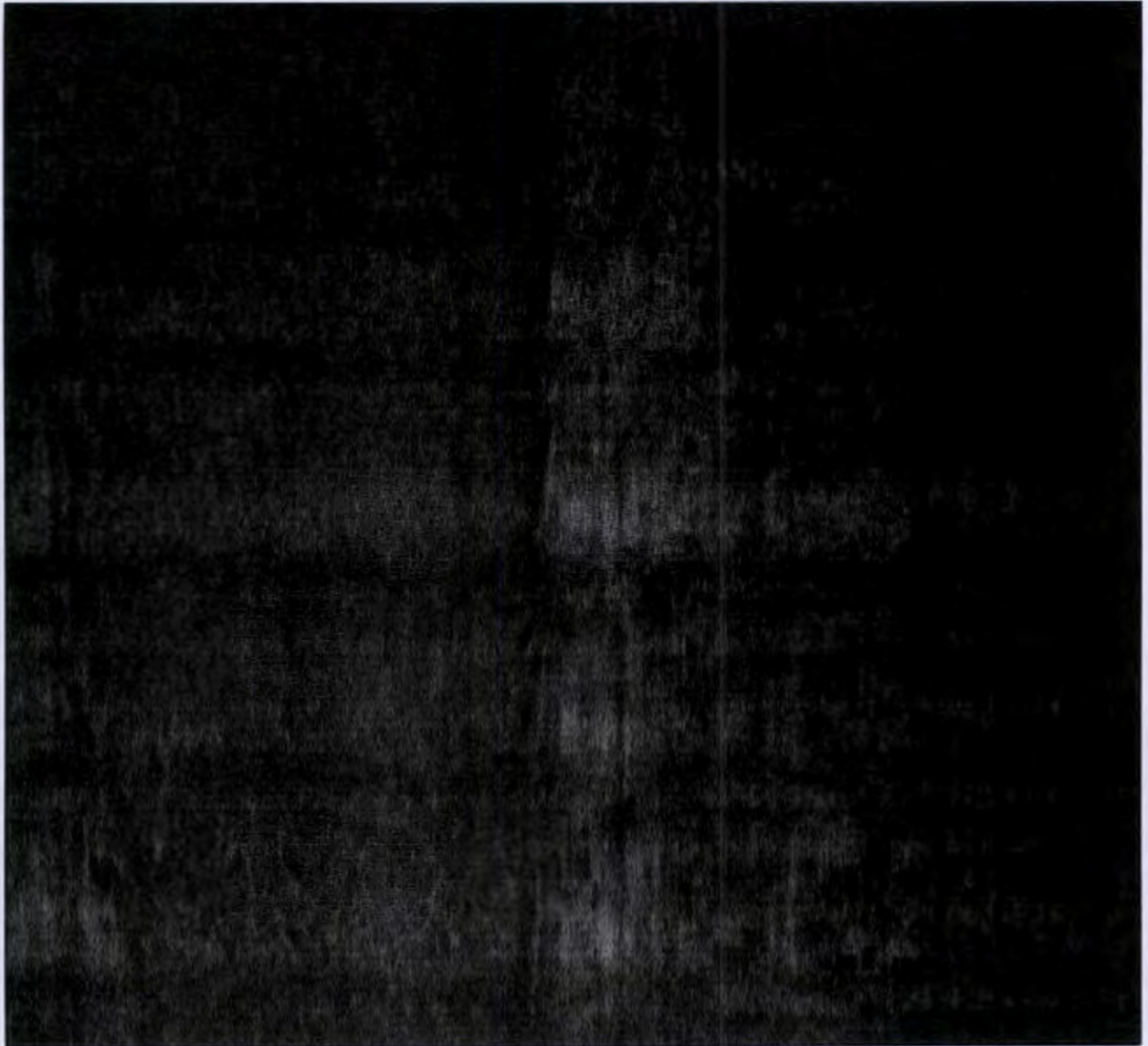
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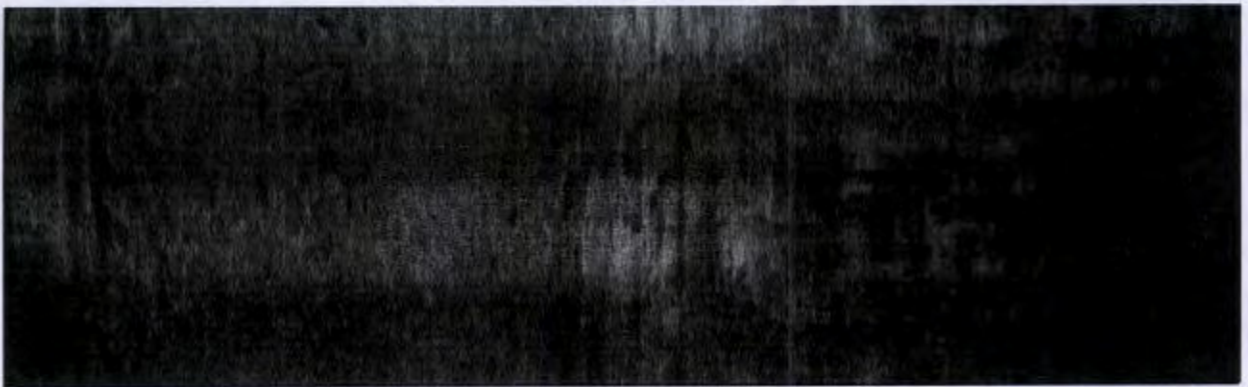
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PLAINTIFF'S TRIAL EXHIBIT 0040\_0055

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47381



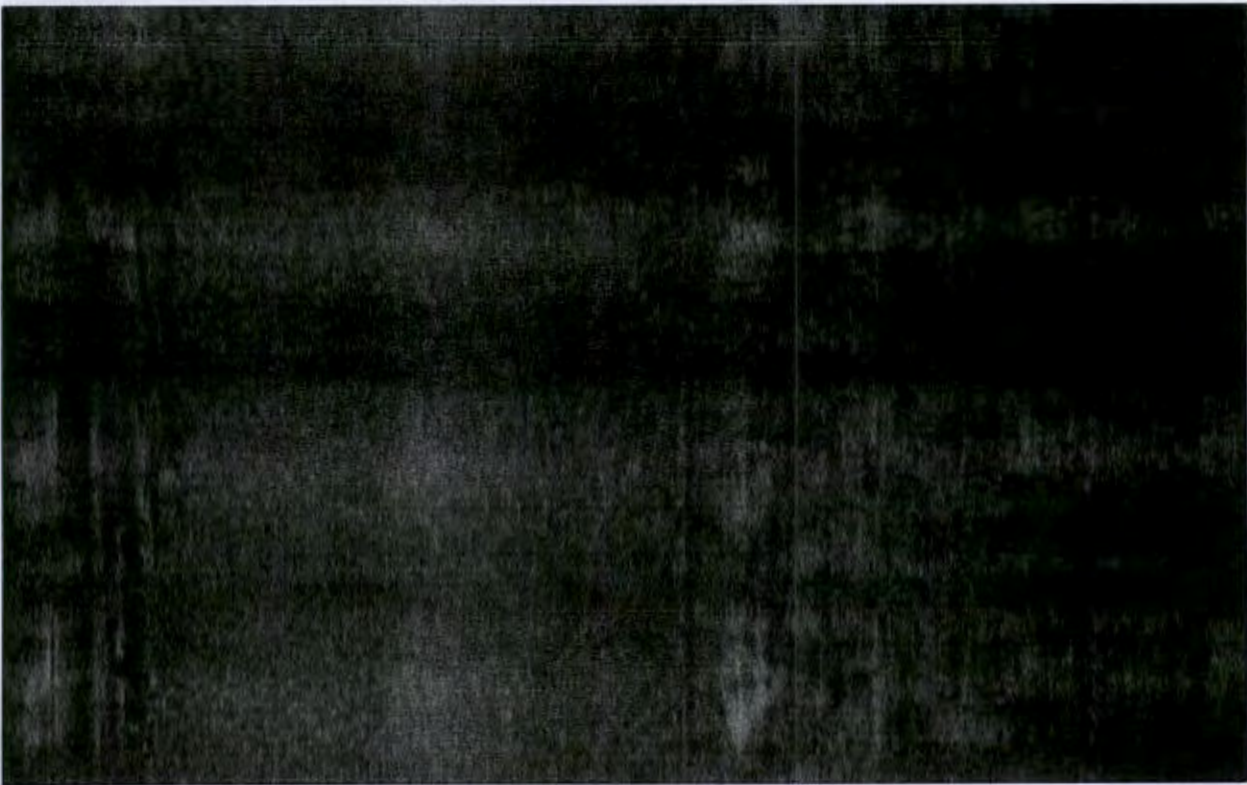
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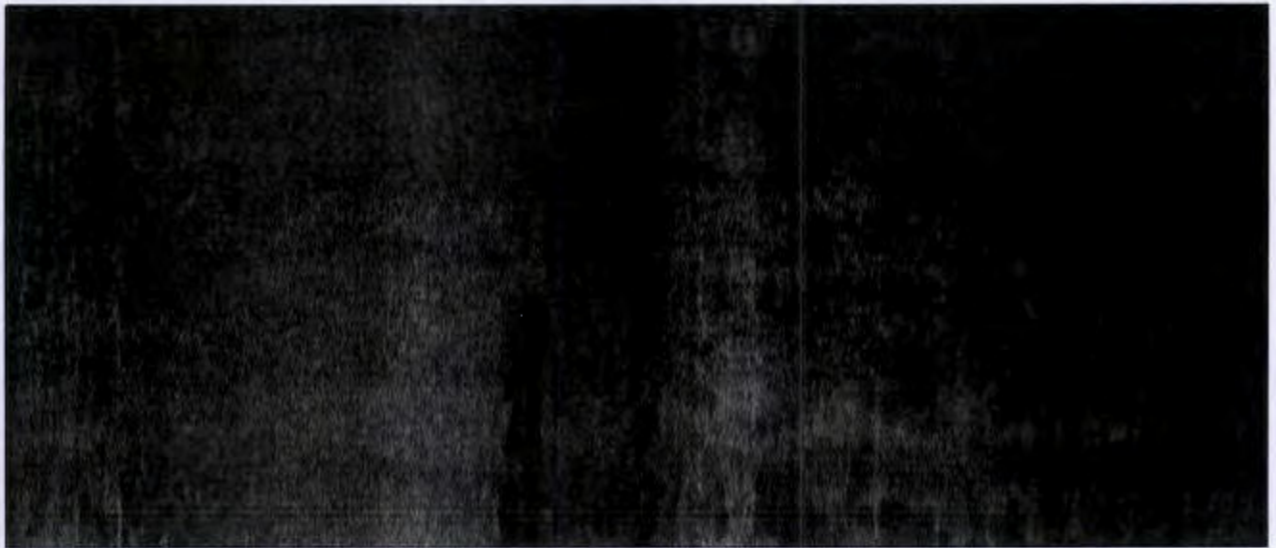
10/11



10/12







10/13



10/14



[REDACTED]

1630 - RN and MD arrived on set to assess patient. Patient appeared agitated and was short towards RN. Patient states he is ok at this time. Per patient's sister, he is upset with the director for making him do too many unnecessary takes when he is not feeling well.

1930 - patient finished filming and was extremely agitated leaving the set. Patient kicked in the door of his trailer and refused to speak to director. Patient was verbally aggressive to another person on the set so no apparent reason. Per MD patient is to take Xanax 2mg to reduce his agitation at this time.

[REDACTED]

10/15

0645 - patient awake and states he slept from 2200-0430. Patient continues to be agitated about work and is verbalizing having desires to escape with drugs. Patient given positive reinforcement for processing feelings and encouraged to call his so we friends for support regarding the feelings he is having. Patient has a 2245 appointment with psychiatrists. Patient self administered routine AM meds and Xanax 1mg.

0845 - MD informed of patients state of mind and continued agitated. He is on his way to assess patient.

1230 - patient had fallen asleep and is now wake talking with MD. It has been decided patient is under too much stress at it would be best for him to stay home and rest today. Per md order: seroquel 50mg, neurontin 900mg administered. Plan is for patient to stay home and rest today.

2330 - patient relaxed and played music throughout the afternoon. He fell asleep around 1900 and continues to sleep at this time.

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New med orders:  
Increase lamictal 75mg qAm  
Neurontin 600mg q4-6hrs  
Seroquel 37.5mg tid, 50mg HS

10/16



10/17 -



10/18



10/19





10/20



10/22

0100- patient self administers HS meds and heads to back of plane to sleep.

Now in Georgia -5 hrs

0300 - arrived at hotel. Patient requested additional melatonin to help get him asleep and to adjust to time change. Melatonin 20 mg administered. Patient asked to text rn when he awakens later today.

1530 - patient states he awakened at 1430 and self administered am meds. He requested an emergency session w psychiatrists to discuss feeling about arguments with fiancé and would like some tools to help him feel with his emotions. Appointment made for 1900.

2010 - patient spoke to psychiatrists for 50 min and was open and honest with his feelings. He feels better after conversation but also feels he is in a "no win situation" with fiancé. Patient will meet with psychiatrists in person next week. Plan is for patient and fiancé to go to dinner this evening. Patient is feeling exhausted and wants to stay home but does not want to upset fiancé. Patient encouraged to text rn if he needs anything throughout the night.

10/23

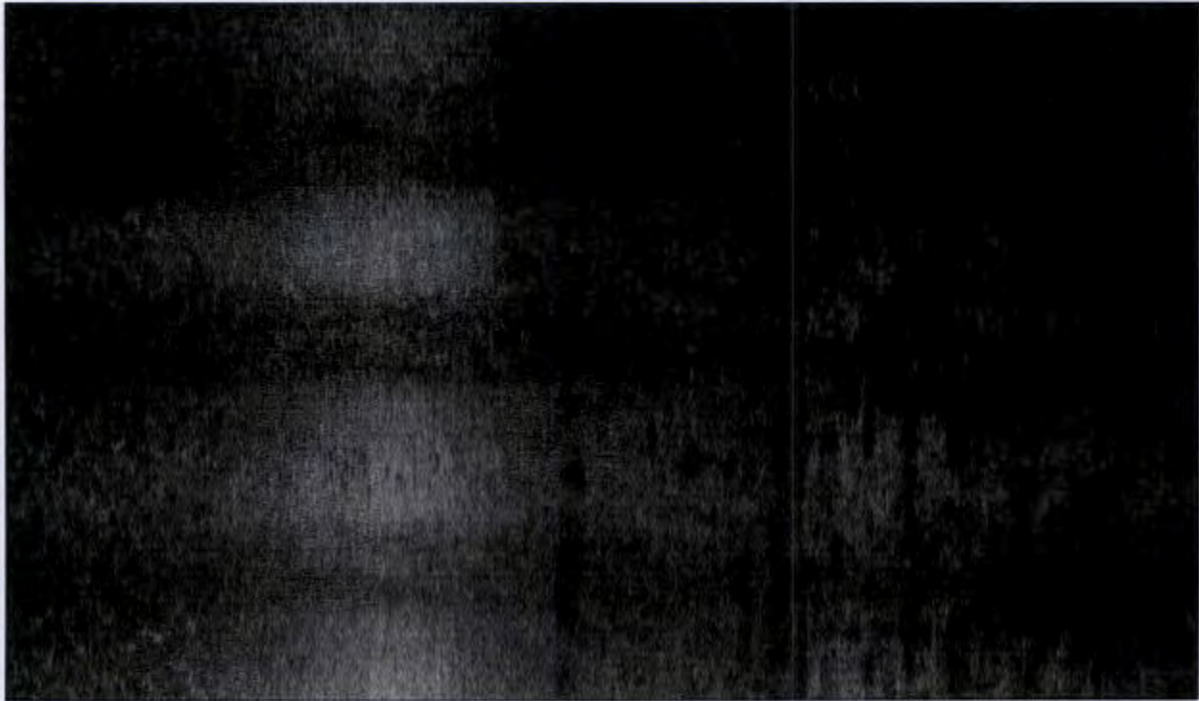
1520 - text patient to see if RN could stop by and check in. When RN arrived in the room patient was agitated and felt fiancé was using the term mania to explain his behavior and excuse herself from any fault during arguments. Patient was upset by this label. RN processes feelings with patient and he was able to see fiancé' negative behaviors. Patient looks forward to meetings with psychiatrists next week as he is stressed about current state of his relationship. Report given to MD. Patient given routine meds for 10/24 to self administer. Patient will text rn if needed throughout the evening.

10/24





10/25



10/26/14



10/26/14

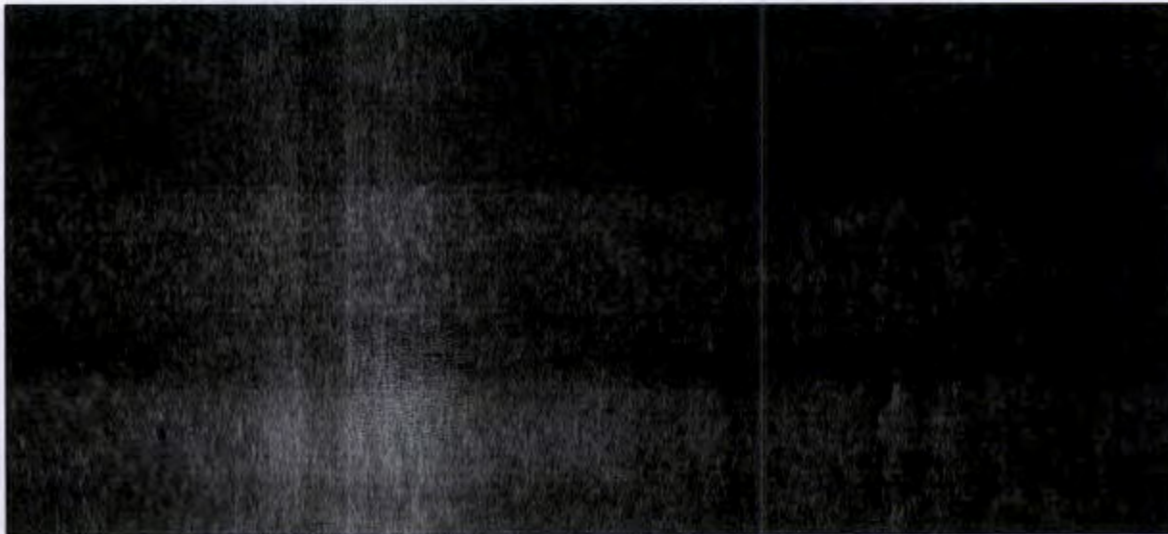


10/27/14



10/28/14

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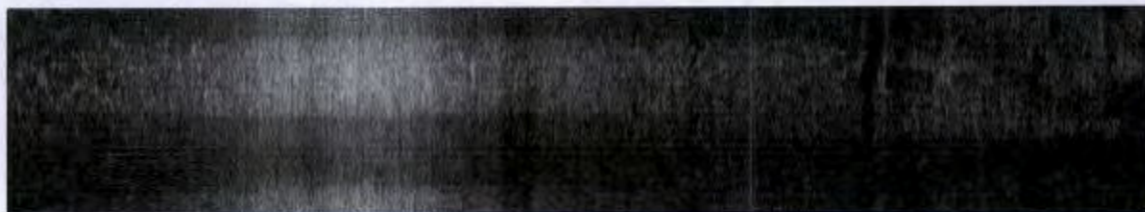
10/29/14



10/30



10/31



19STCP04763

Kipper 0116



11/1



11/2



11/3

1130 - RN arrived a patient's home at 1930. Patient stated he had not eaten all day. Assistant ordered burgers and patient ate 25%. Patient was focused on relationship with fiancé and is struggling with conflicted emotions. Patient encouraged to process these feelings with therapists tomorrow. Patient was hyper focused about relationship issues. MD and therapists notified about patients state of mind. Patient given routine meds for 11/3 and 11/4 and plan is for RN to see patient tomorrow around noon.

11/3

1210 - RN stopped by patient's home and he was asleep sitting up on the couch. Patient's nephew was at house and informed RN that patient was up



till 0830 this morning. Report given to MD and he is concerned with patient's sleep cycle. New medication orders given:

D/C previous seroquel orders  
Start Seroquel 50mg QID

1700 – RN went back to patients house. He was chatting with a friend and is feeling stressed about his relationship. He feels she is not being truthful with him and he is not sure how to confront her about this when she arrives home. Patient encouraged to discuss his feeling and concerns with his therapists tomorrow. RN emailed therapists to let him know how patient was feeling. Patient's plan is to hang out with friend for the evening. Patient encouraged to take his HS meds at a reasonable hour and to try to go to bed early and get back on a healthy sleep cycle. Routine medications for 11/4 left with patient to self-administer.

11/4/14



11/5/14





11/6/14 -

11/4



11/10



11/11



11/14



11/17

1400 - RN and MD went to patients house to assess him. Patient appeared anxious and depressed over relationship issues. Patient continues to be ambivalent about relationship status. Patient has not been sleeping. Seroquel HS increased to 150mg for tonight. Patient agrees to take only medications prescribed by MD and to work to get his sleep cycle normalized. Patient agreed to let RN know if he feels he cannot handle his emotions and requires more medication. Patient will resume seeing psychiatrists next week when he is not working.

2105 - per patients assistant, patient has left to go out to dinner with fiancé.

11/17

0845 - per patient's security, he spent the night with his fiancé downtown.

1300- received text from patient to meet him at 1600 back in Hollywood.

1930 - patient stated he had a nice night with fiancé and they are working things out. He said he got a good nights sleep and felt much better today. Report given to MD and MD would like to continue patient on Seroquel 150mg at HS x2 more nights. Patient will work in Lancaster for the next 3 days and was given routine meds for 11/18 & 11/19 for self administration. Patient will contact RN via phone if he needs anything. Patient will be back home during the nights.

11/18

[REDACTED]

11/19 -

[REDACTED]

11/20

[REDACTED]

11/21

11/22 -



11/23



11/24



11/25 -



11/26 -



11/27 -



11/28 -

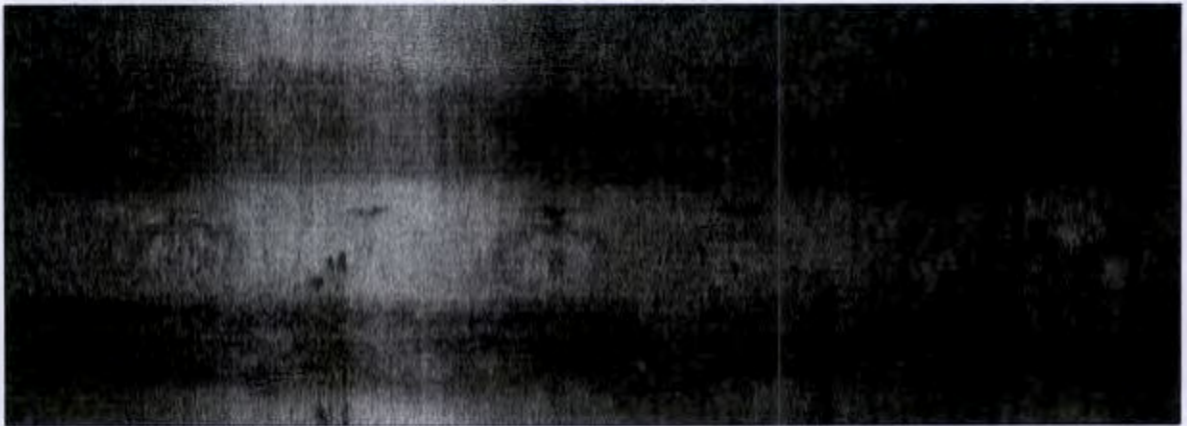


11/29





11/30



12/1/14

12/2/14



12/3



12/4





12/5

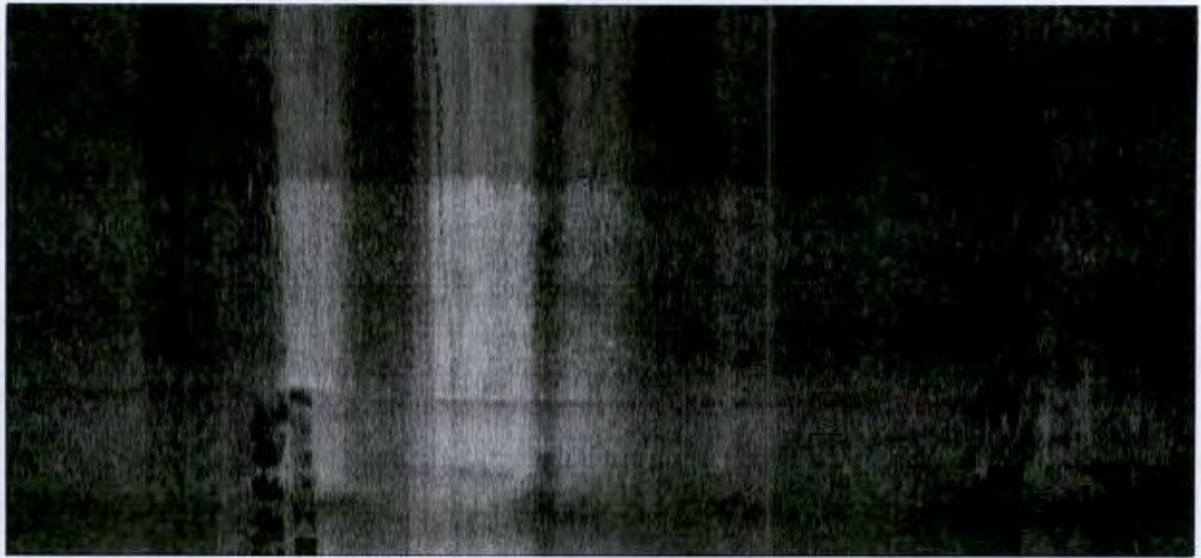


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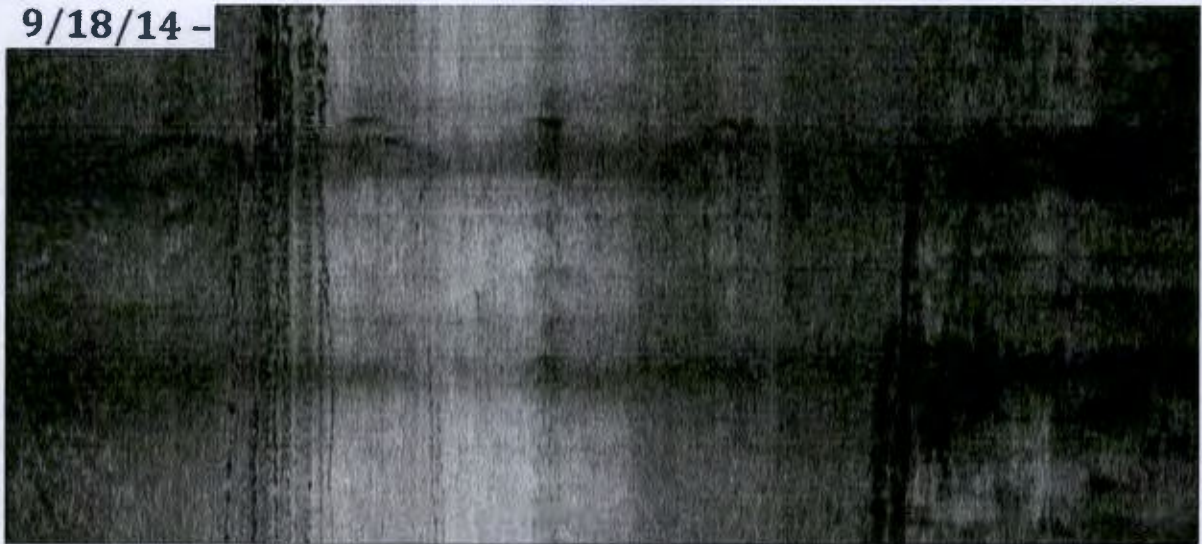


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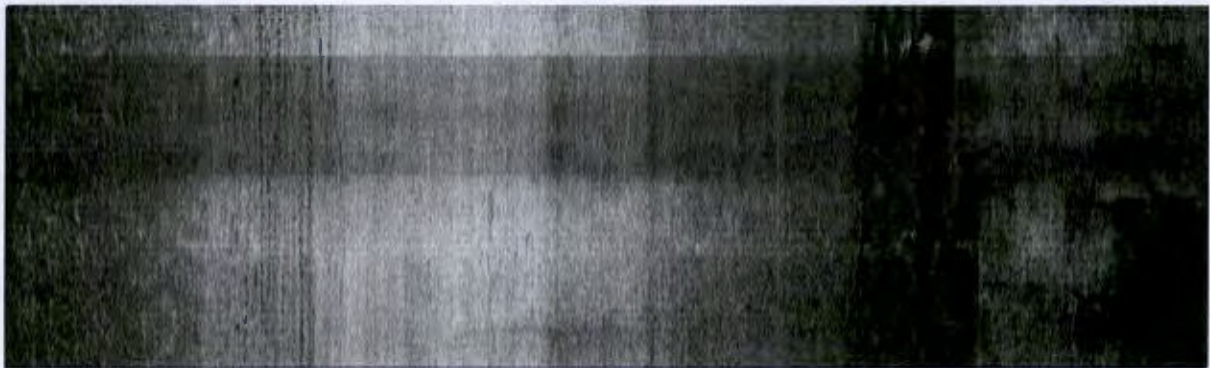




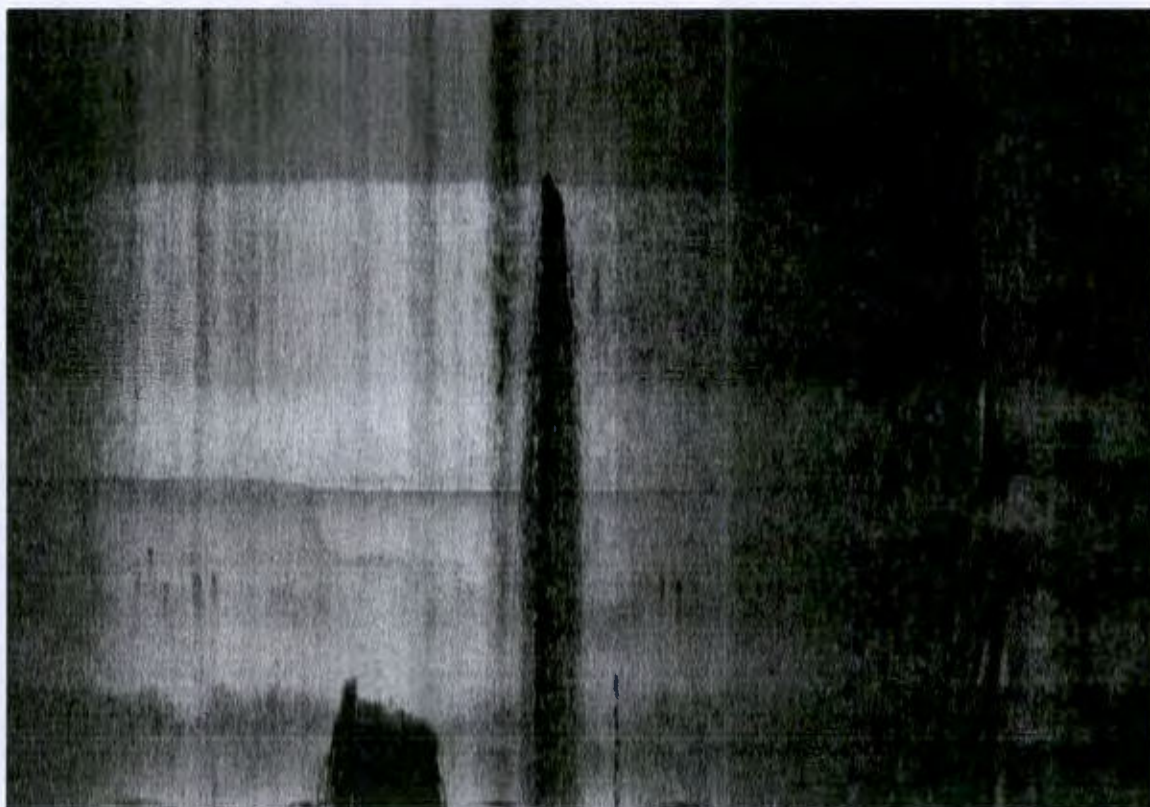
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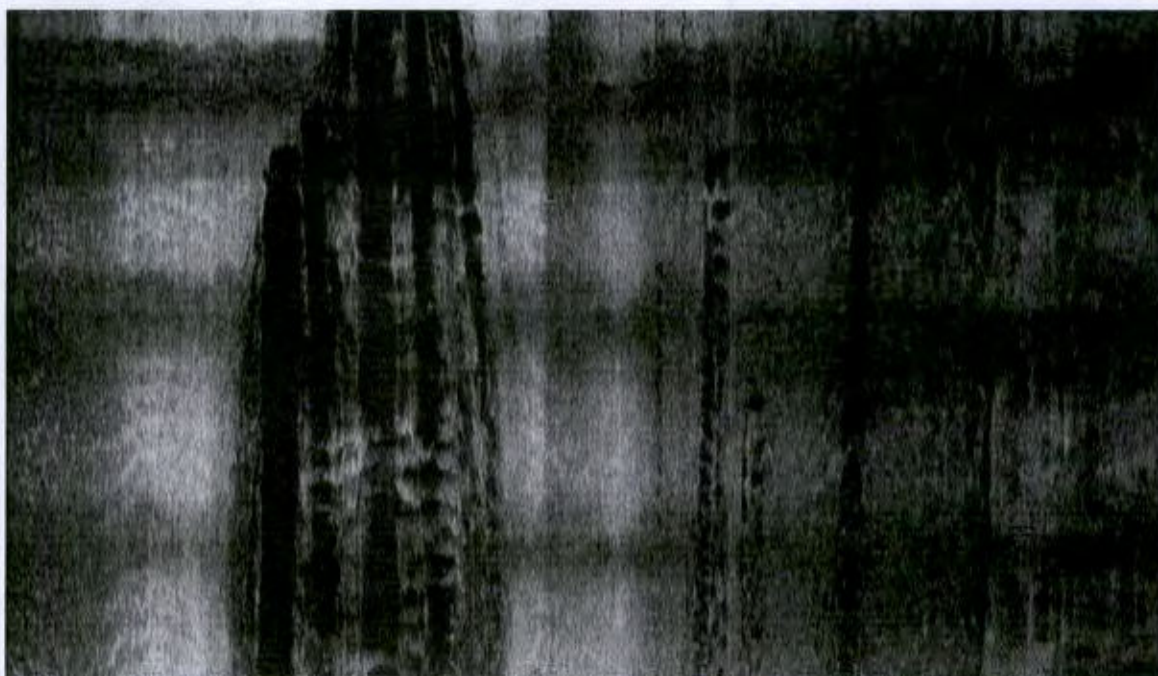
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9/20/14 -



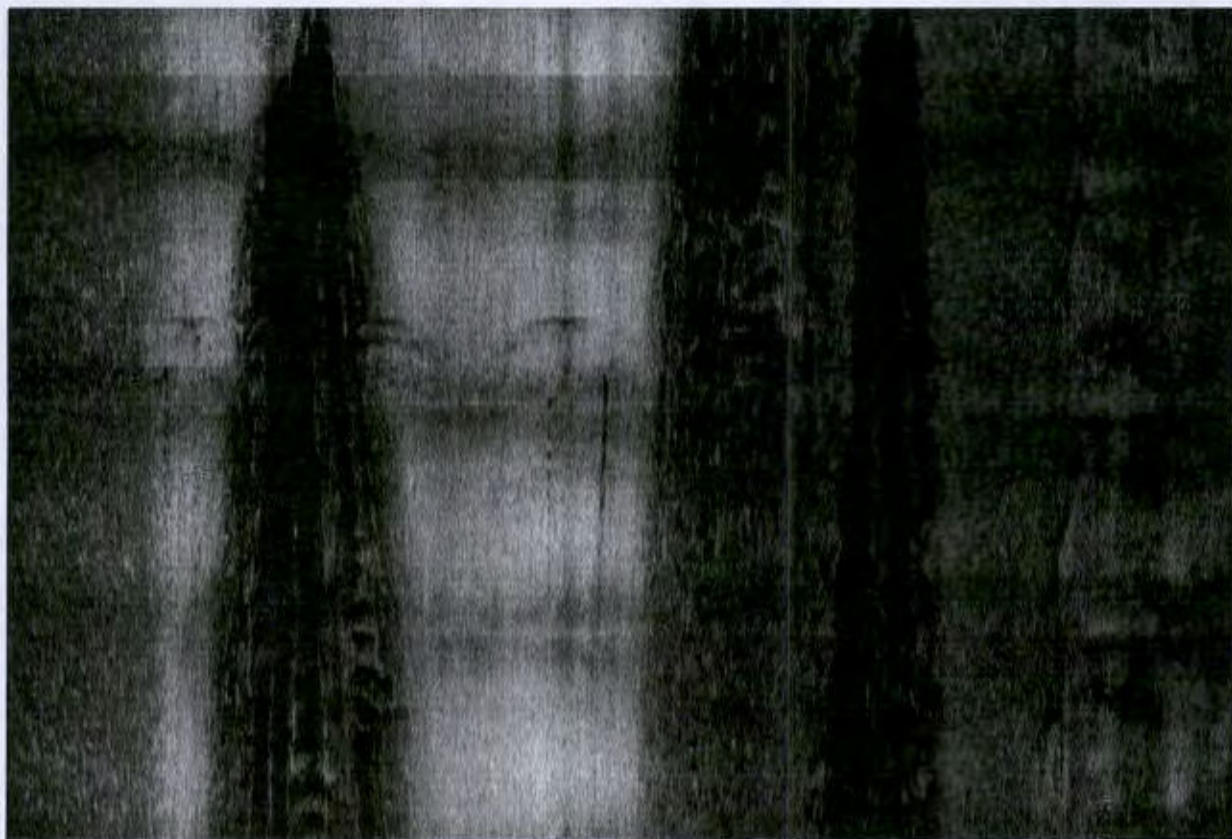
19STCP04763

Kipper 0125





9/21/14





**9/22/14**

**0125-** RN received text from patient stating that he had been in an argument with fiancé and she "had a nasty freakout" and he would like RN to come give him "some fuckin' knockout yum, yum. RN instructed patient to take prn Neurontin 300mg prn and Seroquel 50mg and that RN was on her way over.

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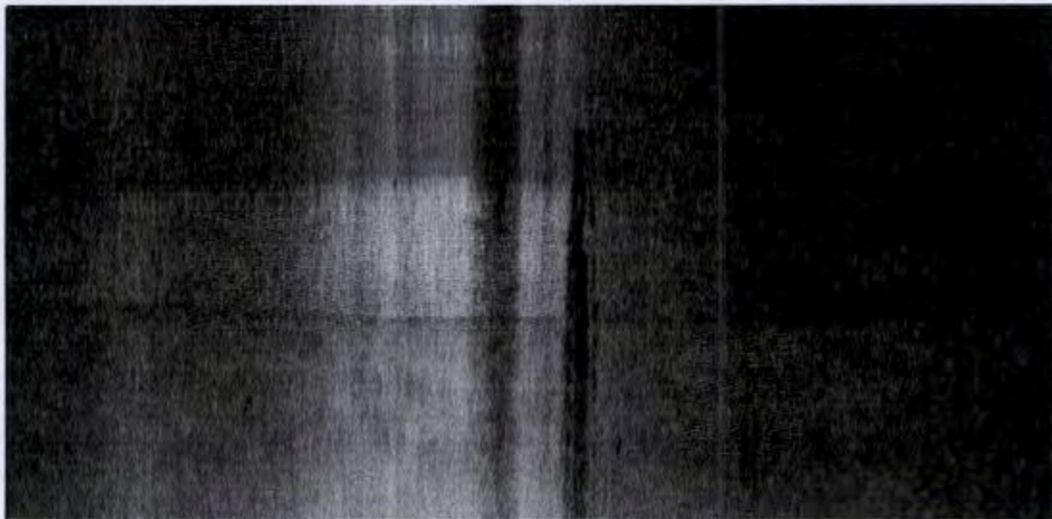
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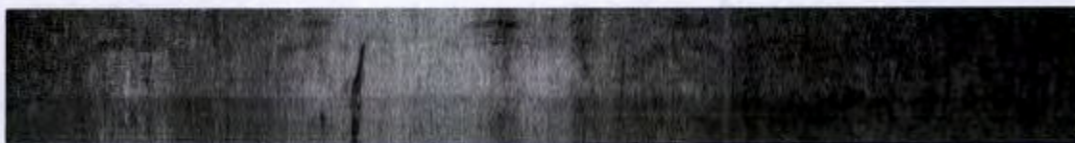
it. Report given to MD via email. RN will visit patient at work in a few hrs.

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9/23/14

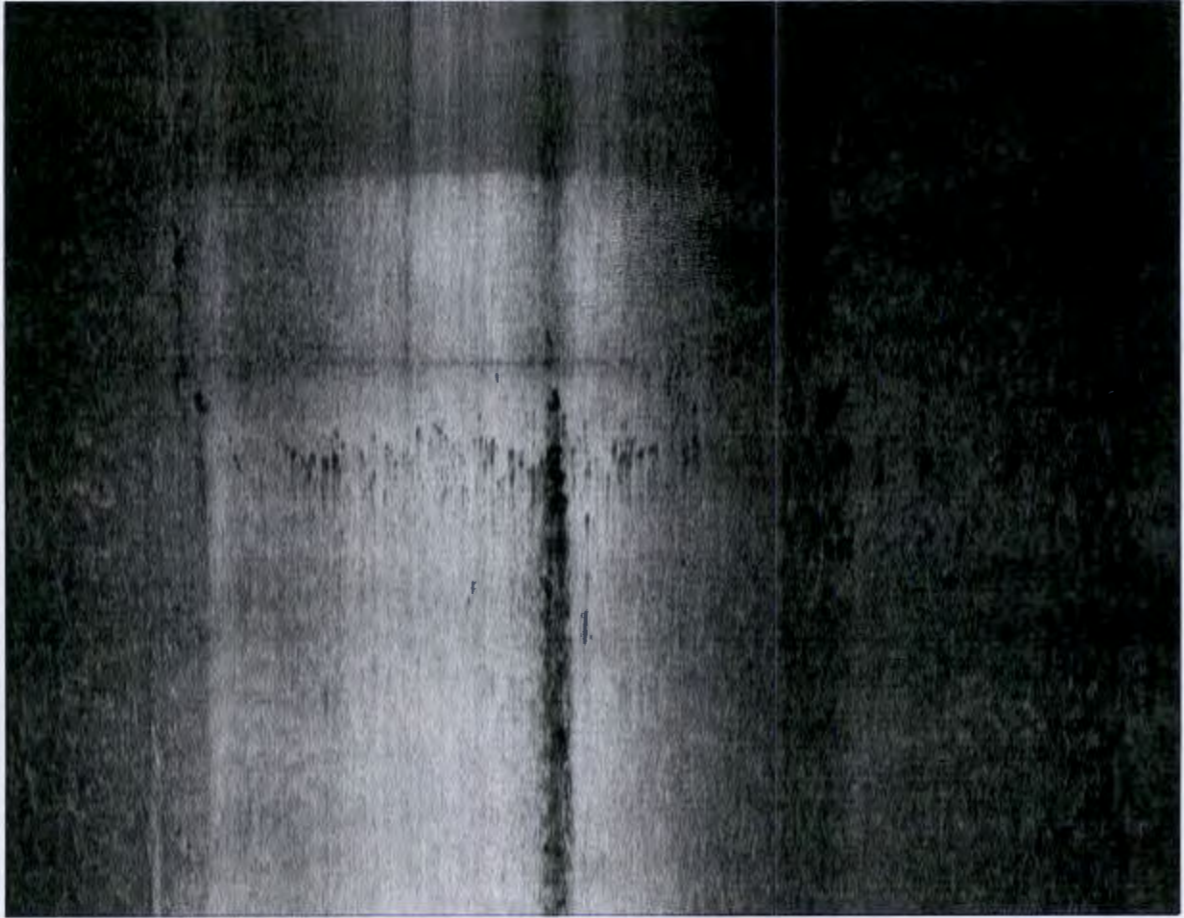


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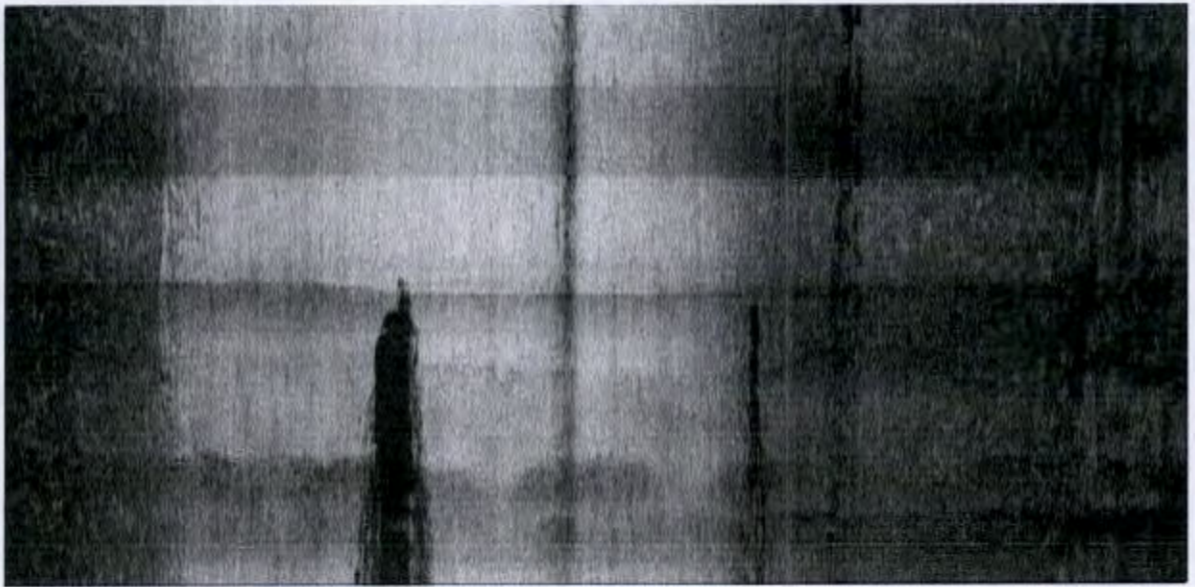


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Kipper 0128

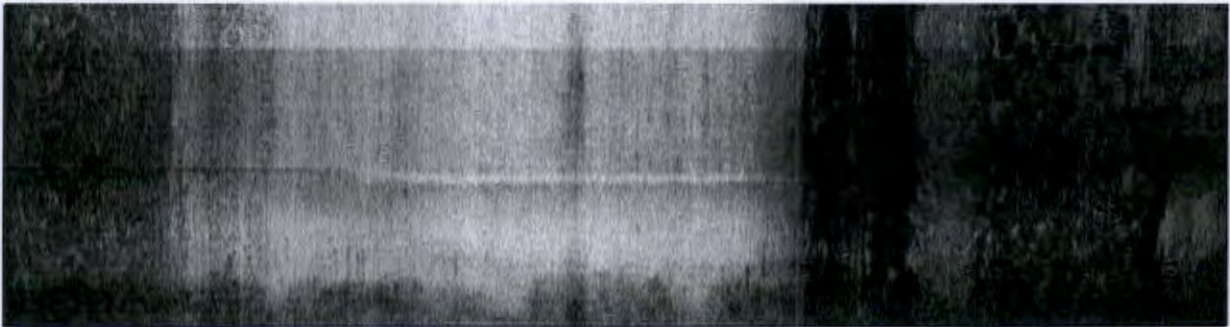


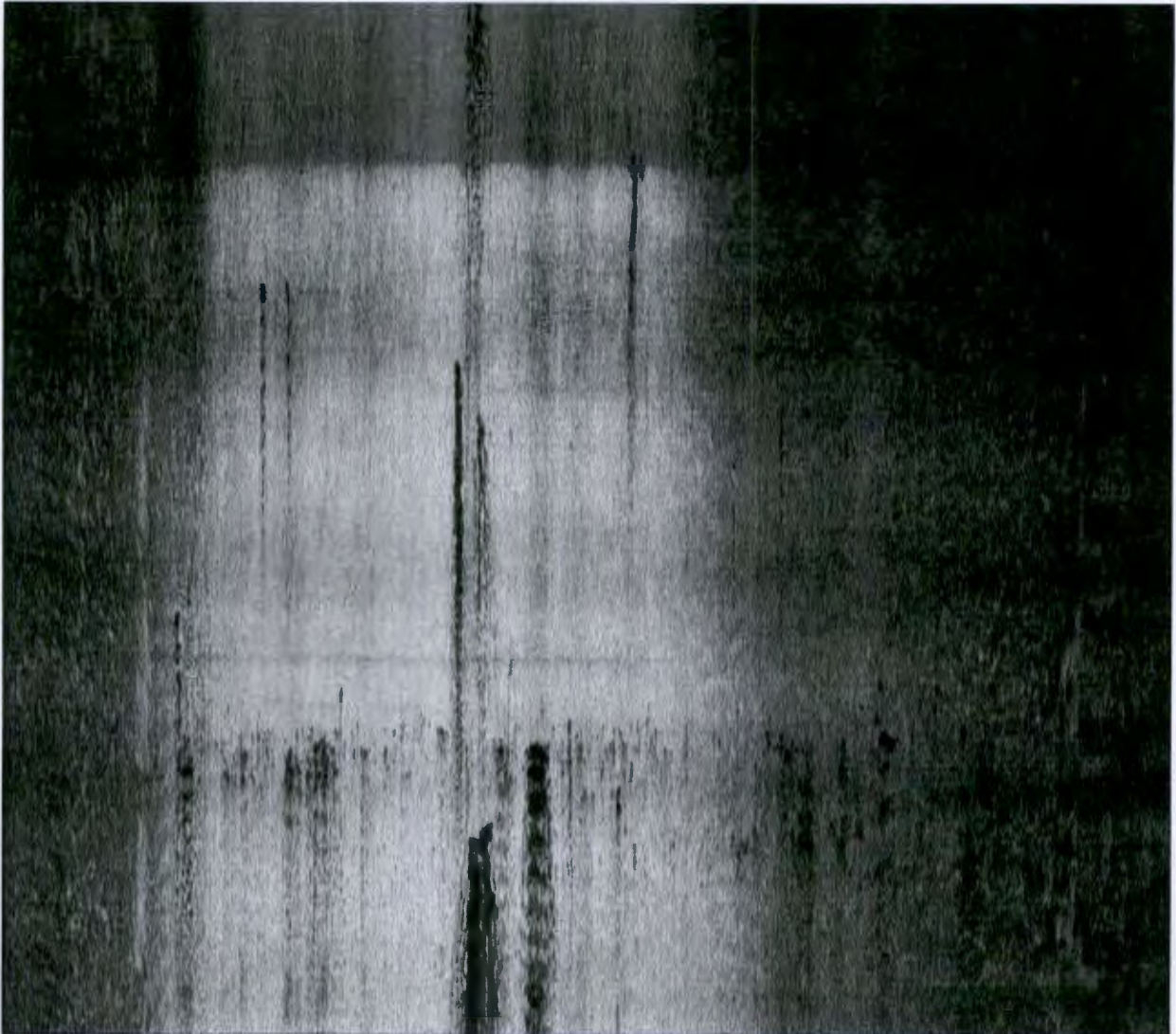
9/25/14



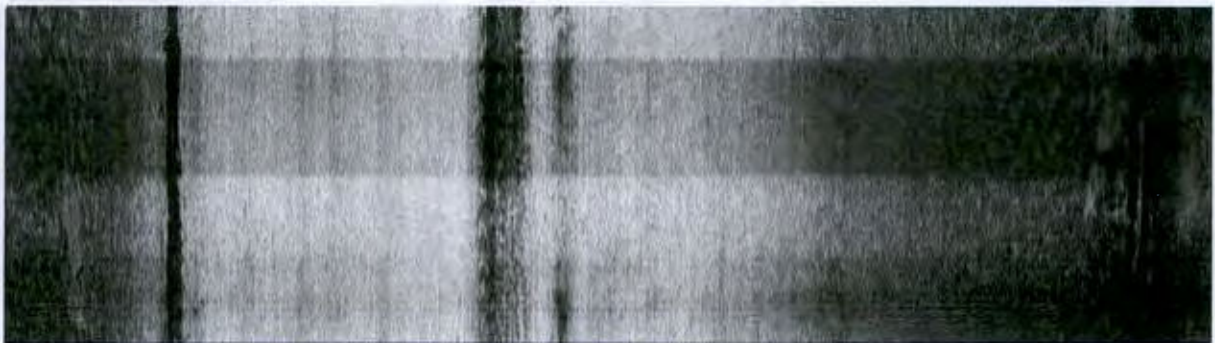


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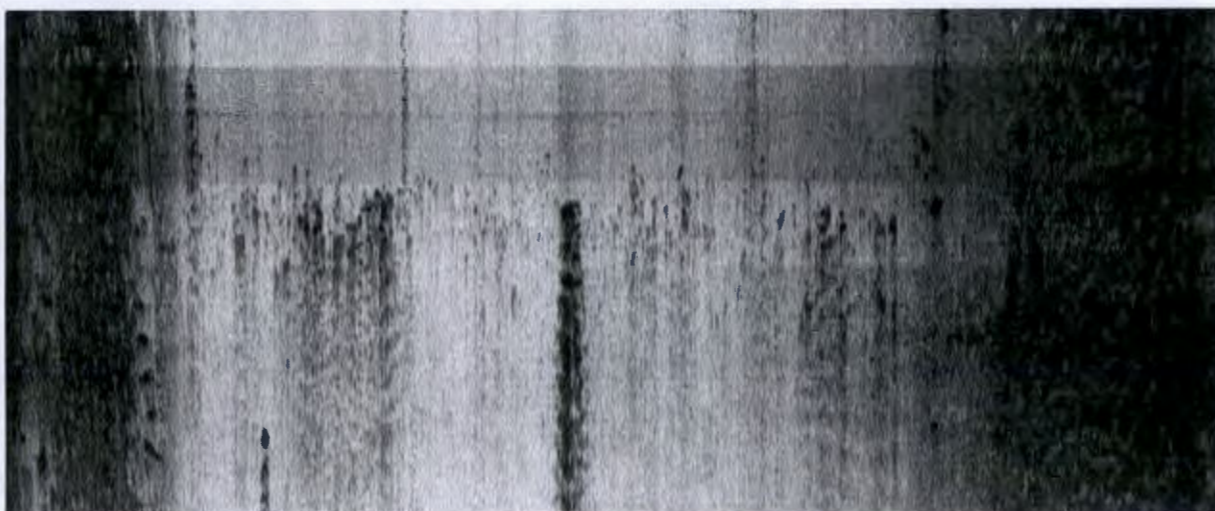


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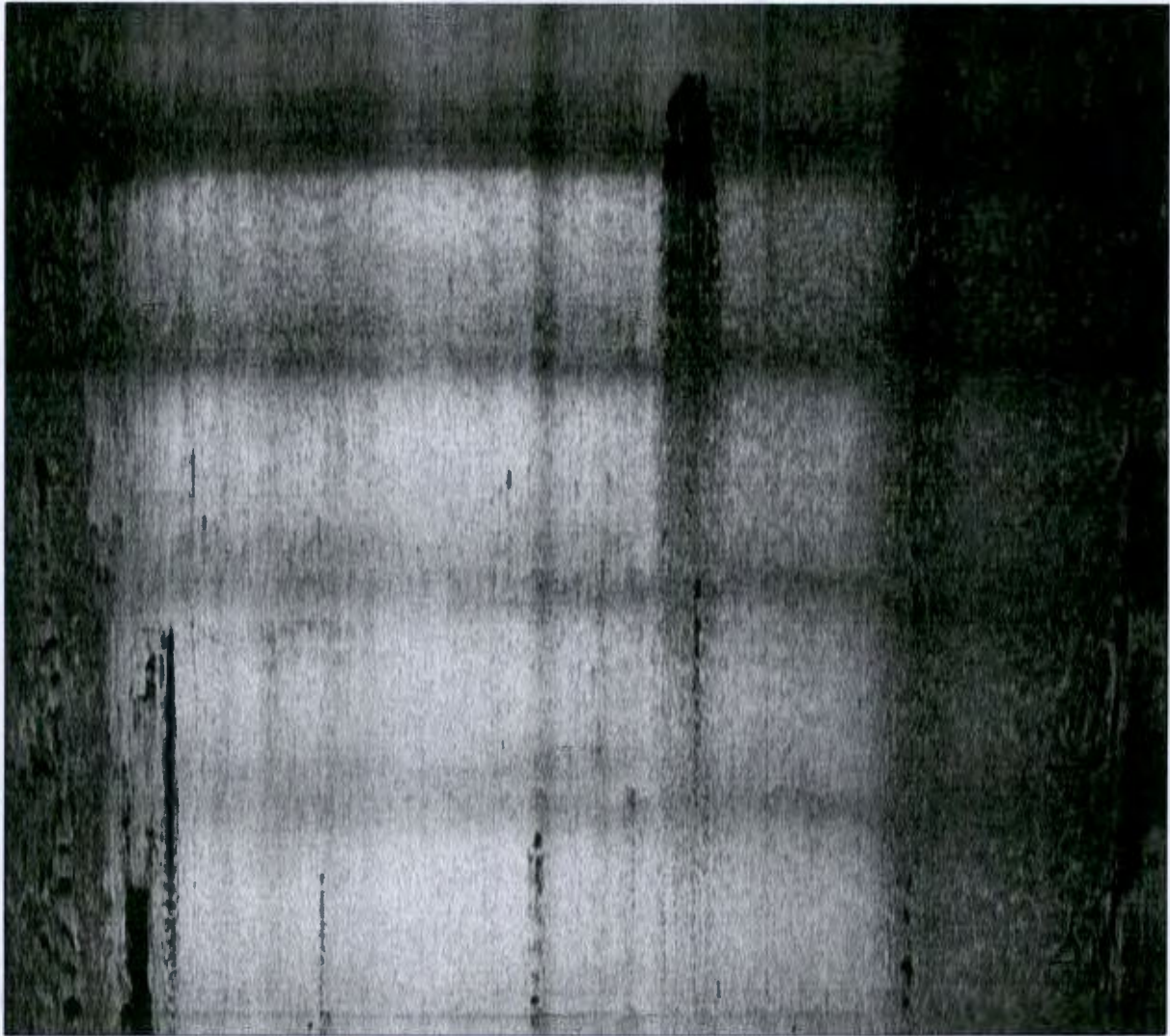
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9/29/14



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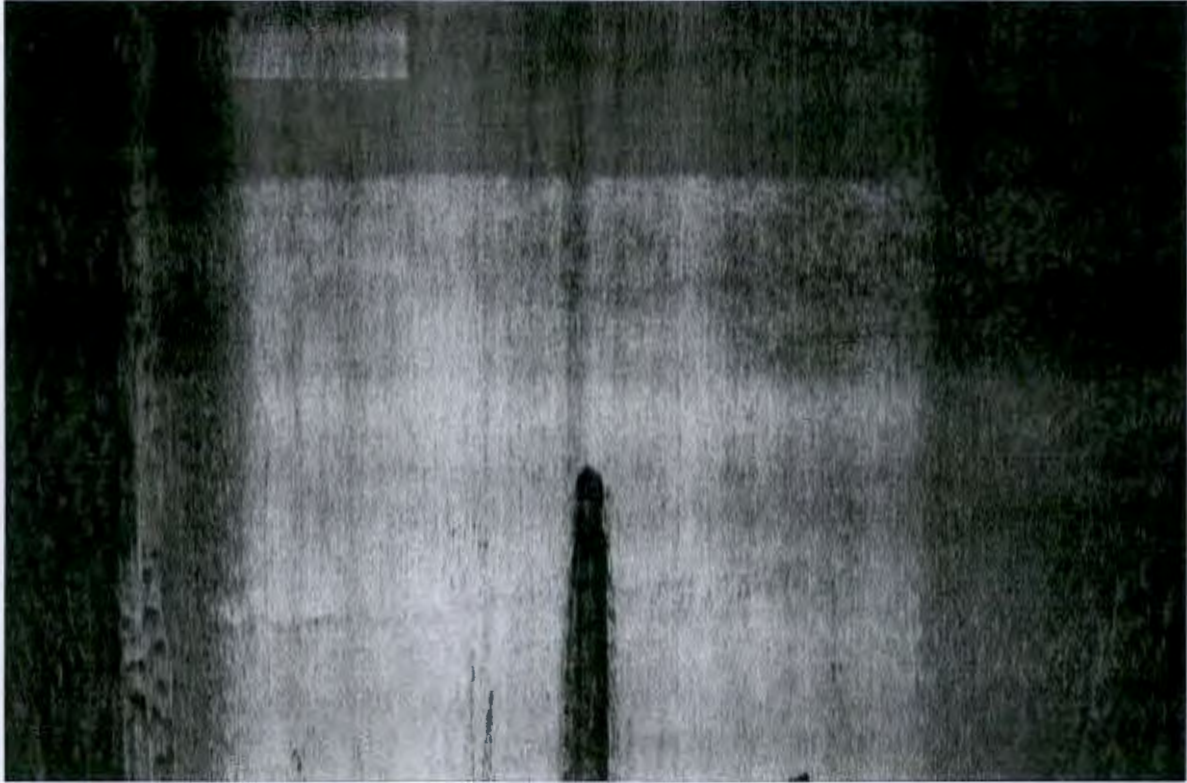
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Kipper 0133  
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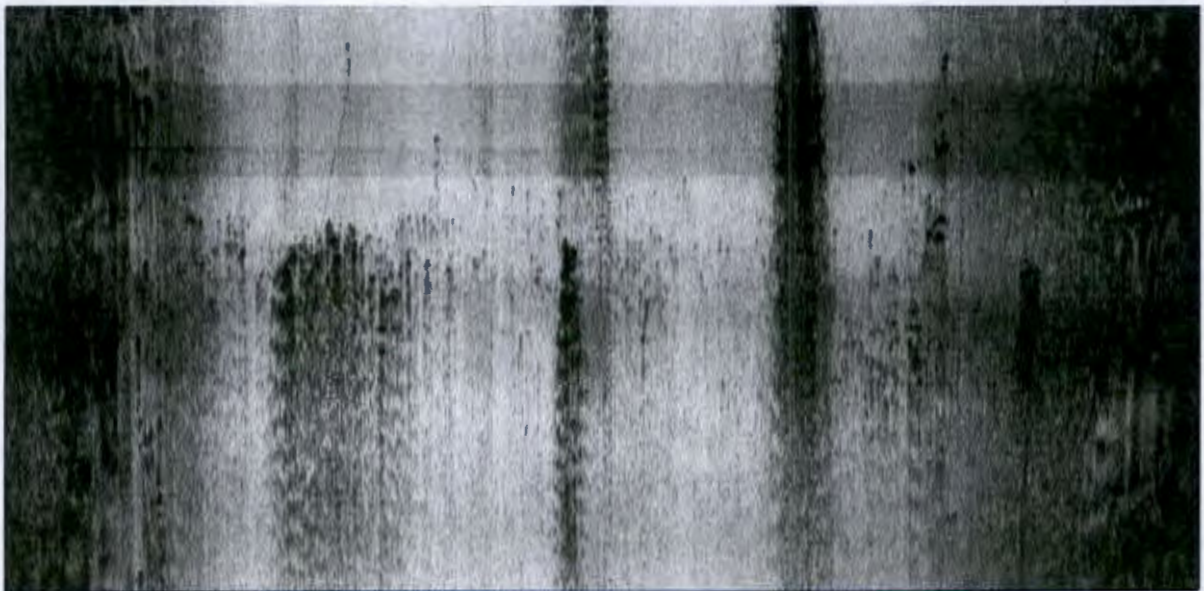




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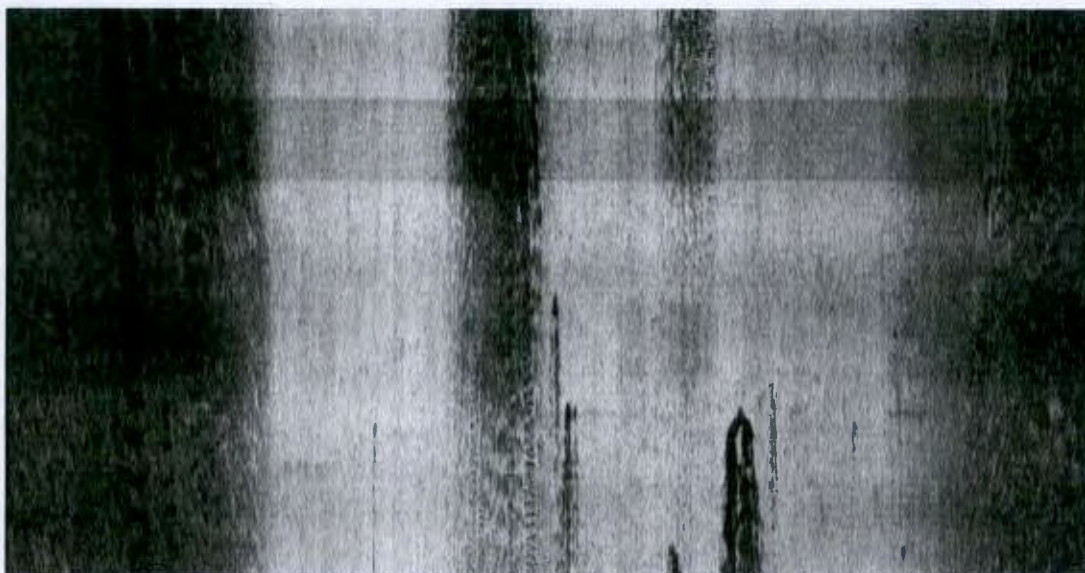
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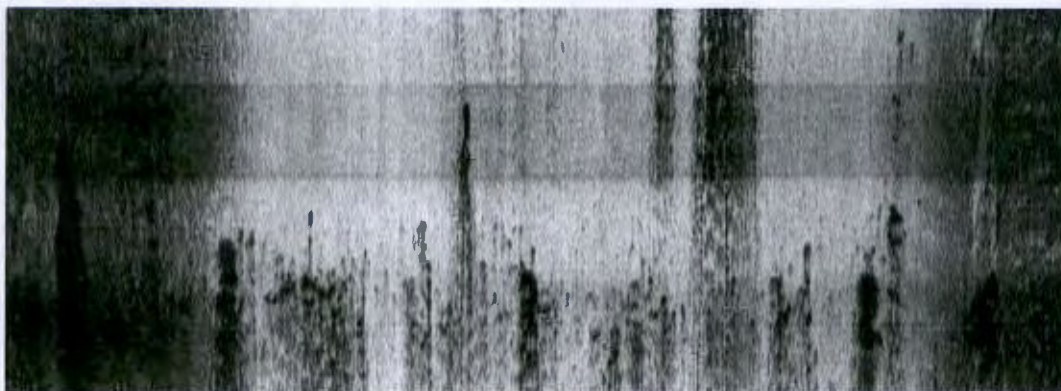
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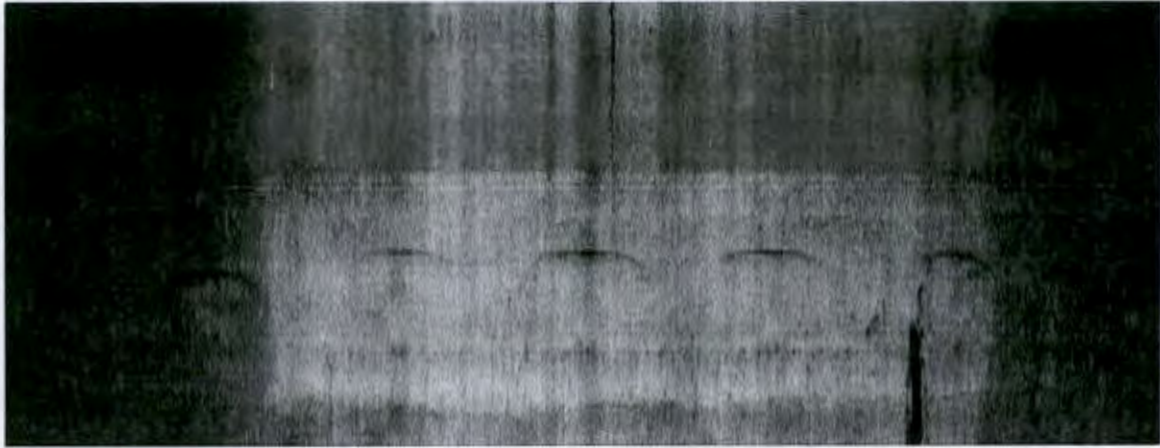


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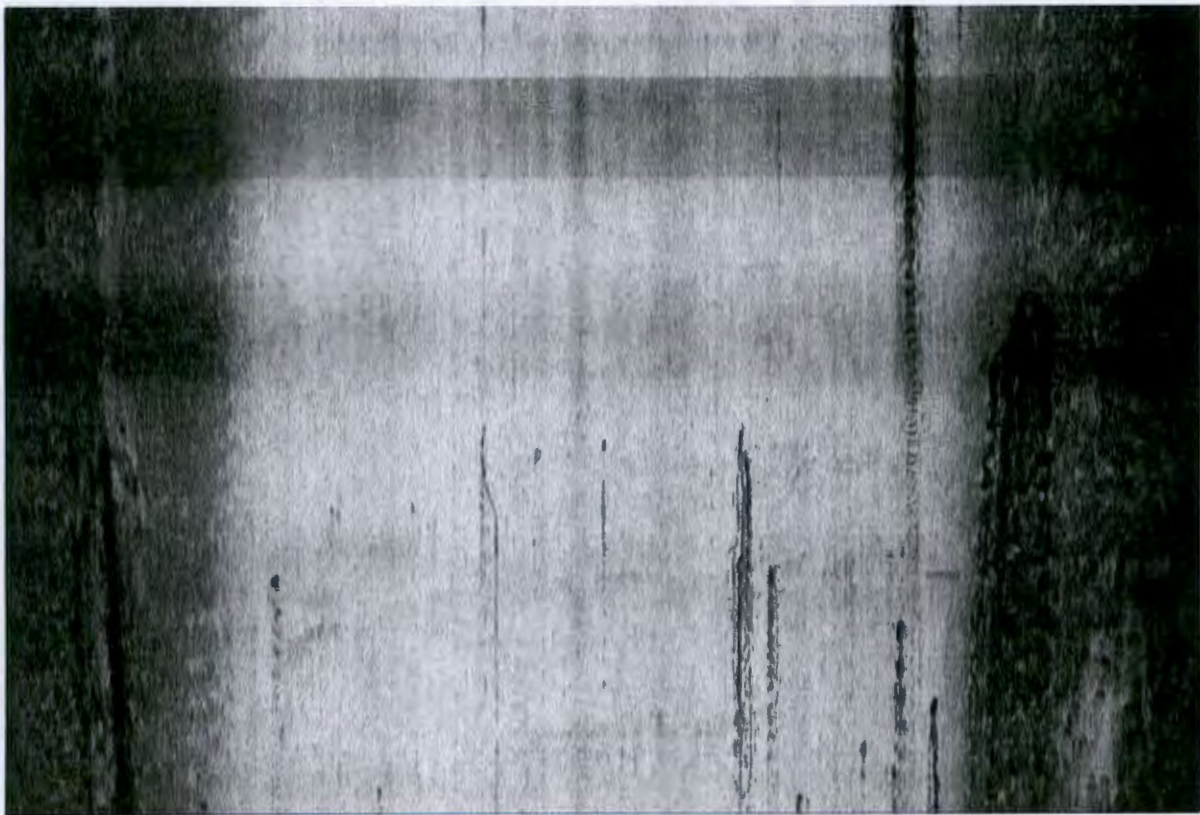


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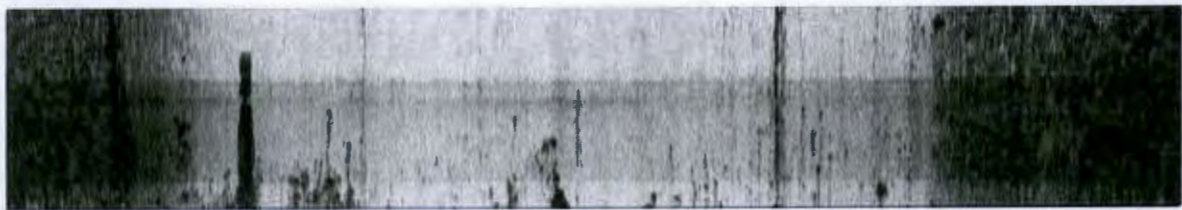
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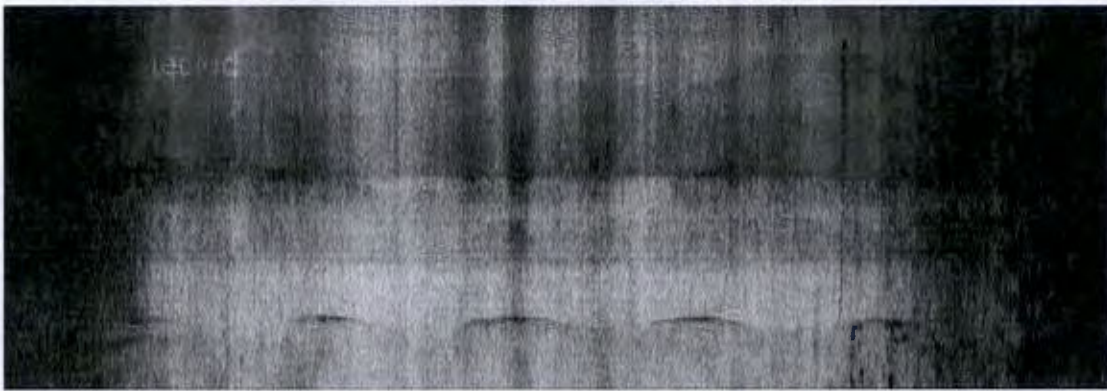
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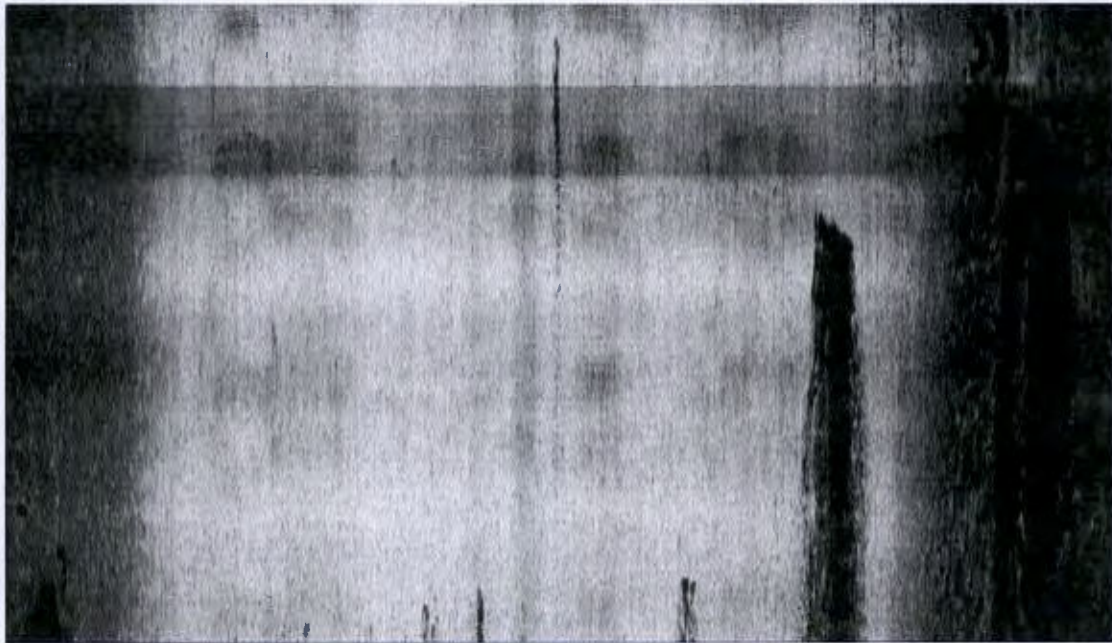
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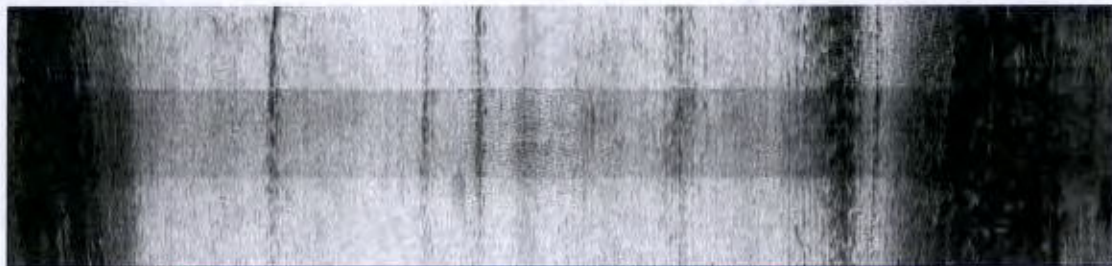
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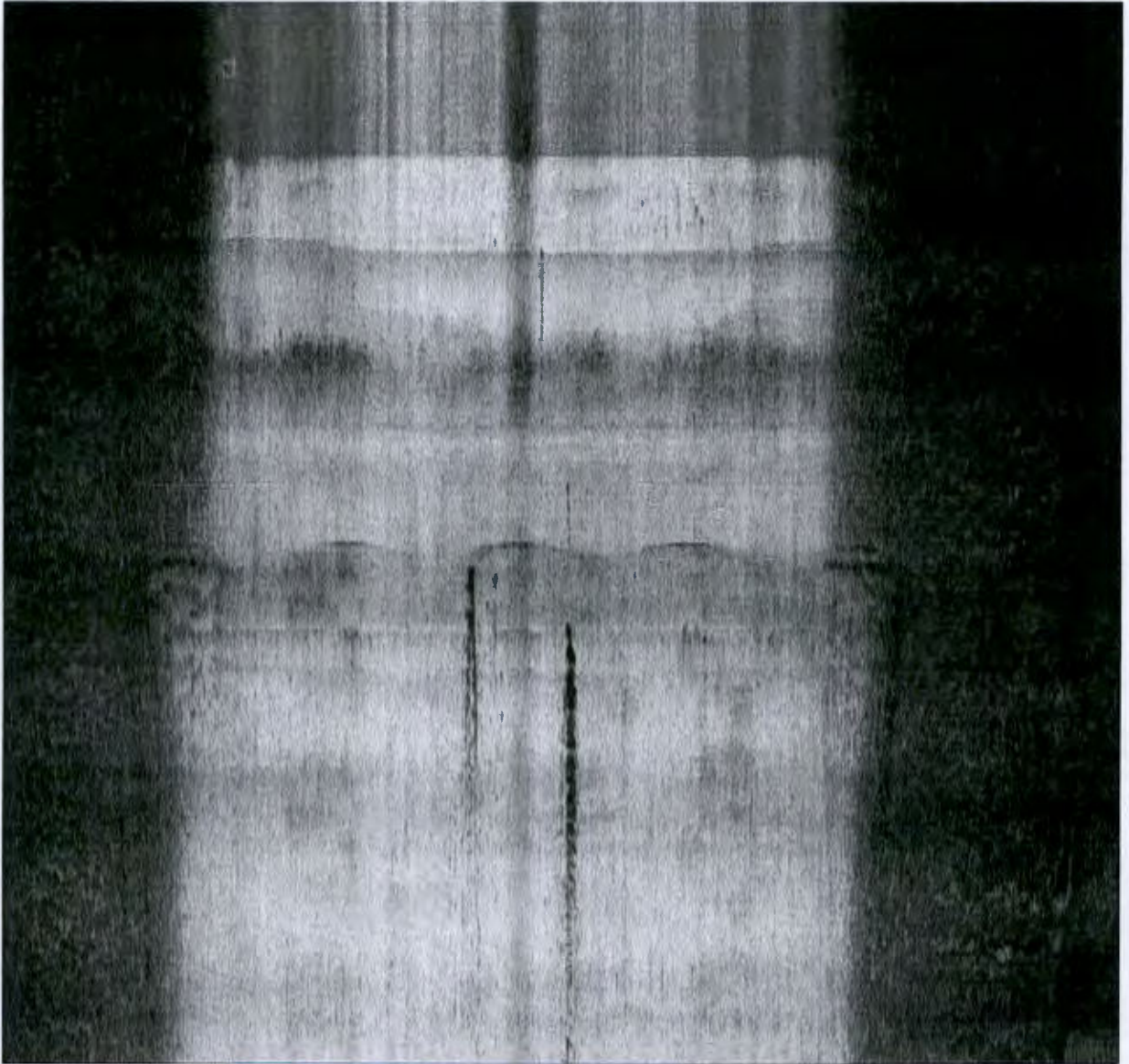


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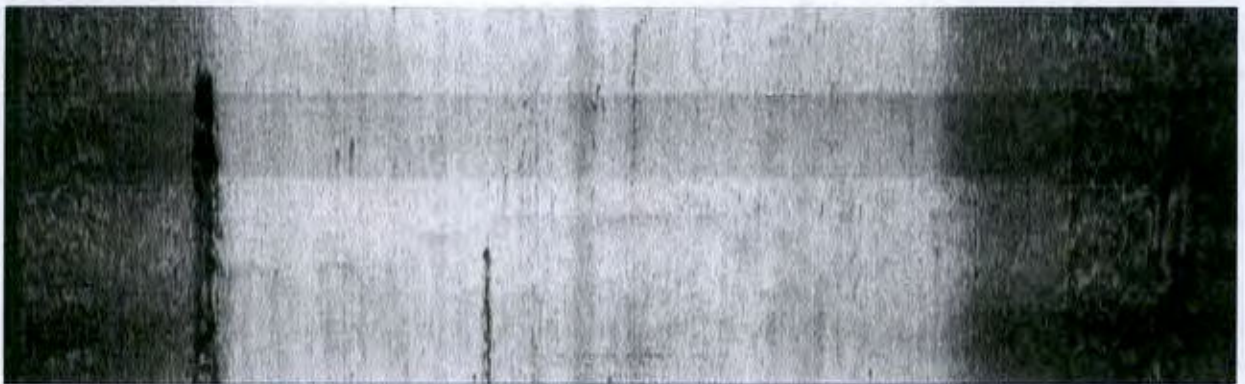


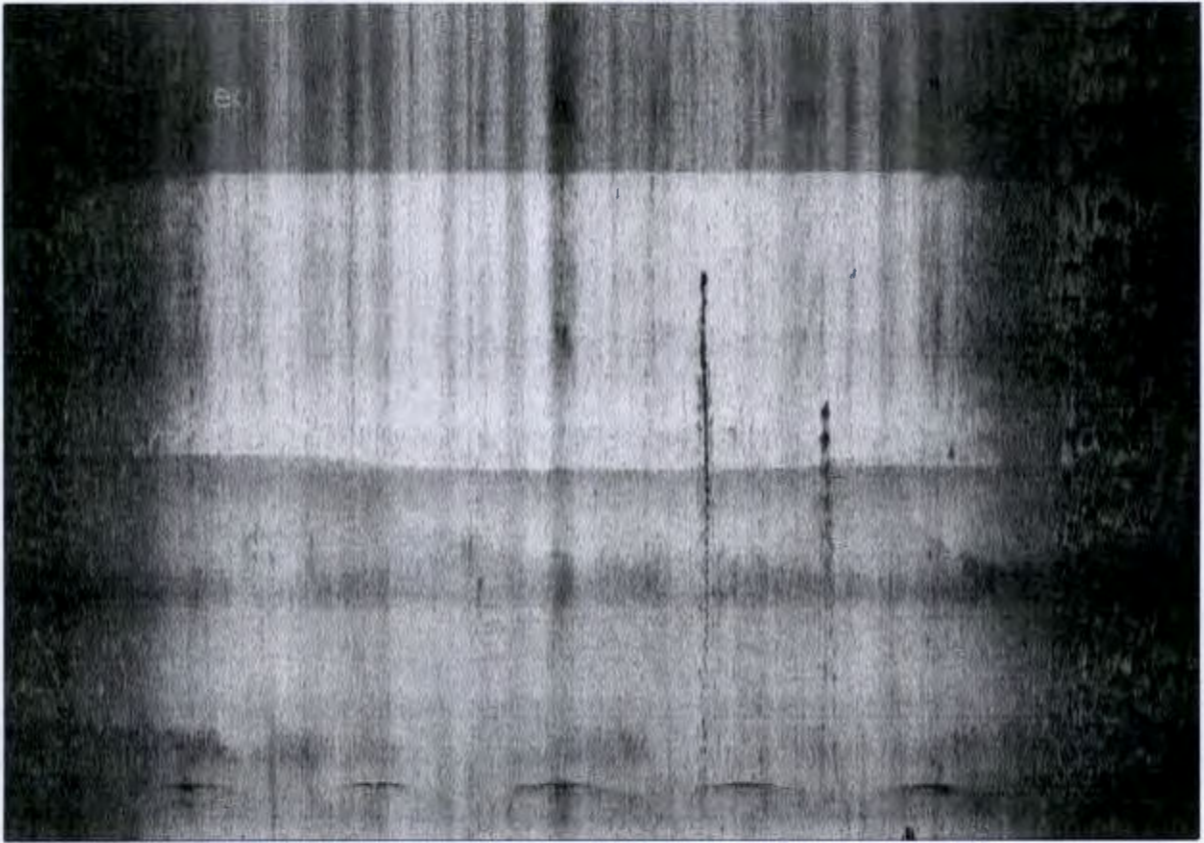
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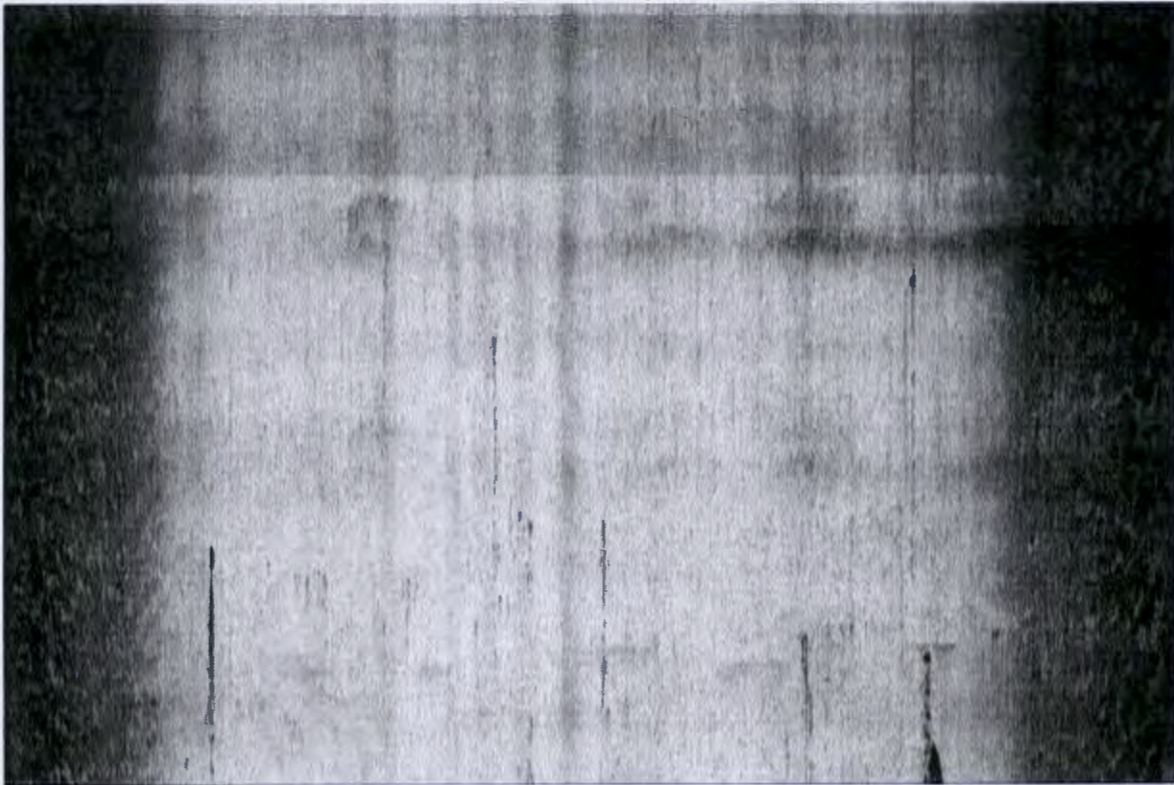


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10/11



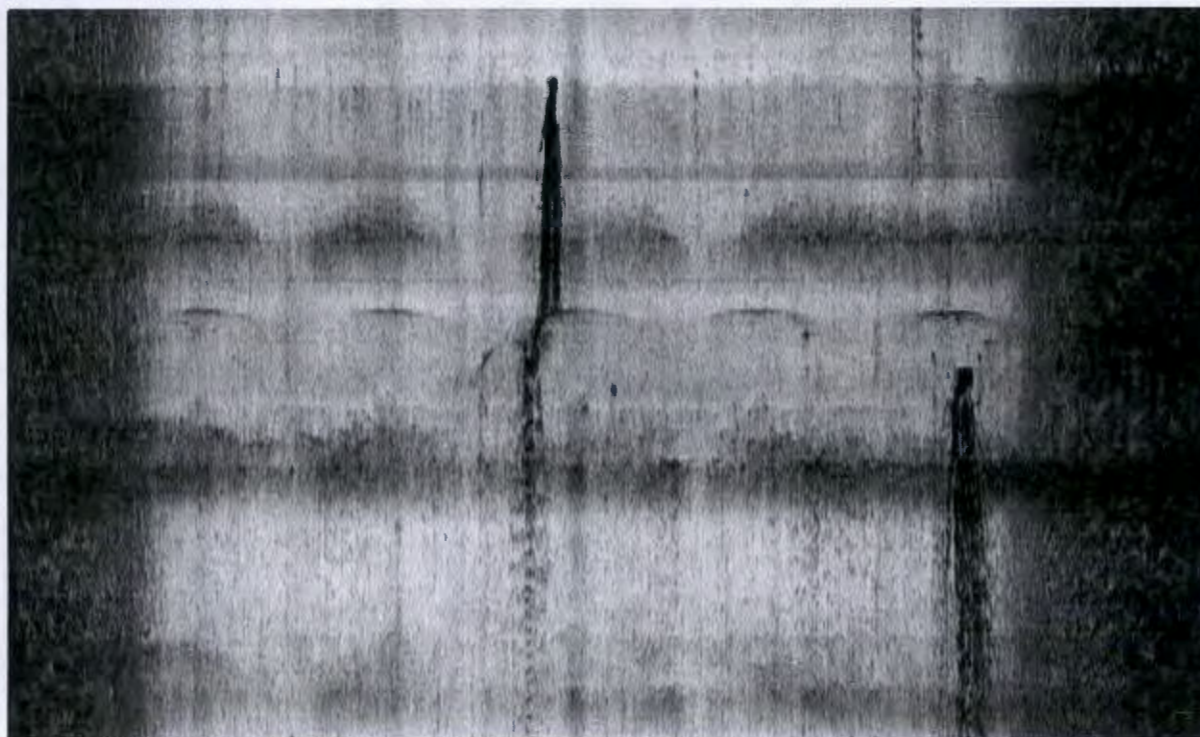
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PLAINTIFF'S TRIAL EXHIBIT 0040\_0087

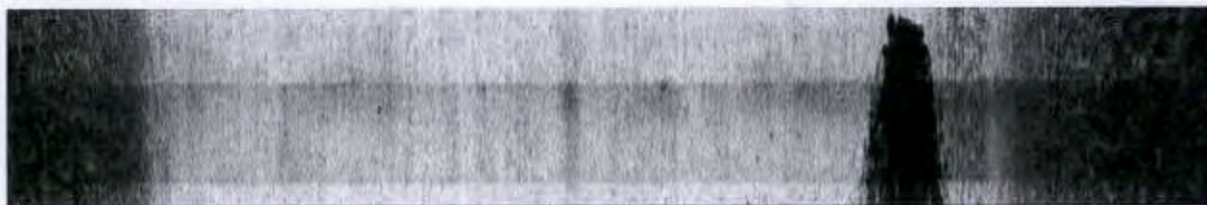
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10/13



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New med orders:

Increase lamictal 75mg qAm

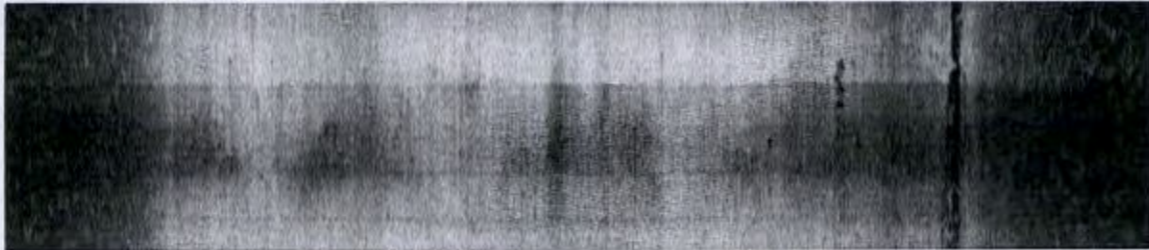
Neurontin 600mg q4-6hrs

Seroquel 37.5mg tid, 50mg HS

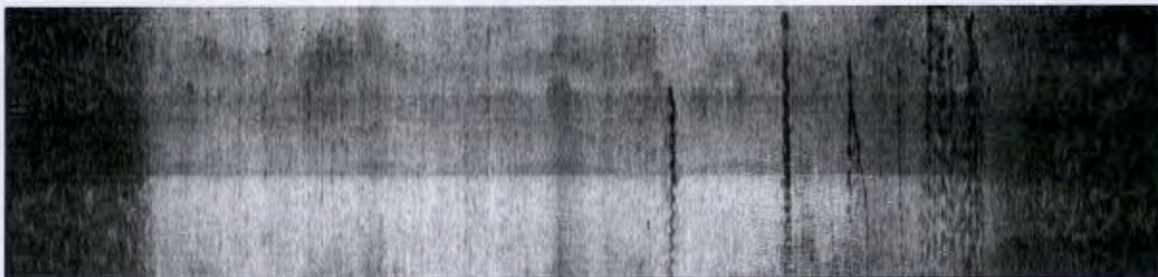
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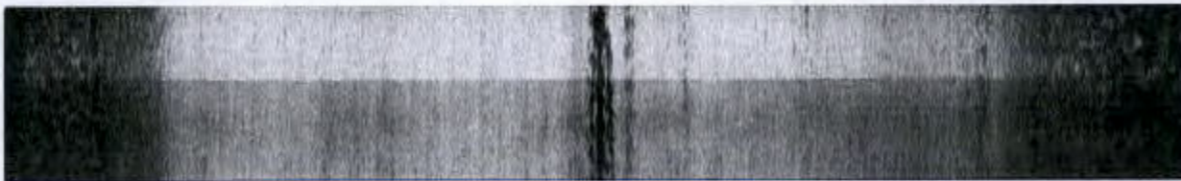
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10/18



10/19

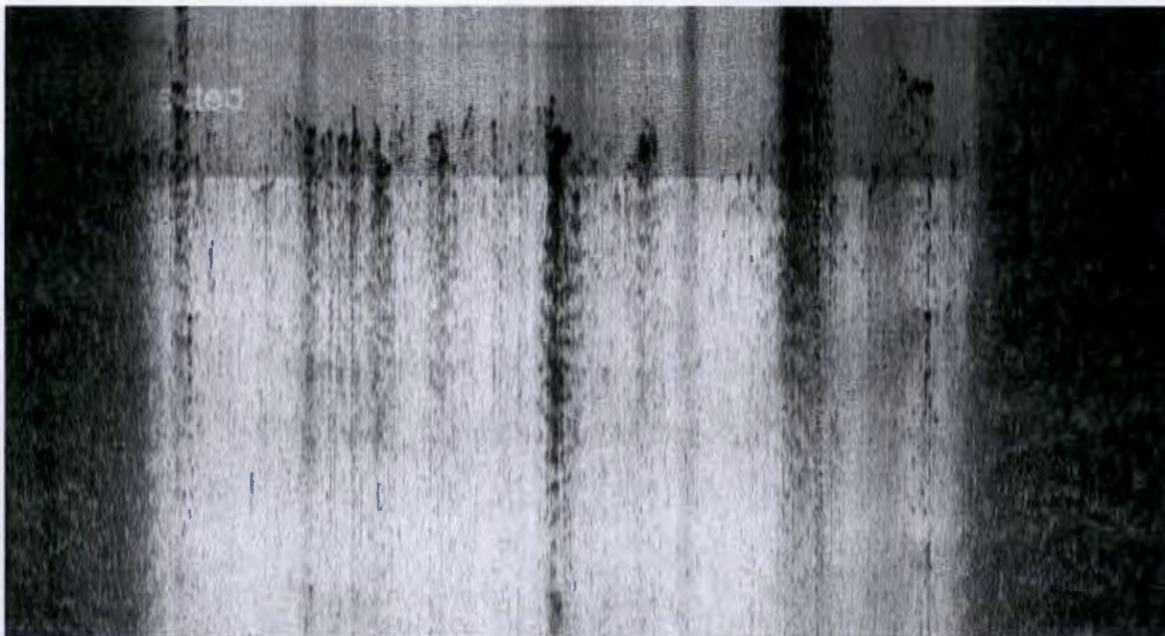


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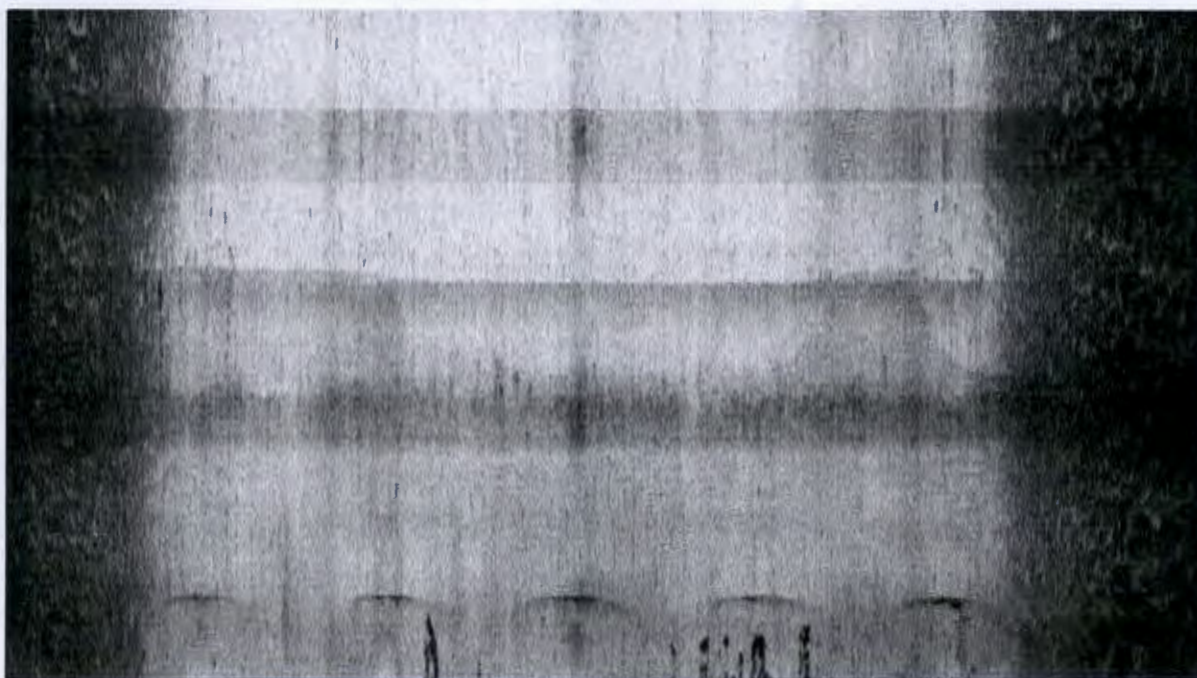
PLAINTIFF'S TRIAL EXHIBIT 0040\_0089

Kipper 0141  
47415





10/20



10/22

0100- patient self administers HS meds and heads to back of plane to sleep.

Now in Georgia -5 hrs

0300 - arrived at hotel. Patient requested additional melatonin to help get him asleep and to adjust to time change. Melatonin 20 mg administered. Patient asked to text rn when he awakens later today.

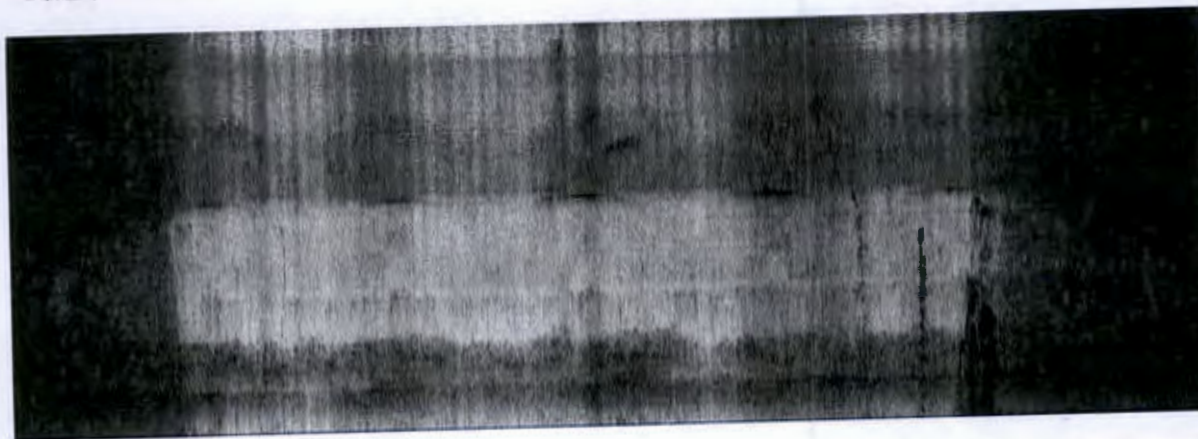
1530 - patient states he awakened at 1430 and self administered am meds. He requested an emergency session w psychiatrists to discuss feeling about arguments with fiancé and would like some tools to help him feel with his emotions. Appointment made for 1900.

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10/23

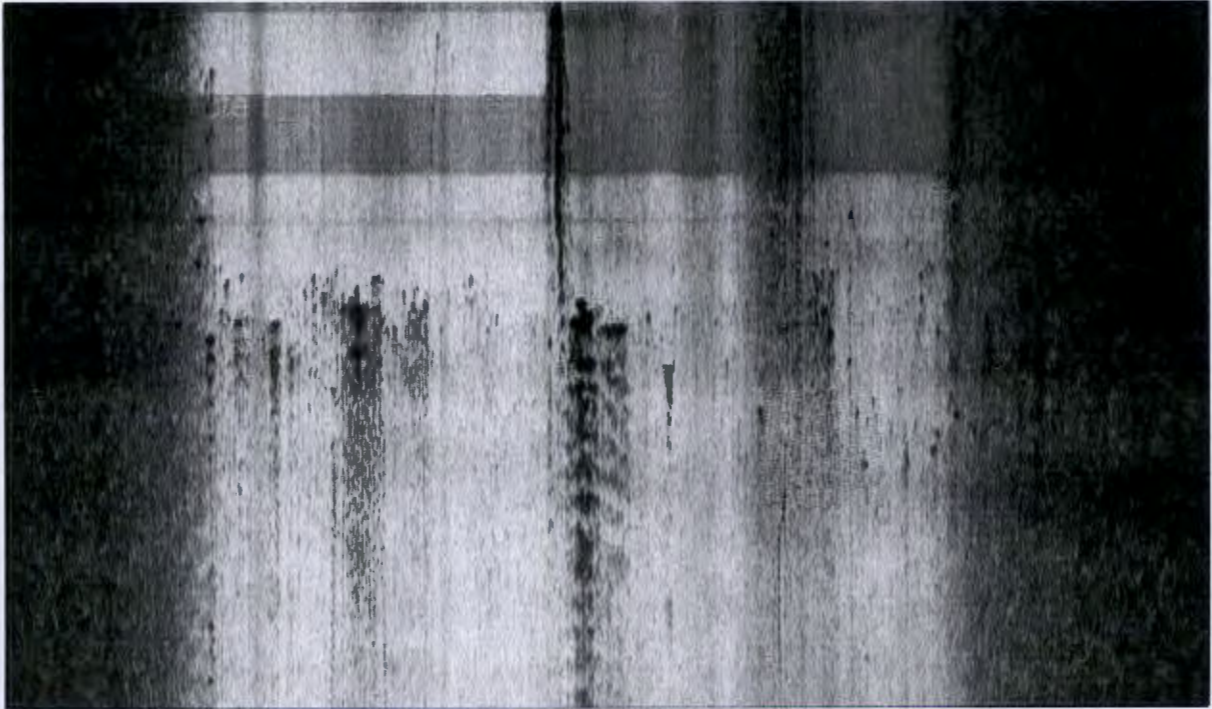
1520 - text patient to see if RN could stop by and check in. When RN arrived in the room patient was agitated and felt fiancé was using the term mania to explain his behavior and excuse herself from any fault during arguments. Patient was upset by this label. RN processes feelings with patient and he was able to see fiancé negative behaviors. Patient looks forward to meetings with psychiatrists next week as he is stressed about current state of his relationship. Report given to MD. Patient given routine meds for 10/24 to self administer. Patient will text rn if needed throughout the evening.

10/24

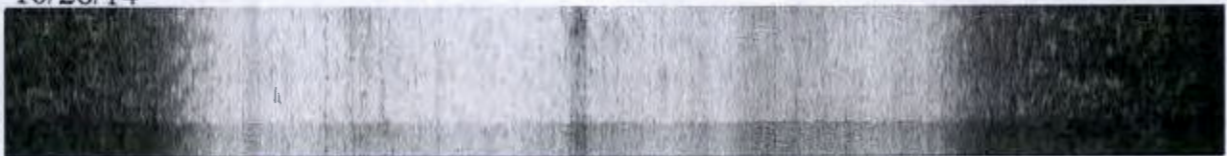




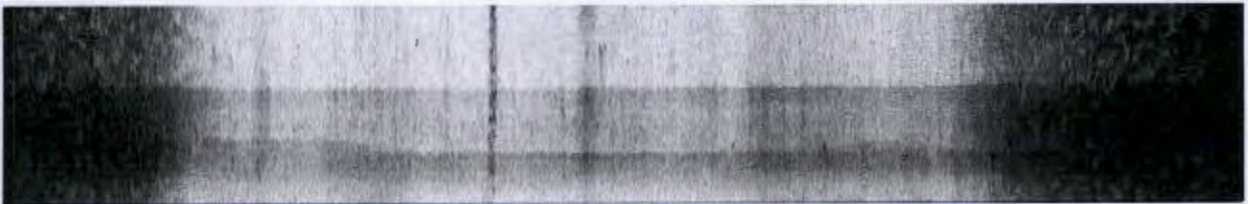
10/25



10/26/14



10/26/14

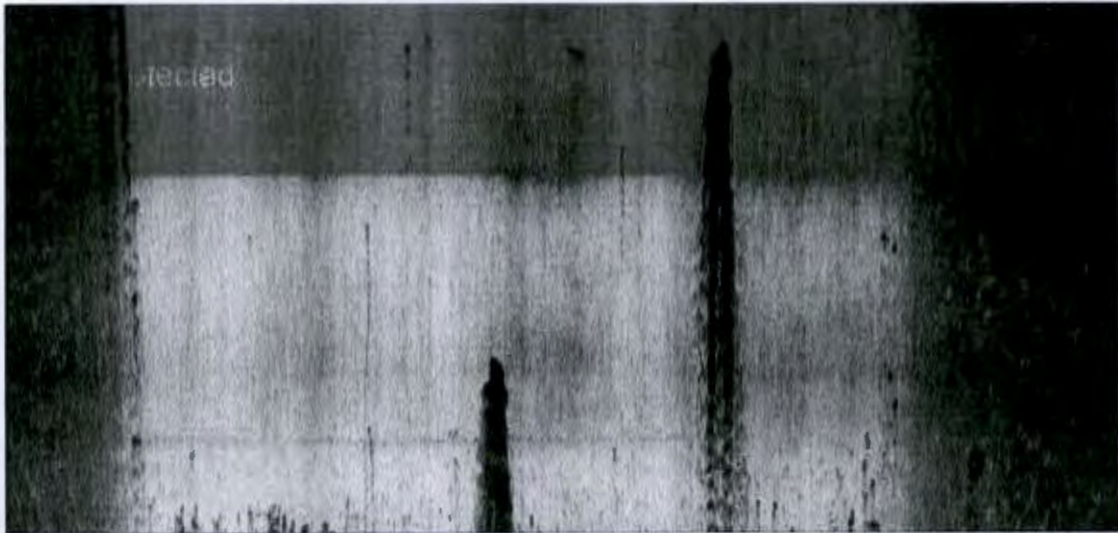


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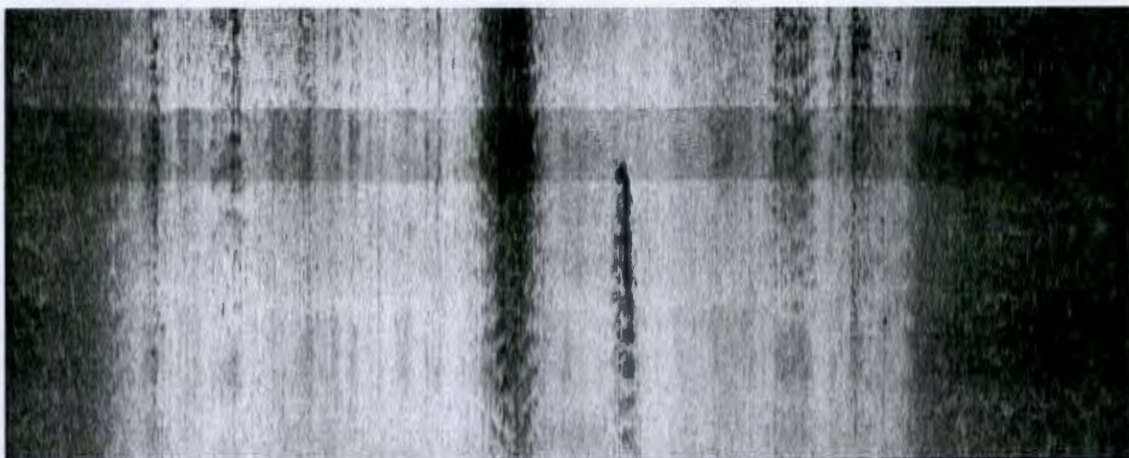


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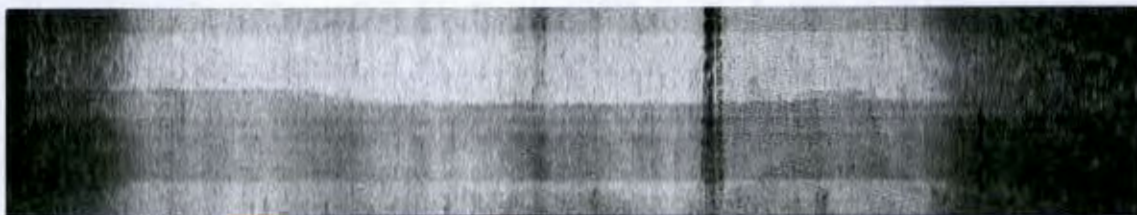
10/29/14



10/30



10/31

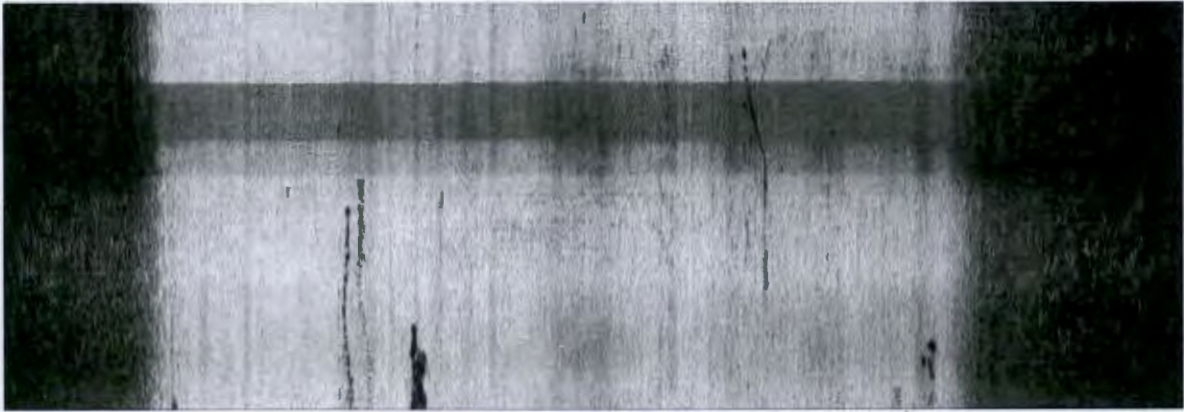


19STCP04763

Kipper 0145



11/1



11/2



11/3

1130 - RN arrived a patient's home at 1930. Patient stated he had not eaten all day. Assistant ordered burgers and patient ate 25%. Patient was focused on relationship with fiancé and is struggling with conflicted emotions. Patient encouraged to process these feelings with therapists tomorrow. Patient was hyper focused about relationship issues. MD and therapists notified about patient's state of mind. Patient given routine meds for 11/3 and 11/4 and plan is for RN to see patient tomorrow around noon.

11/3

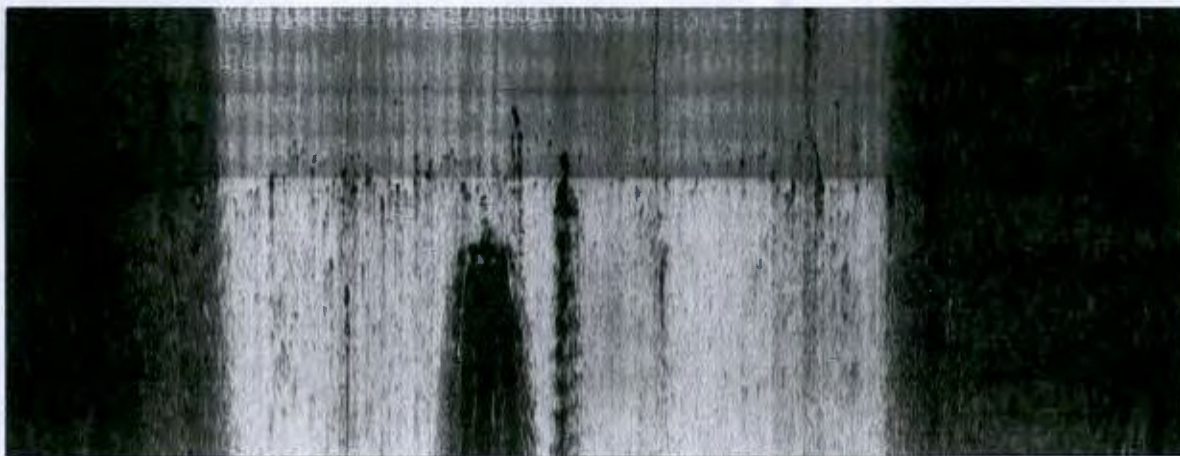
1210 - RN stopped by patient's home and he was asleep sitting up on the couch. Patient's nephew was at house and informed RN that patient was up

till 0830 this morning. Report given to MD and he is concerned with patient's sleep cycle. New medication orders given:

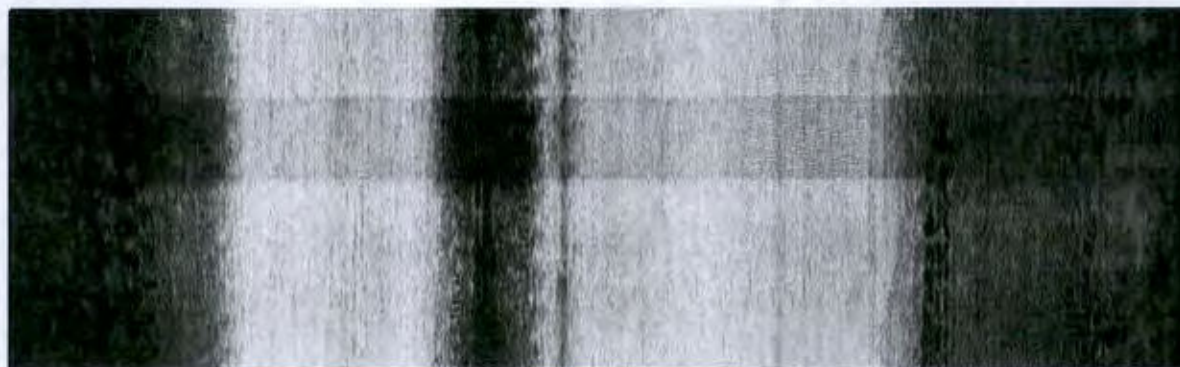
D/C previous seroquel orders  
Start Seroquel 50mg QID

1700 – RN went back to patients house. He was chatting with a friend and is feeling stressed about his relationship. He feels she is not being truthful with him and he is not sure how to confront her about this when she arrives home. Patient encouraged to discuss his feeling and concerns with his therapists tomorrow. RN emailed therapists to let him know how patient was feeling. Patient's plan is to hang out with friend for the evening. Patient encouraged to take his HS meds at a reasonable hour and to try to go to bed early and get back on a healthy sleep cycle. Routine medications for 11/4 left with patient to self-administer.

11/4/14



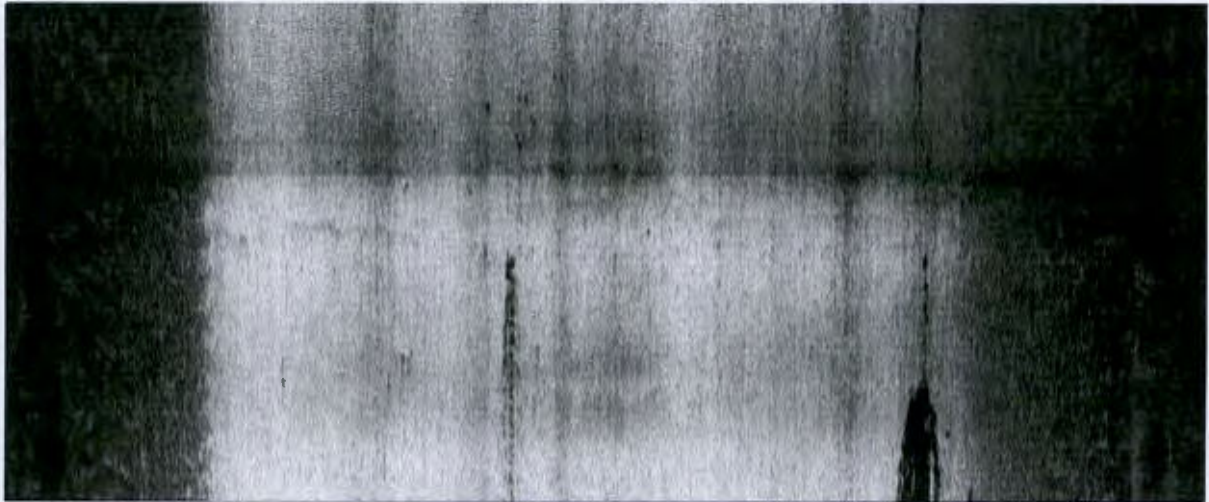
11/5/14



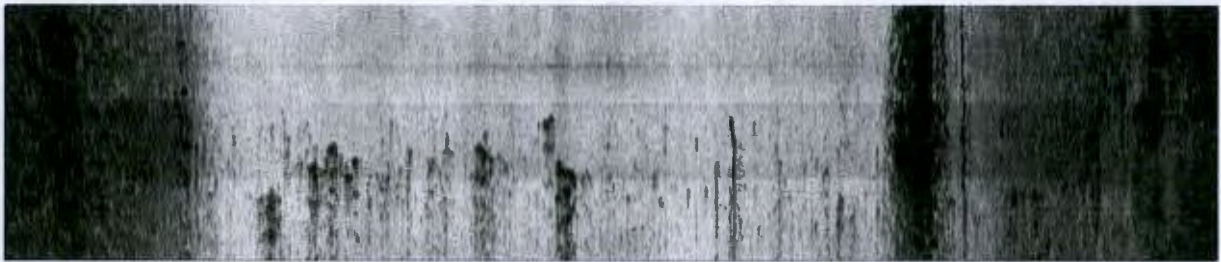


11/6/14 -

11/4



11/10



11/11



11/14



11/17

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1400 - RN and MD went to patients house to assess him. Patient appeared anxious and depressed over relationship issues. Patient continues to be ambivalent about relationship status. Patient has not been sleeping. Seroquel HS increased to 150mg for tonight. Patient agrees to take only medications prescribed by MD and to work to get his sleep cycle normalized. Patient agreed to let RN know if he feels he cannot handle his emotions and requires more medication. Patient will resume seeing psychiatrists next week when he is not working.

2105 - per patients assistant, patient has left to go out to dinner with fiancé.

11/17

0845 - per patient's security, he spent the night with his fiancé downtown.

1300- received text from patient to meet him at 1600 back in Hollywood.

1930 - patient stated he had a nice night with fiancé and they are working things out. He said he got a good nights sleep and felt much better today. Report given to MD and MD would like to continue patient on Seroquel 150mg at HS x2 more nights. Patient will work in Lancaster for the next 3 days and was given routine meds for 11/18 & 11/19 for self administration. Patient will contact RN via phone if he needs anything. Patient will be back home during the nights.

11/18



11/19 -



11/20



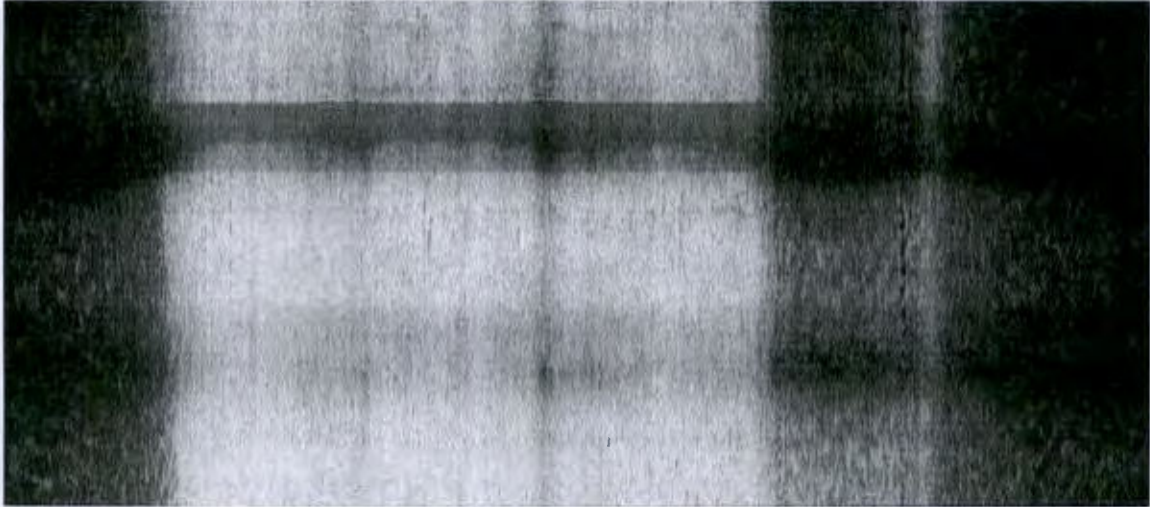
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11/22 -



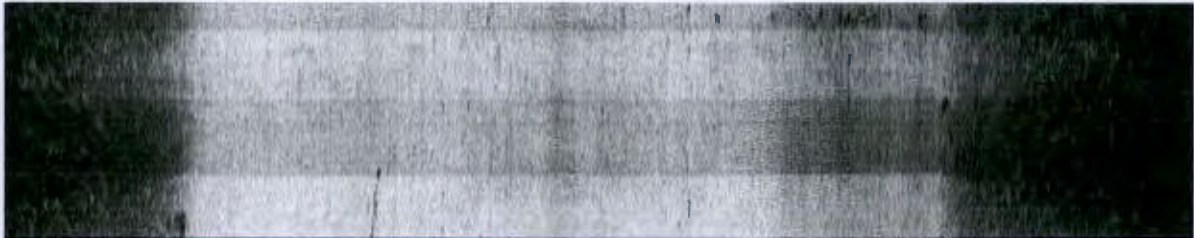
11/23



11/24



11/25 -



11/26 -



11/27 -



11/28 -

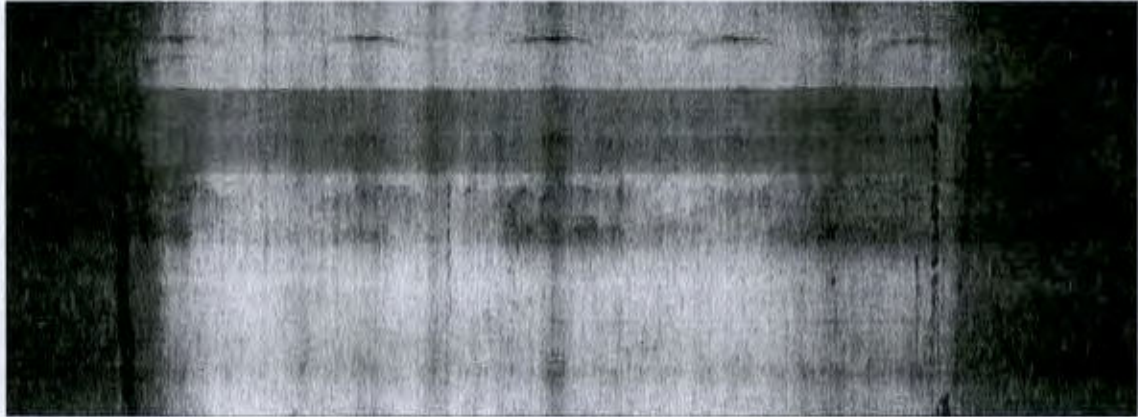


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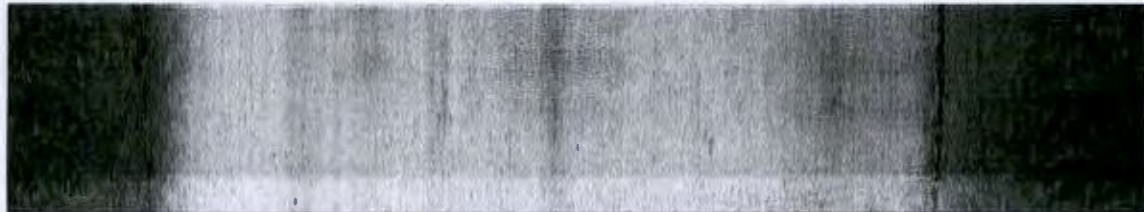


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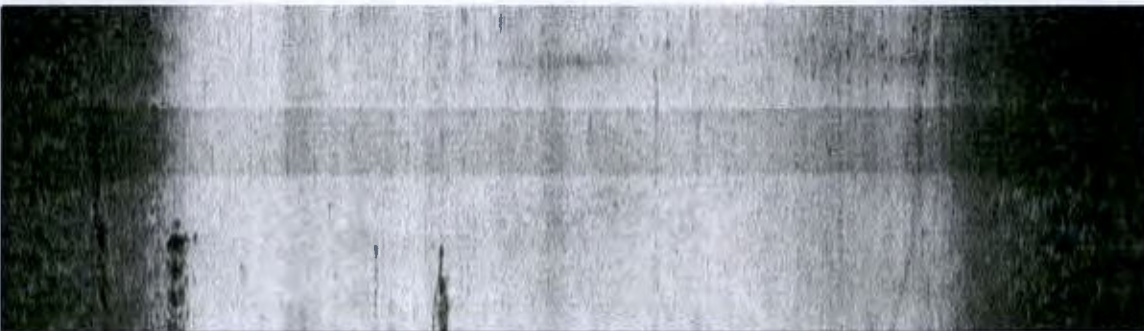


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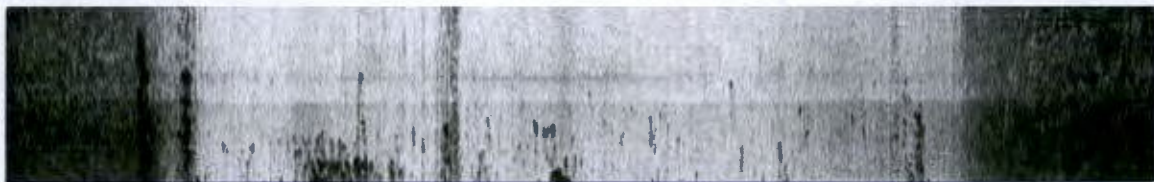
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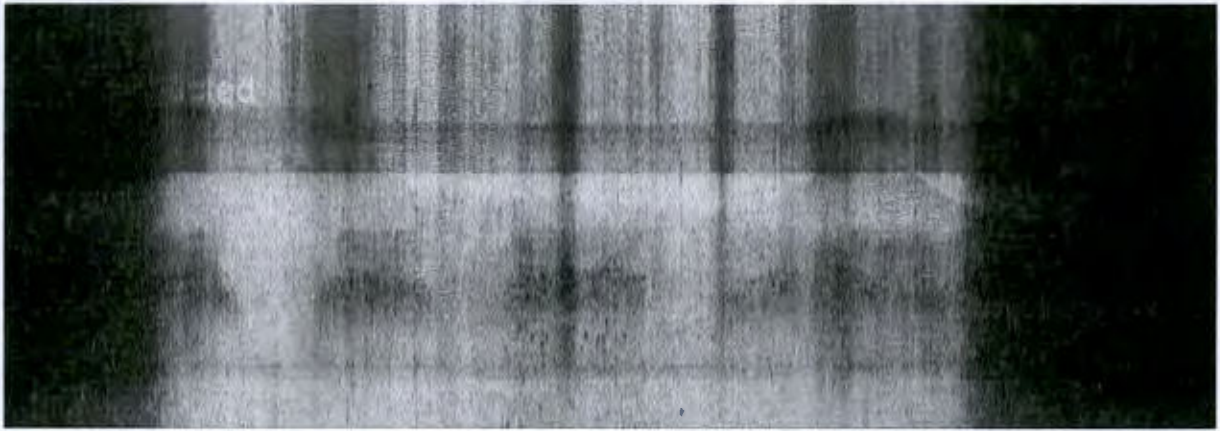


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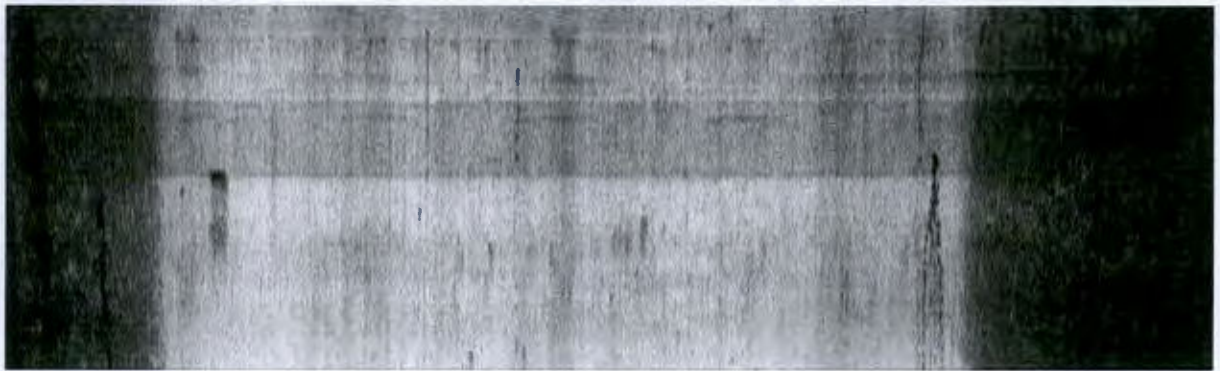


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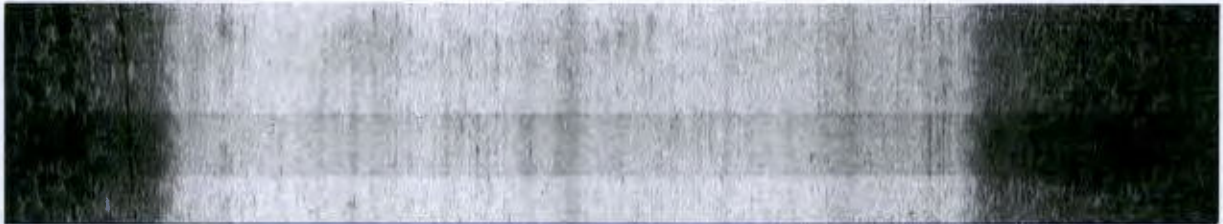




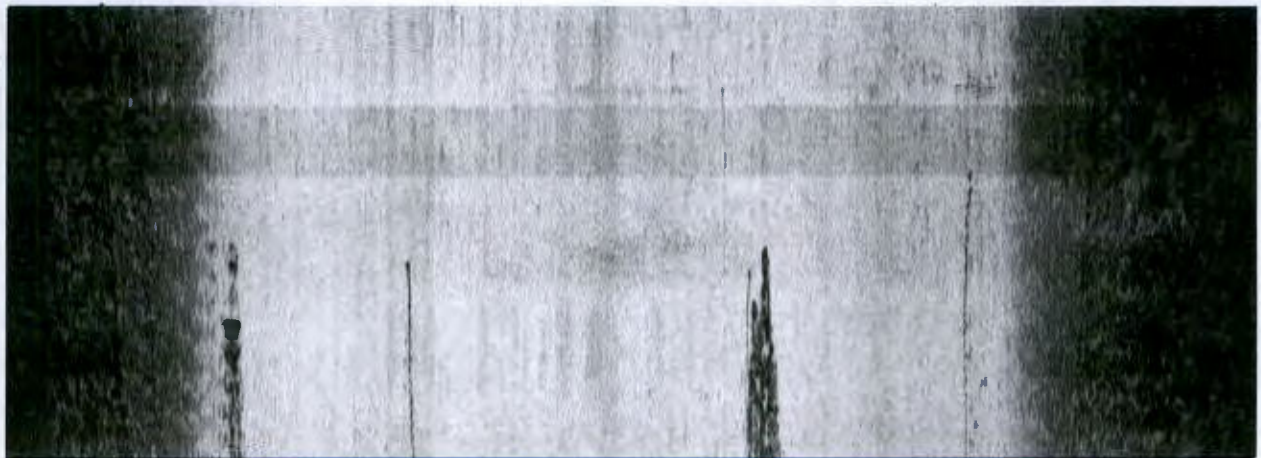
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12/6



12/7



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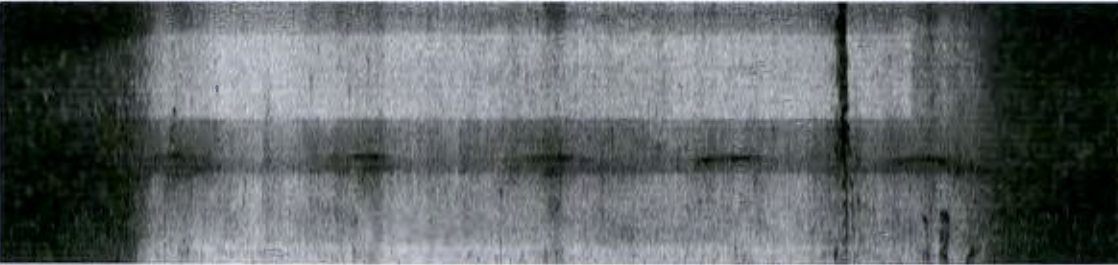
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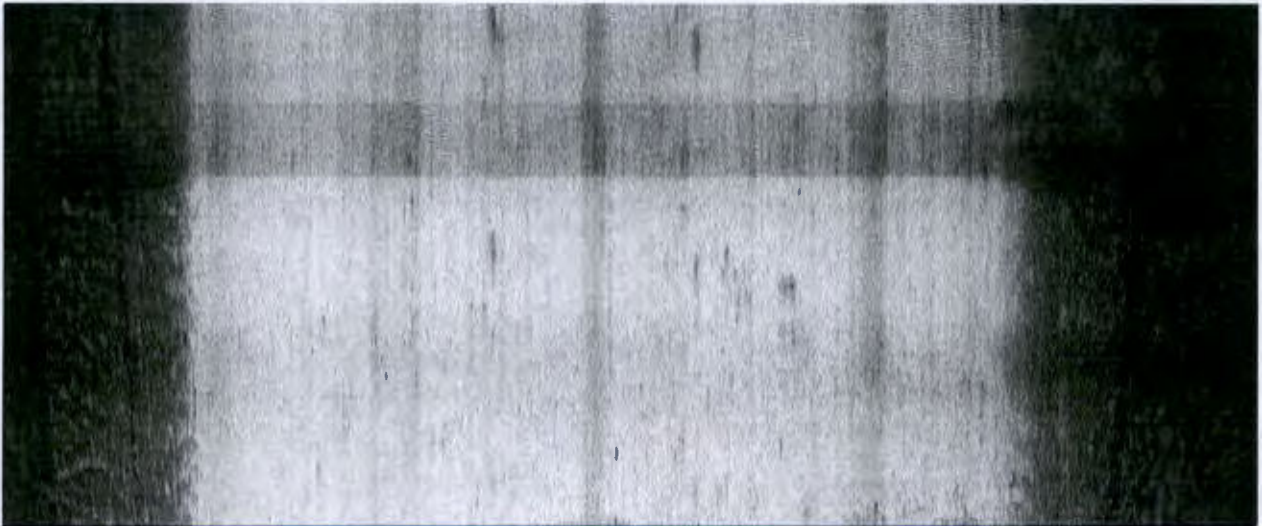
12/9 -



12/10 -



1/7/14

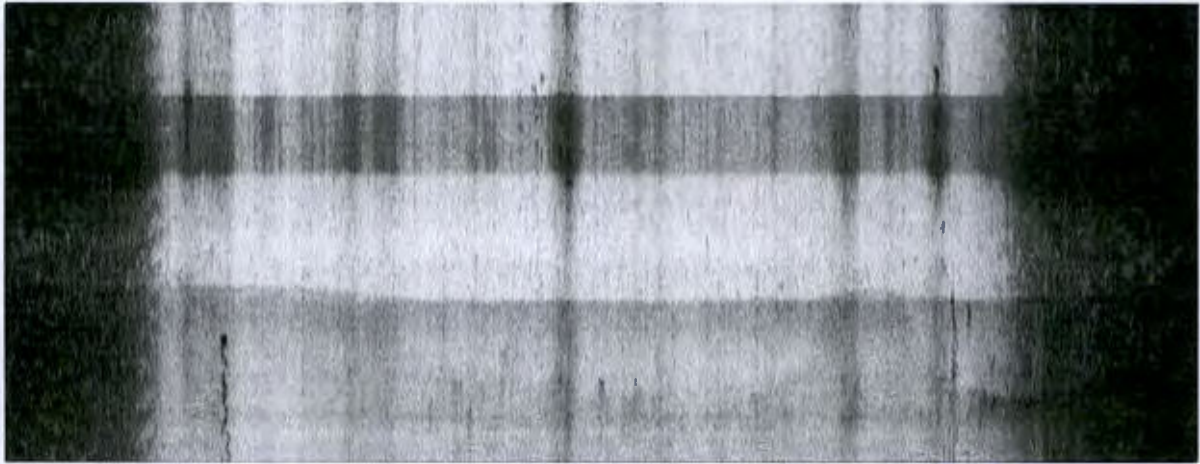


1/8/14

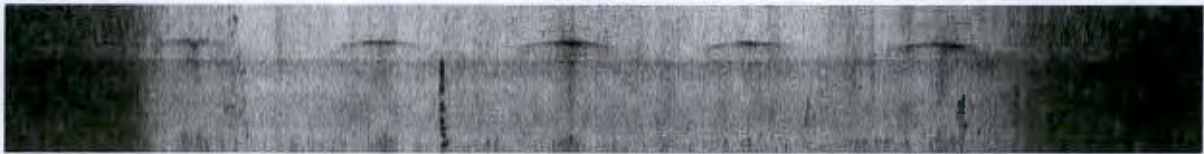




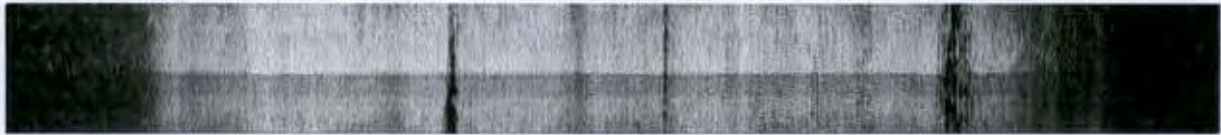
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1/13/15 -



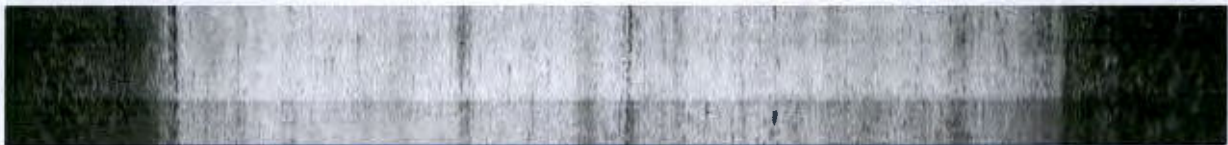
2/1



2/3



2/4 -



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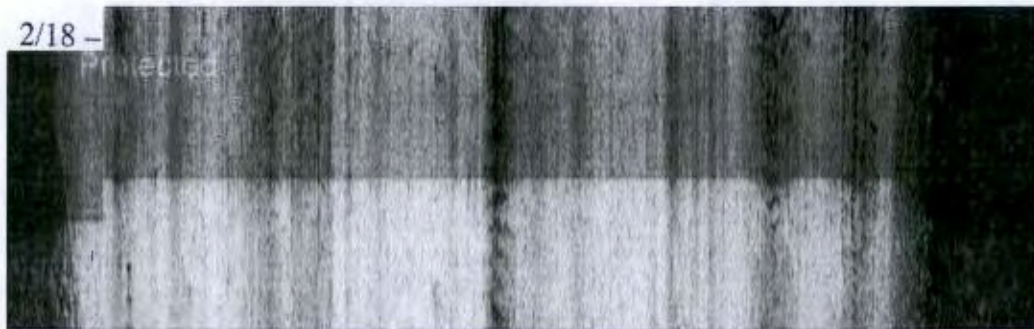
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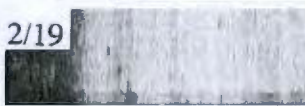
2/18 -



2210 -



2/19



2/20 -



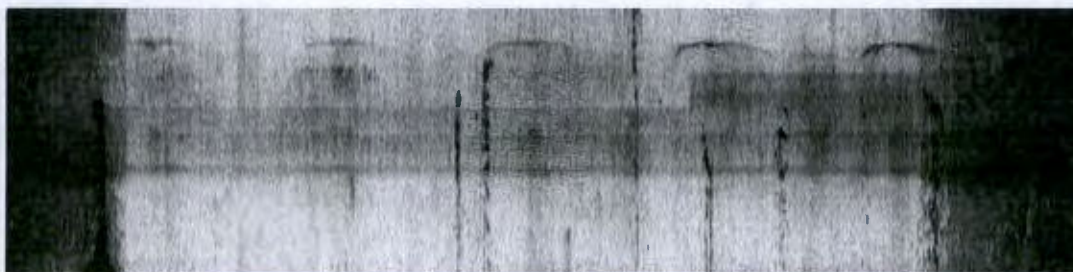
2100 -



2200 -



2/21 -

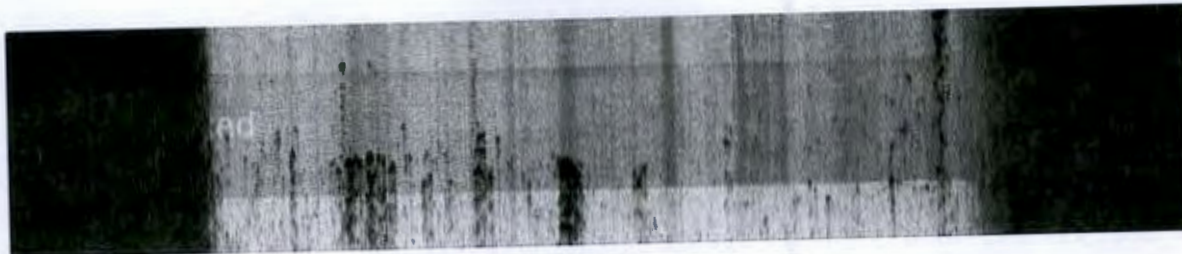


2/22



19STCP04763

Kipper 0156



2/27 [redacted]

3/7/15 –

1130 – MD received a text msg from client that he had been arguing with wife and that he had cut his finger. According to patient his assistant and security were on their way to pick him up.

New Med Order

Augmentin 875 mg BID x10D

1300 – Patient was having a hard time leaving the house so security suggested the MD and RN go to house to see patient. Upon arrival to house patient was sitting in car ready to leave. MD assessed patient's finger and will spend more time with patient at the location he is being moved to.

1530 – MD cleaned and dressed wound to R middle finger. RN, MD, security and assistant will be taking patient to ER to have finger wound properly cleansed and treated. Patient given Toradol 60 mg IM ROUQ and Augmentin 875mg PO.

1130 – Patient and staff returned from ER at 2130. Patient was seen by ER MD and hand specialists. Wound was cleaned and dressed and patient was given a tetanus shot L deltoid and given IV antibiotics. Discharge instructions were for patient to see hand specialists tomorrow to discuss possible treatment options for finger. Upon arrival back to apartment patient discussed feeling of anger and sadness about relationship. Patient was encouraged to stay away from wife as the relationship is toxic. Patient expressed verbal understanding and why they needed to separate. MD offered patient Valium 10mg IM to help with his anxiety and anger but patient refused. RN and MD suggested that patient take his bedtime meds and go to sleep and patient refused. Patient was talking about wanting to



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drink alcohol but did not obtain any.

3/8/15 -

0145 -

Patient has been on phone with his security guard that is staying with his wife at their rented house. Patient is discussing wanting to go home to LA tomorrow and rehashing night. Patient's personal security guard came to stay with patient. RN will be next door and instructed security to call during the night if needed.

□ □  
□

x

19STCP04763

PLAINTIFF'S TRIAL EXHIBIT 0040\_0106

Kipper 0158

47432

3/20 - 1835 - pain 6/10, Toradol 60 mg IM ROuQ

MD orders

Toradol 60mg IM q6h pain  
Valium 5mg IM q6h anxiety  
Valium 10mg IM qhs  
Continue all routine Meds

Monday 3:30 follow up  
OT 4pm for splint.

2015 - patient stated pain level decreased to 4/10. Right arm placed in splint to decrease pulsating sensation in finger.

2115 - Motrin 800 mg, Valium 5mg

3/21/15 - 0115 - patient in good spirits. Pain 6/10. Patient self administered routine HS medications. Toradol 60mg IM LUOQ, Valium 10mg RUOQ administered. Patient encouraged to be settled in bed within 30 min and instructed to sleep with arm elevated. Patient instructed to call RN during the night if he experienced any pain or right when he awakes in the morning. Patient verbally agreed.

0730 - report given to MD via telephone.  
New Med Orders

D/C previous Toradol order  
Toradol 60 mg q4h pain

1000 - Toradol 60mg IM ROUQ, Valium 5mg IM RUOQ. Pain 6/10.  
Patient slept from 0200 - 0930. In good spirits. Report given to MD via text. VS 149/94 P 70.

1105 - patient states pain continues to be 6/10. Motrin 800mg administered.

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1200 - status of patient reported to MD via telephone.

1400 - patient states his pain continued to be a 6/10. Toradol 60mg LUOQ. Patient self administered routine noon Meds.

1530 - patient spoke to MD. No changes at this time. Valium 5 mg IM ROUQ administered.

1845 - Toradol 60mg IM LOUQ. Patient continues to state that pain in at 6/10 but that he is able to tolerate it. Patient is social and pleasant. Patient continues to smoke cigarettes. RN continues to educate on the importance of smoking cessation and the effects on the healing process. Patient states he will switch to a vapor cigarette tomorrow.

3/22/15

0105 - Toradol 60mg IM LUOQ, Valium 10mg RUOQ. Patient encouraged to take his routine HS medications at this time so he can get to sleep soon but he refused. Stated he will take them within 30 min. Patient instructed to call RN during the night if he awakens with any pain. If not, patient to call RN first thing in the morning. Patient left with a Motrin 800 mg prn pain during the night.

1615 - patient stated he slept from 0400 - 1300. Vs 139/85 p 64. Pain 5/10. Toradol 60mg IM RUOQ, Valium 5mg LOUQ. Patient self administered routine afternoon Meds.

2015 - patient states that his pain has been better today and was a 3/10 after last Toradol injection. Currently 5/10. Toradol 60mg IM LOUQ, Valium 5mg RUOQ administered. Patient plans to have a quiet night watching tv with wife.

03/23

0120 - Toradol 60mg IM LOUQ, Valium 10mg IM RUOQ administered. Patient self administered Routine HS medications. Patient states his wife is trying to argue with him. Patient encouraged to go to bed as they both have important appointments tomorrow and reminded

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him the importance of a healthy sleep pattern while he is healing.  
Patient encouraged to call RN during the night if needed. If not, RN will return to home at 11am.

0545 - call to loft

0820 - torod, val

1445 - torod, val

F/u Thursday afternoon and Tuesday afternoon. Skin graft bandage off week from Tuesday. Pin off in two weeks.

2000 - patient informed wife is coming to talk to him and he became extremely anxious. Toradol 60mg IM LUOQ and Valium 5 mg RUOQ administered.

3/24 -

0030 back at lofts. Patient and wife appear to be getting along and all is peaceful but them. Toradol 60mg IM RUOQ, Valium 10mg LUOQ. Patient stated he would self administer his routine Meds within 30 min and go to bed. Patient instructed to call Rn if needed during the night.

1445 - RN informed by patients security that he patient was awake and was leaving in 5 min to go to studio to record. RN went to asses patient. Stated pain was 4/5. Toradol 60 mg LOUQ, Valium 5 mg -RUOQ administered. Patient stated the Valium really helped him last night as it was a stressful evening with wife. He stated he is "ok" emotionally and plans to spend the afternoon with friends. Patient instructed to check in RN this afternoon to let her know where to meet him for afternoon Meds. Patient encouraged to do his finger exercises but refuses to take bandages off.

2145 -

3/25

0215 - Toradol 60mg IM, Valium 10mg IM, administered. Patient

resting in bed- self administered routine HS Meds.

1330 - patient states pain 4/10. Toradol 60mg IM LOUQ, Valium 5mg IM RUOQ. Patient self administered routine AM Meds. Patient informed Valium would be switched to PO and tapered down over the next 3 days. Patient in good spirits and stated he slept from 0230-1300. Patient encouraged to do his finger exercises but refuses to take bandages off.

New med order

Valium 5 mg TID X3 days.  
Valium 5mg PRN q6h severe anxiety.

3/26

0145 - RN called to patients home. Upon arrival patient and wife were fighting in garage. When argument became heated patient removed himself from situation and had security drive him to another home. Patient and wife spoke on know for an hr and patient became anxious. Toradol 60 mg IM LOUQ and Valium 10mg LOUQ administered. Patient has decided to return home to speak to wife. Security will accompany patient.

1510 - arrived at patient house to take him to follow up appt. States pain 5/10. Toradol 60mf IM RUOQ. Patient is in good spirits s d states all is peaceful between him and wife. Patient, wife, security and RN off to follow up appt.

1930 - patient arrived home from follow up appt. Per surgeon finger healing appropriately. Bandage was changed and MD stressed importance of doing finger exercises daily to ensure finger does not lose movement. MD also stressed importance of not smoking and the effects in healing process. Next follow up is Tuesday. Patient states his finer was hurting due to wound care and movement. Toradol 60mg IM, RUOQ administered.

2330 - patient called to request pain medication. Toradol 60mg IM LOUQ administered. Patient encouraged to take his routines HS

medications and get a good night sleep. Patient to call RN when he wakes up. If after 1300, Erin, RN will be covering for the afternoon and will be at house to assess patient and his wife.

3/27 -

1300 - per security patient still asleep. Erin, RN will be on call for patient this afternoon.

2310 -met Erin, RN at patients home. He states his pain was 9/10 today. Patient unsure if he hit his finger last night during his sleep or during the day. Toradol 60mg IM administered. Patient self administered routine HS Meds. Patient did finger exercises. RN will return tomorrow at noon to assess patient but he is instructed to call if he needs anything prior to that. Patient left with a Toradol 10mg PO prn pain during the night.

3/28 -

1210 - patient states he slept from 0300 - 1100. States his pain level is 9/1 again today. Toradol 60 mg IM LOUQ administered. Patient did finger exercises. Splint was re applied and dressed. Patient's right arm placed in sling.

Per MD call in concerta 18mg #6. Take 3 tabs Qam.

D/C all routine Seroquel  
Seroquel 50-100mg prn q4-5 hr anxiety or agitation.

1810-

2330 -

3/29

1000 - arrived at patients home and is is sleeping soundly on couch.

1250 - patient awake and states his pain is 9/10. Toradol 60mg IM LUOQ administered. Patient will be switched to Mobic 7.5mg Qd

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starting tomorrow and Toradol will be discontinued. Patients states he slept from 0300-12:45 and feels rested.

1830 - checked in with patient to see how he was feeling. Stated he was in pain. Instructed Patient to take Toradol 10mg PO.

1920 - checked in with patient via text to see his Toradol helped his pain and patient states he had not taken it.

2015 - patient called to say he was going to studio to record and did not take Toradol PO as he wanted an injection. Patient met RN and hotel and Toradol 60 mg LUOQ administered. Patient requested and was given Valium 5mg PO. Patient unsure if he will spend the night in W Hollywood or Downtown. RN offered to go see patient at either place before he goes to bed. Patient not sure he will need that and requested to take a dose of Toradol and Valium with him. Patient given 2 tabs Toradol 10mg with instructions for HS and AM and 1 tab Valium 5 mg PO to take prn anxiety.

2210- reached out to patient via text to see if he wanted RN to come to west Hollywood. No response.

3/29

0115 - RN received a text from patients wife stating that she was concerned he was "fucked up". RN called security and patient's assistant who is with patient. Per assistant, patient has smoked marijuana tonight but there has been no evidence of any other drug or alcohol use. Wife informed of this.

0330 - per assistant patient will spend the night at his home in west Hollywood.

0535 - text from patients wife stating she just spoke to patient and he is awake and stating he cannot sleep and cannot find HS Meds. Call to patient and reminded him where Meds are. Patient responded and stated he is taking Meds at this time and going to sleep.

0935 - report given to Erin, RN. She will pick up new medications from

pharmacy and start concerta 36mg QD and mobic 7.5 mg QD prn pain.

2215 - patient reports increased pain in finger. States it's a 11/10. Call to MD and he orders to increase HS neurontin from 600mg to 1200 mg.

3/31

0130 - patient continues to c/o pain 10/10 which is causing anxiety and insomnia. Toradol 10mg PO and Xanax 1mg PO administered.

0220 - patient sleeping soundly on couch.

0900 - patient awake. States finger pain is 7/10. Patient self administered routine am Meds and mobic 7.5mg.

1415 - patient preparing to leave for follows up with surgeon. Plan is to remove bandages from skin graft today. Per MD give patient Toradol 60 mg IM and Valium 5mg PO 45 min prior to appointment. Medications administered. Patient stated mobic did not help relieve his pain this morning. Patient also states he is not feeling the concerta is working as well as the adderall did. Status reported to MD.

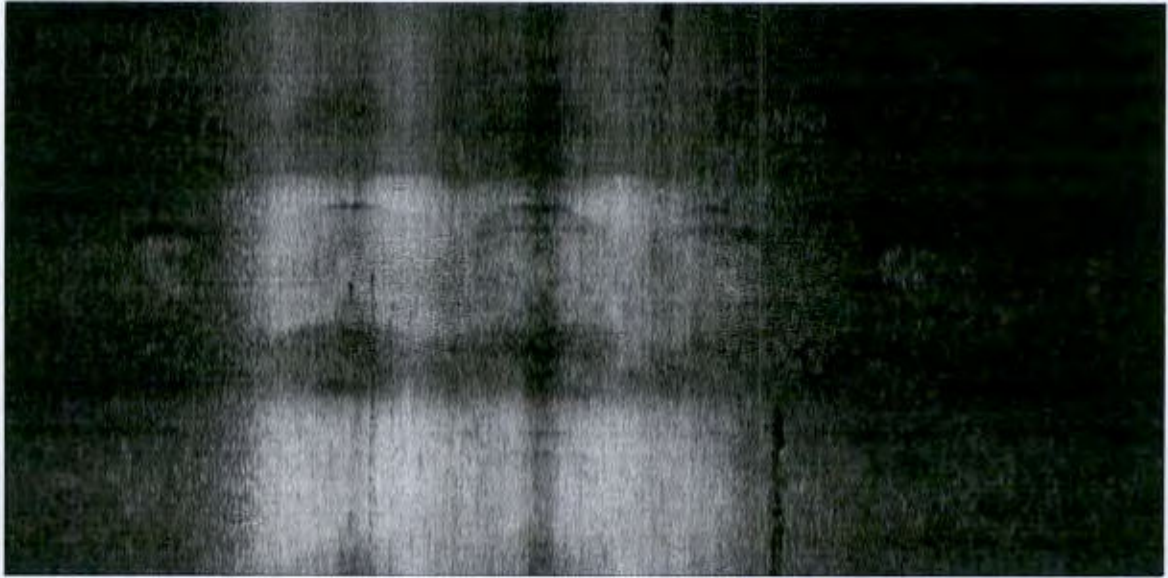
1615 - at follow up with surgeon bandage was removed from skin graft. Graft took 100% but there was an infection under bolster. Finger was drained, pin was removed and rocephin 1G was administered during appt. Patient will follow up with surge again on Thursday. Per surgeon patient might experience increased pain for 1-2 days. Surgeon ordered rocephin 1G IM for tomorrow and would like a WBC drawn. RN from PMD's office will come to patients home tomorrow to give antibiotic and draw labs. Report given to MD.

2320 - patient states finger pain is 8/10. Toradol 60mg IM RUOQ administered. Patient self admin routine HS Meds and is relaxing watching TV. Plan is for RN to come. Back at 1030 tomorrow to assess patient. Patient instructed to call RN if needed before that.

4/1 -







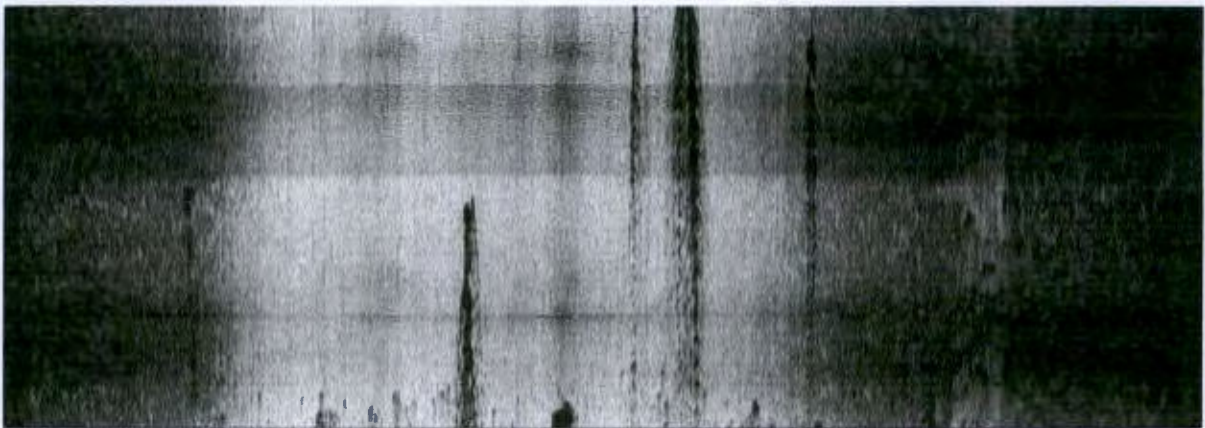
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4/4

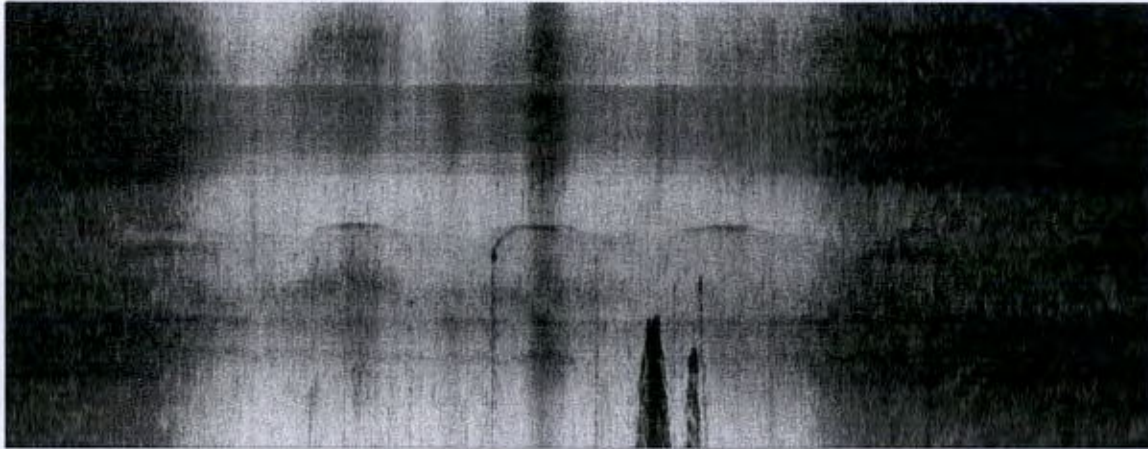


4/11





4/12



4/13

1300 - per Md RN is to meet patient at follow up appt with hand surgeon and hand therapy. Text sent to patient to let him know RN would be at appt.

1500 - Bandage changed and hand exercises done at appt with surgeon's office. Per RN at surgeon's office and occupational therapist, hand is healing well and finger has good range of motion. Exercises to be done 3-5 times per day. Patient is in good spirits and said he has not smoked marijuana in 3 days. States he feels majority of his issues with his wife have been from him using drugs and alcohol. Patient states he will no longer sneak / use and wants to enjoy clarity.

2130 - per assistant patient has been resting and watching tv all evening.

4/14 -

1400 - RN and MD arrived at patients home to have meeting to set treatment plan and boundaries while traveling in Australia.

Med changes

Discontinue Inderal LA 80mg  
Discontinue metformin 500mg BID

Patient would like to continue working with medical team. Patient states he did not respond over the weekend as he has gotten rid of his phone. Plan is for RN to communicate with security on when she will visit patient daily. Patient informed RN will be over late morning tomorrow.

4-15

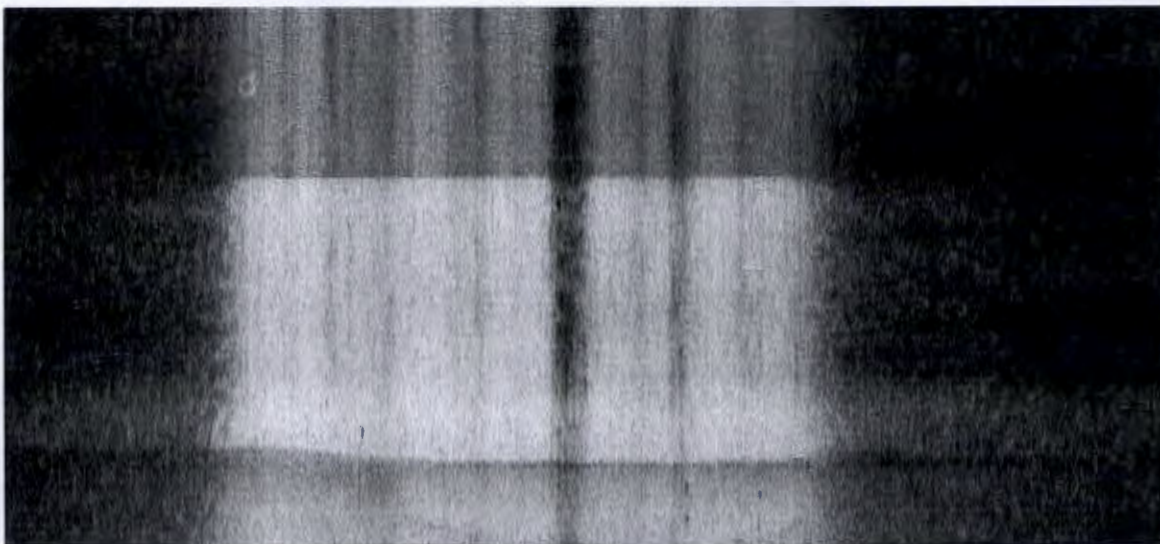
1035 – patient's assistant and security infringed RN will be at house around noon to see patient, assist him in hand exercises and change bandages.

1215 - arrived at patient's home. Assistant was in hallway and informed RN that patient was in a bad mood and told assistant he did not need anything from him today. RN was let in home by security and knocked on patient's bedroom door to let him know she was there. Patient screamed "what!". RN informed patient she was just letting him know she was there and would be down stairs. About 5 minutes later security came into house and informed RN that patient has told security to get everyone out of his home and he did not want any more unexpected guests. RN left property and informed MD of the events. Per MD drop tomorrow's Meds off with security and do not reach out to patient again - wait for patient to reach out to medical team.

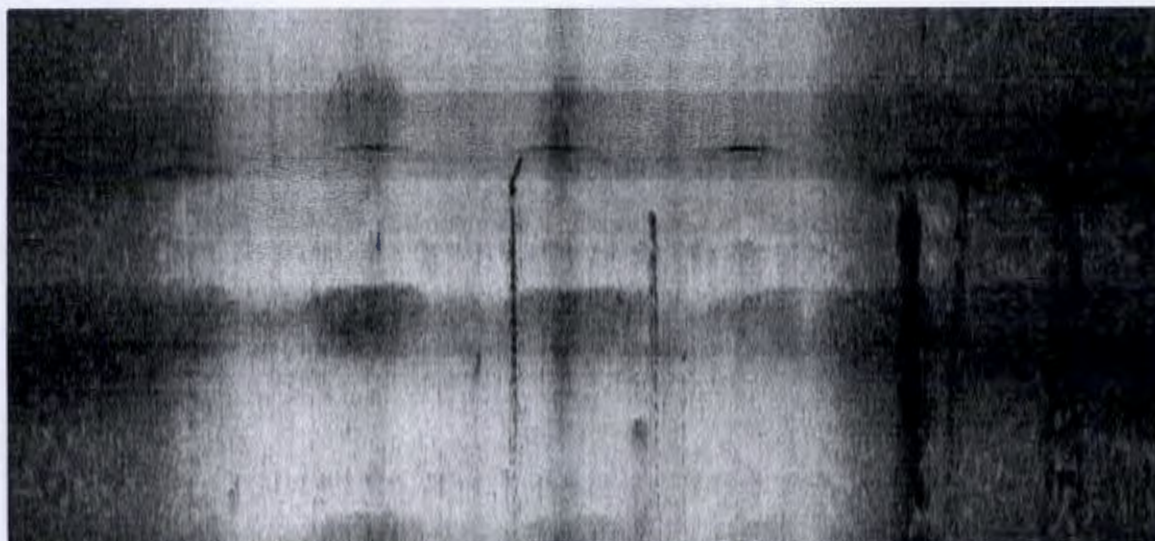
2145 - patient text RN to apologize for his behavior earlier. Explained that was upset with his assistant and needed to be alone. Plan is for RN to visit patient tomorrow at noon to change bandage and assist in hand exercises.

4/16

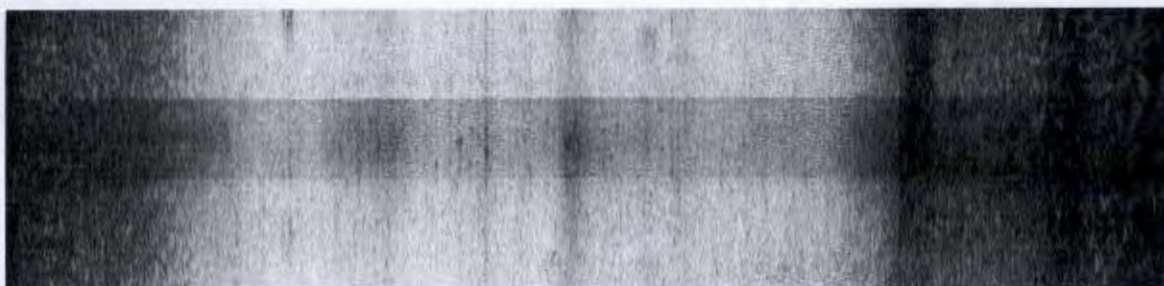




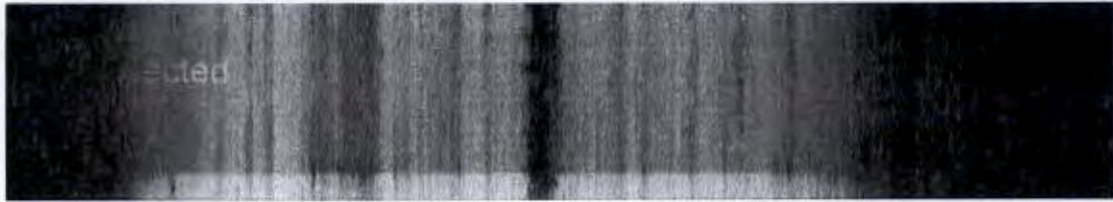
4/17



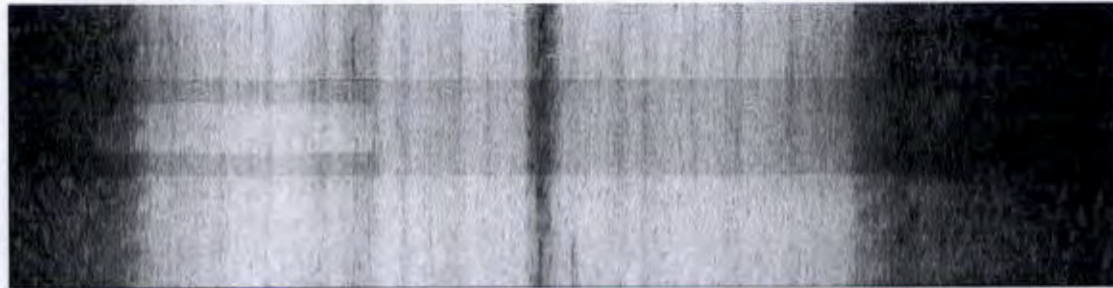
4/18



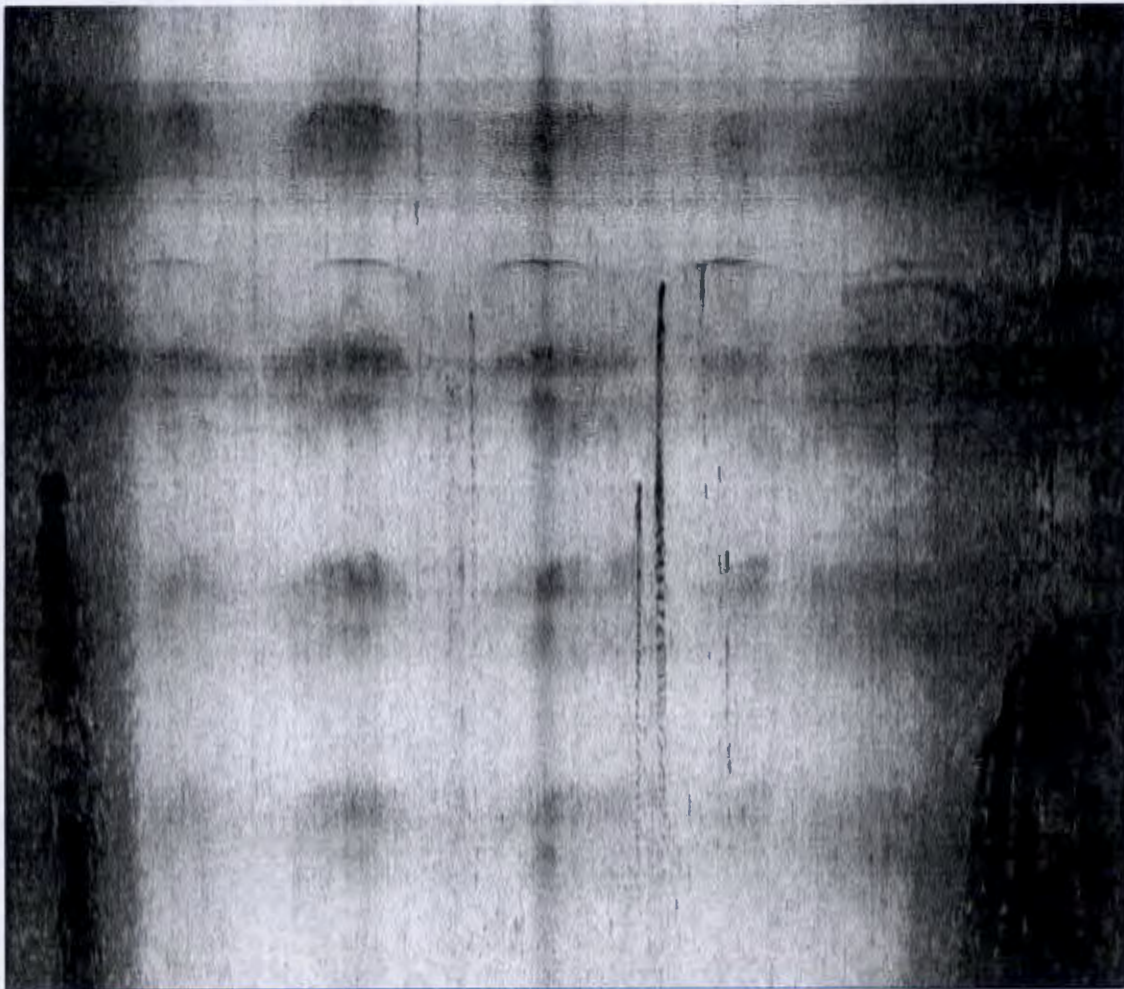
4/19



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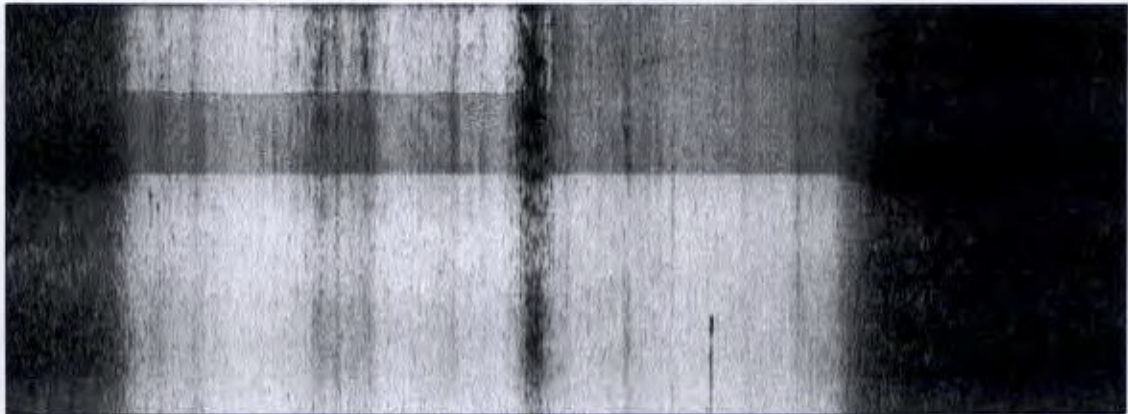


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4/23



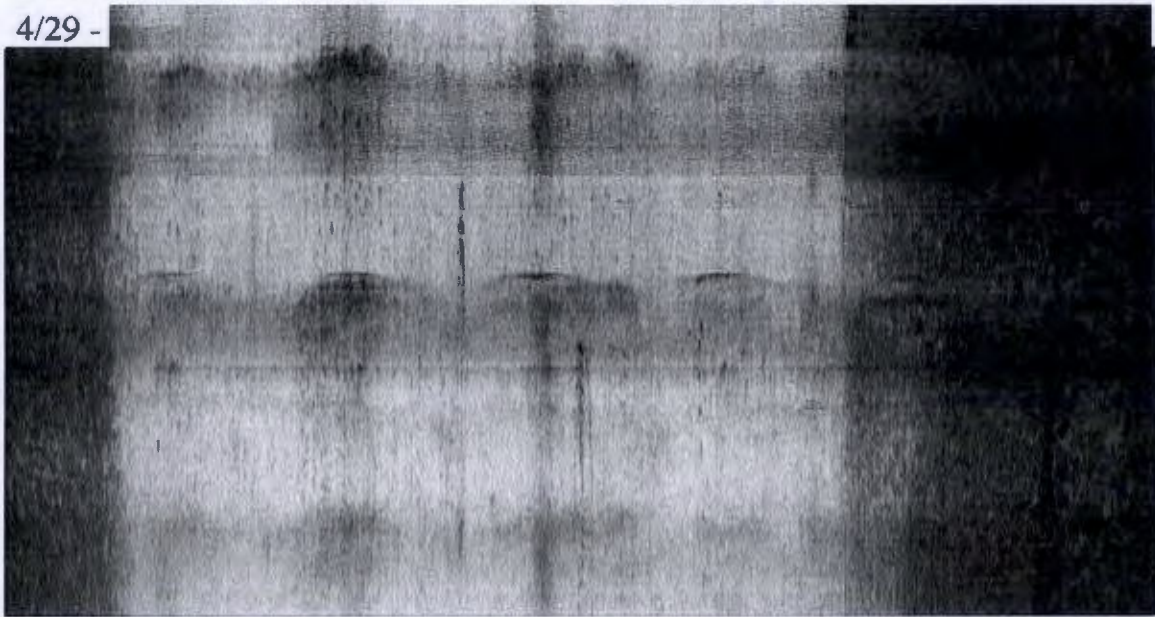
4/27 -



4/28 -

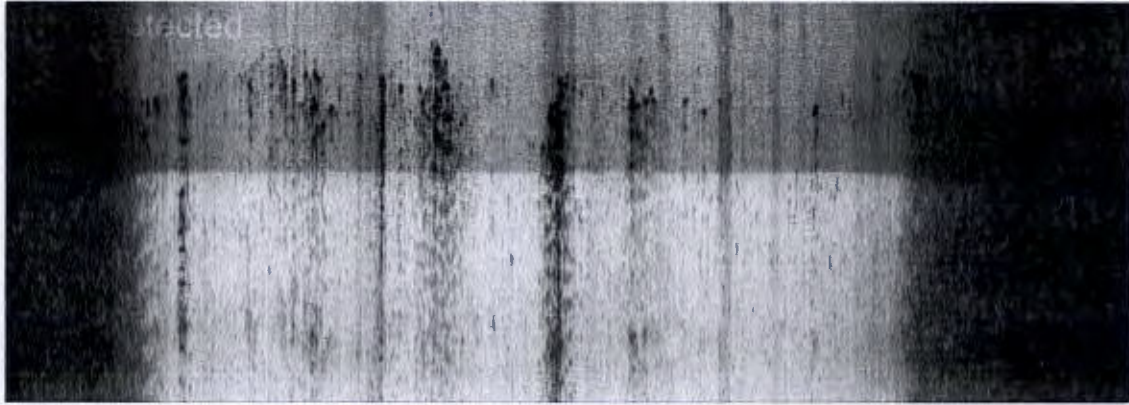


4/29 -



4/30 -

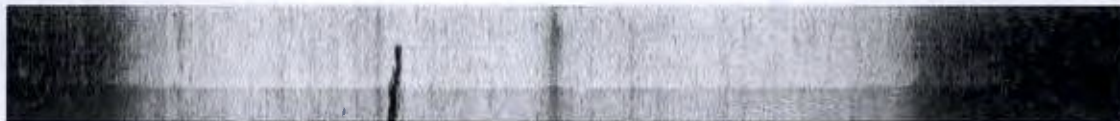




5/1-

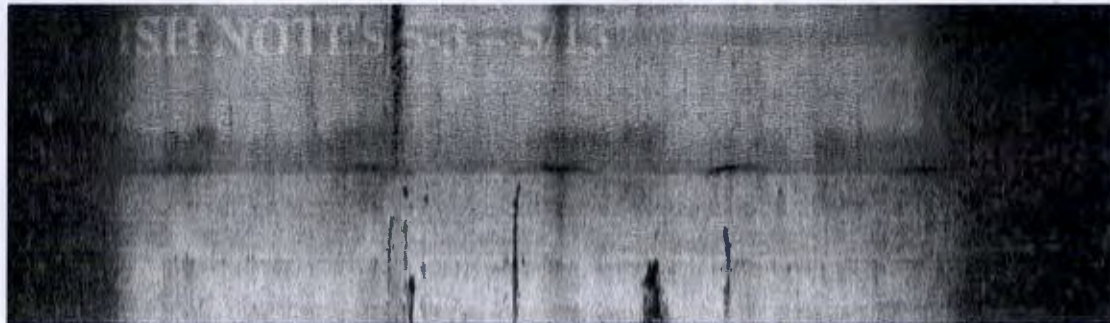


5/2



**FINISH NOTES 5-3 – 5/13**

5/15/15 –

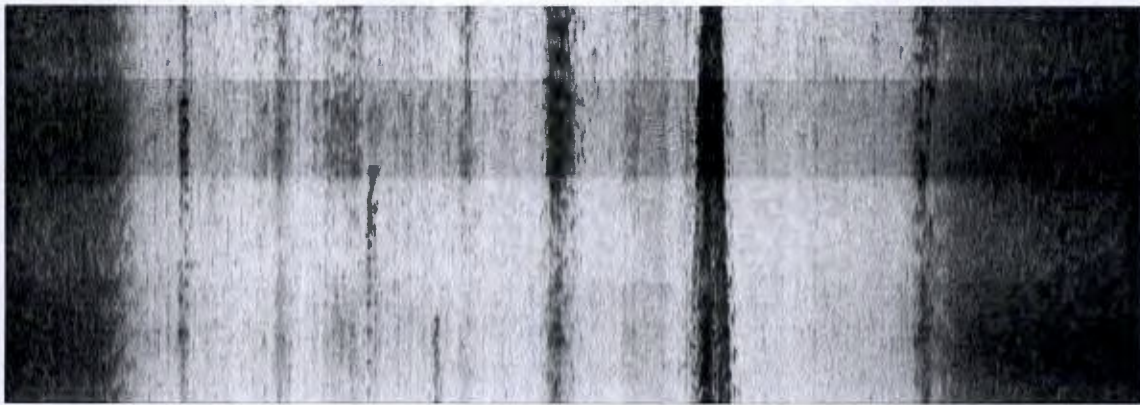


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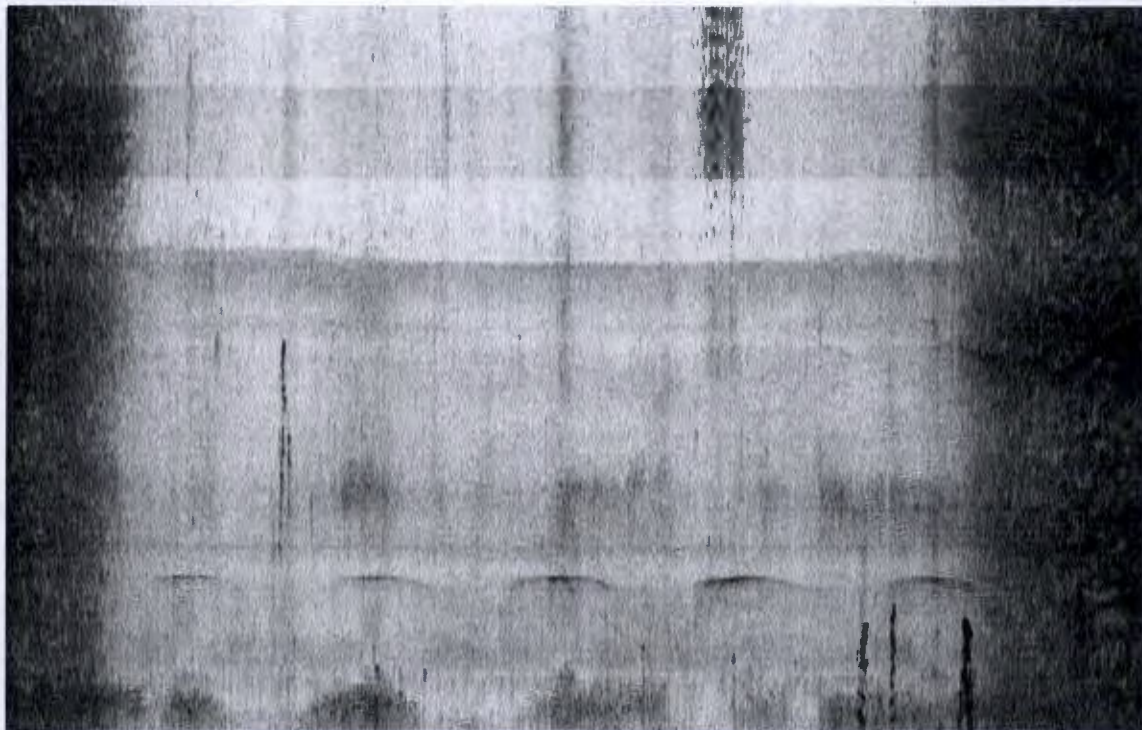




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5/19/15 -

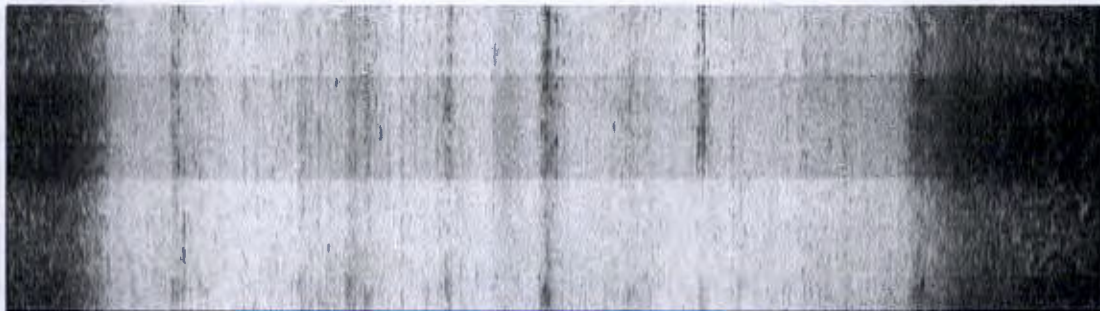




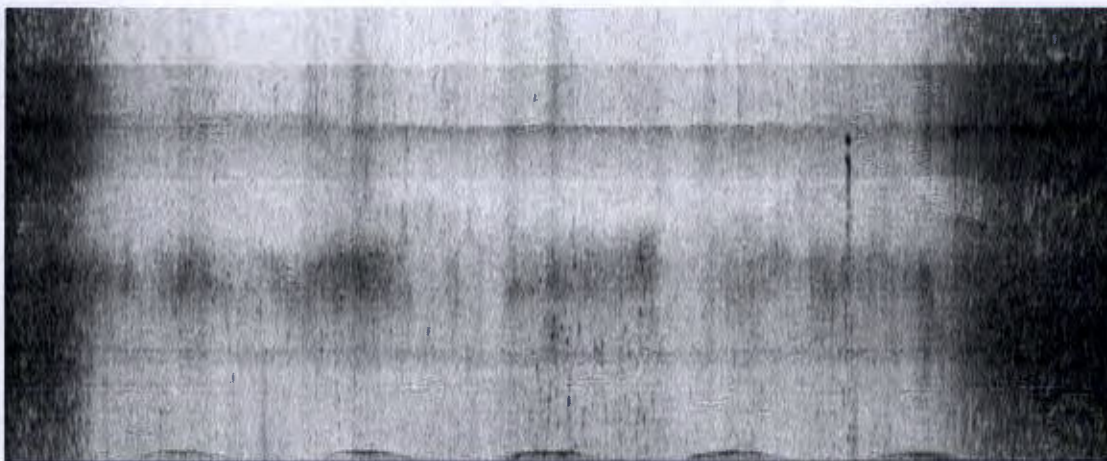
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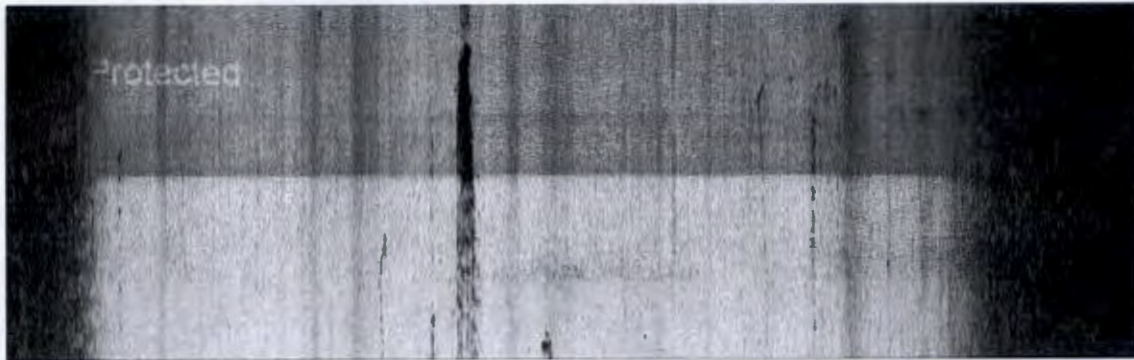


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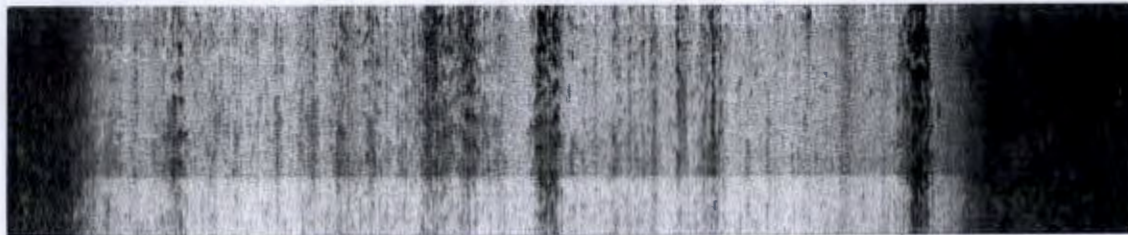




6/28/15

1700– RN received initial results from brain MRI – no obvious abnormalities noted. Final report will be done tomorrow. Patient informed of results.

6/29/15 –



6/30

1300 – RN arrived on set to visit patient. He was upset due to having an argument with his wife. Patient stated he had taken about 4 Xanax 1 mg over the past 24 hours to deal with the stress he was feeling. Patient was able to express his emotions appropriately. Patient stated that he had not slept the night before due to argument with his wife.

1830 – Neurologists visited patient on set and administered steroid injections. She informed patient he could have some minor discomfort in the injections sights and would feel the effect of the medicine with a few days. Patient stated he already could feel some relief of the tension.

1920 – Patient had another argument with his wife. Patient was anxious and was asking for medication to help calm him down. Seroquel 50 mg administered.