

IN THE COURT OF COMMON PLEAS
OF LAKE COUNTY, OHIO

CAROL A. ZOELBEL, Executrix of

the Estate of Lorna Moeller,

Plaintiff,

vs.

Case No.

LAKE EAST HOSPITAL, et al,

01 CV 001107

Defendants.

~ ~ ~ ~ ~

Deposition of PATRICIA FISHLEY,
called for examination under the statute, taken
before me, Michelle A. Bishilany, RDR/CRR and
Notary Public in and for the State of Ohio,
pursuant to notice and stipulations of counsel,
at The Lake County Board of MR/DD,
8121 Deepwood Boulevard, Mentor, Ohio, on
Tuesday, January 7, 2003, at 1:35 p.m.

~ ~ ~ ~ ~

RENNILLO REPORTING SERVICES
A LEGALINK AFFILIATE

1. The first part of the document is a list of the names of the members of the committee who have been appointed to study the problem of the shortage of housing in the city of New York.

2. The second part of the document is a list of the names of the members of the committee who have been appointed to study the problem of the shortage of housing in the city of New York.

1 APPEARANCES:

2
3 On behalf of the Plaintiff:

4 Becker & Mishkind, by

5 **JEANNE M. TOSTI, ESQ.**

6 660 Skylight Office Tower

7 1660 West Second Street

8 Cleveland, OH 44113

9 (216) 241-2600

10
11 On behalf of Defendant Lake Hospital
12 System, Inc.:

13 Reminger & Reminger, by

14 **DAVID H. KRAUSE, ESQ.**

15 1400 Midland Building

16 101 Prospect Avenue West

17 Cleveland, OH 44115-1093

18 (216) 687-1311
19
20
21
22
23
24
25

1 APPEARANCES, Continued:

2
3 On behalf of Defendant Eastwood

4 Residential Living:

5 Moscarino & Treu, by

6 **STEVEN J. FORBES, ESQ.**

7 630 Hanna Building

8 1422 Euclid Avenue

9 Cleveland, OH 44115

10 (216) 621-1000

11
12 On behalf of Defendants Primehealth,

13 Inc., Dr. Heng, Dr. Kessler, Dr. Oh:

14 Reminger & Reminger, by

15 **KATHLEEN A. ATKINSON, ESQ.**

16 1400 Midland Building

17 101 Prospect Avenue West

18 Cleveland, OH 44115-1093

19 (216) 687-1311

20
21 On behalf of Lake County Board of MR/DD:

22 **ERIC J. SCHALTENBRAND, ESQ.**

23 8121 Deepwood Boulevard

24 Mentor, OH 44060

25 (440) 350-5020

1 PATRICIA FISHLEY, of lawful age, called
2 for examination, as provided by the Ohio Rules
3 of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, deposed and
5 said as follows:

6 EXAMINATION OF PATRICIA FISHLEY

7 BY MR. FORBES:

8 Q. Ms. Fishley, my name is Steve
9 Forbes. I represent Eastwood Residential
10 Living in a lawsuit brought by Carol Moeller -- 13:35:17
11 I mean Carol Zoelbel on behalf of Lorna
12 Moeller's estate.

13 Have you ever been deposed before?

14 A. No.

15 Q. I have just two instructions. 13:35:26

16 The first is to answer my questions
17 aloud so the court reporter may take down the
18 answers.

19 The second is if my questions are
20 confusing, I don't make any sense, please ask 13:35:34
21 me to clarify.

22 If you answer it I'm going to
23 assume you understood the question; is that
24 fair?

25 A. That's fair. 13:35:41

1 Q. Your current job is? 13:35:41
2 A. Social worker.
3 Q. For whom do you work?
4 A. Deepwood Center.
5 Q. Your education and training to 13:35:54
6 become a social worker at Deepwood Center, can
7 you explain that to me?
8 A. I have a bachelor's in social
9 service.
10 Q. When did you obtain the BS in 13:36:05
11 social service?
12 A. It's a BA.
13 Q. BA, I'm sorry.
14 A. 1970 -- 1978. It's a long time
15 ago. 13:36:23
16 Q. Where did you get that diploma?
17 A. Cleveland State.
18 Q. After graduating from Cleveland
19 State what did you do, employment-wise?
20 A. I've been here at Deepwood Center 13:36:32
21 since 1976.
22 Q. In 1976 what was your position at
23 Deepwood?
24 A. Residential specialist at the adult
25 residence center. 13:36:47

1 Q. Where is the adult residence 13:36:50
2 center?
3 A. Right up the road, right -- the
4 next building over.
5 Q. The next building on Deepwood 13:36:59
6 Boulevard?
7 A. Yeah.
8 Q. Have your job responsibilities
9 changed since 1976?
10 A. I'm sorry? 13:37:08
11 Q. Have your job responsibilities
12 changed since 1976?
13 A. Oh, yeah. When I was a resident
14 supervisor it was direct care at the adult
15 residence center and working with the direct 13:37:18
16 care staff. After that I was a staff
17 development specialist for Deepwood, and then I
18 was in the case management department until
19 last month.
20 Q. How long were you in the case 13:37:36
21 management department?
22 A. 12 years.
23 Q. Your job immediately prior to that
24 was, you say, resident supervisor?
25 A. Staff development specialist. 13:37:47

1 Q. What is a staff development
2 specialist?

13:37:49

3 A. Conduct all the training and
4 orientation for new employees and maintain
5 certification for the other employees.

13:37:56

6 Q. How many residents are there at
7 Deepwood?

8 A. How many people reside here? 80.

9 Q. After your tenure as the resident
10 specialist what did you do next?

13:38:17

11 A. After resident specialist was staff
12 development.

13 Q. After staff development what did
14 you do?

15 A. Case management.

13:38:26

16 Q. Tell me about the case management
17 job.

18 A. The case management job was we did
19 information referral, placement, intake,
20 monitoring.

13:38:41

21 Q. What is involved in placement?

22 A. Anybody that needs any type of
23 residential placement or vocational placement
24 in our program would come through our office
25 and then we would assist them in finding

13:39:02

1 whatever placement it is they needed, whether
2 it be vocational or residential.

13:39:06

3 Q. How are these individuals referred
4 to Deepwood?

5 A. Oh, various sources. Either
6 through the school systems, sometimes we have
7 an intake procedure that qualifies people to
8 receive services through the county program and
9 we would do that piece first. After we do the
10 initial intake then they would tell us what --
11 the families would tell us what they need and
12 then we would do the placement piece for them.

13:39:15

13:39:31

13 Q. What is the relationship between
14 Deepwood and the county?

15 A. Deepwood is the county board
16 program.

13:39:45

17 Q. Deepwood is a county-run agency?

18 A. Right.

19 Q. Other than the residential housing
20 here at the facility where we're taking this
21 deposition, within Lake County where else would
22 you place individuals who would qualify for the
23 program?

13:39:52

24 A. There is a number of intermediate
25 care facilities for the mentally retarded.

13:40:05

1 There is group homes such as Eastwood and we
2 have a supported living department that assists
3 people in living in the community either in
4 homes or apartments.

13:40:10

5 Q. I believe the phrase you used was
6 intermediate living?

13:40:30

7 A. Intermediate care facility for the
8 mentally retarded, ICFMR. That would be a
9 Medicaid program facility and it would be
10 places like Deepwood Center, Broadfield,
11 Stewart Lodge, there's one more, Lakeland
12 Living Opportunities.

13:40:44

13 Q. Can you distinguish between an
14 ICFMR and a home like Eastwood for me?

15 A. The ICFMR is a larger facility,
16 they're Medicaid funded, generally have more
17 services, speech, OT, 24 hour nursing. It'd be
18 similar to the nursing homes for the elderly.

13:41:02

19 Q. How is a decision made to place a
20 resident in the ICFMR or the group home?

13:41:27

21 A. Generally it's based on the client
22 need. There's some people for various reasons
23 that need a larger facility, need 24 hour
24 nursing, behavioral issues where they need more
25 intense staffing.

13:41:46

1 Q. Who makes that decision?

13:41:48

2 A. Interdisciplinary team, a team of
3 professionals made specifically for that
4 consumer.

5 Q. Are there general categories of
6 folks who are on an interdisciplinary team?

13:42:08

7 A. It would be speech, OT, if they're
8 receiving those services, social worker, the
9 team leader would be a habilitation or program
10 coordinator, family members would be on the
11 team.

13:42:19

12 Q. Is the placement decision
13 periodically reviewed by anyone?

14 A. It's reviewed at the annual, annual
15 team meetings every year as to the
16 appropriateness of the placement.

13:42:35

17 Q. Do these teams meet quarterly?

18 A. They do.

19 Q. So the county would maintain
20 documentation on the quarterly team meetings?

13:42:44

21 A. Uh-huh.

22 Q. I'm sorry, yes?

23 A. Yes.

24 Q. Did you know who was on Lorna
25 Moeller's team?

13:42:54

1 A. When she was over here at the
2 workshop it would have been the workshop staff.
3 The later years when she retired from the
4 workshop it would have been her home staff, a
5 county case manager, and I believe that was it.

13:42:54

13:43:09

6 Q. Was there a habilitation specialist
7 on the team?

8 A. That would have been through
9 Eastwood at the time because she had left
10 employment here.

13:43:27

11 Q. Do you know when she retired?

12 A. Oh. I'm not 100 percent sure, I'm
13 guessing, the early 90s. That may not be
14 accurate, though, we'd have to look that up.

15 Q. But Deepwood still would maintain
16 records regarding Lorna Moeller's vocational
17 experience here as well as placement decisions
18 that were made throughout her life?

13:43:51

19 A. We would maintain those records.

20 Q. Is there a record retention policy?
21 Do you ever throw them out, shred them, do
22 anything with them; do you know?

13:44:05

23 A. I'm not sure. I know they go to a
24 barn and I don't know what happens after that.

25 Q. In your role as case manager was it

13:44:24

1 ever within your function to review group homes
2 or ICFMRs to see if they were performing
3 appropriately and consistent with state
4 regulations?

13:44:26

5 A. That was one of the main functions
6 of the case management department, we would do
7 what's referred to as monitoring.

13:44:39

8 Q. Were you involved in monitoring
9 ICFMRs?

10 A. We were -- individuals in the
11 ICFMRs.

13:44:55

12 Q. An ICFMR would be governed by
13 federal regulations, right?

14 A. Medicaid. Right, Medicaid
15 regulations.

13:45:09

16 Q. There would also be state
17 regulations that are relevant?

18 A. Yeah.

19 Q. Are there also county regulations,
20 county rules? I'm looking for your working
21 knowledge based upon reviewing these places and
22 what you would do to enforce rules.

13:45:15

23 A. What we did at the county level was
24 we had a quality of care or quality of life
25 assessment.

13:45:31

1 Q. What is a quality of life
2 assessment?

13:45:38

3 A. It's a series of questions for the
4 quality of life, the consumer answered the
5 questions as to whether or not they were happy
6 with the different aspects of their life, job,
7 community access.

13:45:48

8 Q. How often would you have a resident
9 or consumer review a quality of life assessment
10 or prepare a quality of life assessment?

13:46:07

11 A. At least once every three years.

12 Q. Would that be true of individuals
13 residing in group homes in Lake County?

14 A. Yes, it would.

15 Q. If a group home violated the state
16 or federal rules what were the options for you
17 as a monitor and a regulator?

13:46:23

18 A. That would go through the state
19 licensure department and they would review
20 those.

13:46:43

21 Q. Would you make a report to the
22 state licensure department?

23 A. We were sending the quality -- the
24 assessments, quality review or quality of care
25 to the state licensure department and then they

13:46:54

1 would make that part of their --

13:46:57

2 Q. Are there also annual inspections
3 of group homes, surveys?

4 A. Through licensure or through --

5 Q. Through anybody.

13:47:11

6 A. I can't answer for what licensure
7 did, I'm not sure what those requirements were,
8 I don't know when they were scheduled to go
9 out.

10 Q. As a monitor, in your role were you
11 ever involved in county or state surveys of
12 group homes?

13:47:20

13 A. On occasion.

14 Q. What would your role be?

15 A. Basically the only time that we
16 would be sitting in would be the exit interview
17 when the state would make the recommendations.

13:47:33

18 Q. If a group home within Lake County
19 was cited for any violations would you be
20 apprised of those violations?

13:47:47

21 A. Not necessarily.

22 Q. What options as a monitor did you
23 have to regulate the homes, the group homes?

24 A. Very little. We could make
25 recommendations.

13:48:04

1 Q. What recommendations could you 13:48:06
2 make?

3 A. We could make recommendations, if
4 somebody wasn't happy with the amount of phone
5 calls they could make or if they could make 13:48:21
6 phone calls we would make recommendations that
7 they could -- they had the right to make a
8 phone call, I'm not even sure, you know, on a
9 daily basis or on a time -- clients would want
10 to talk for two hours on the phone, the 13:48:43
11 facility would have one phone, and we would try
12 to negotiate, you know, instead of two hours
13 can they talk ten minutes uninterrupted, those
14 kinds of issues.

15 Q. Is it fair to say that you would be 13:48:58
16 an intermediary on behalf of the resident?

17 A. Yeah, that's fair to say.

18 Q. Can you compare your role to the
19 role of the ombudsman?

20 A. In the general nursing homes? 13:49:14

21 Q. Keeping it in housing for the
22 mentally retarded.

23 A. Not having seen a lot of the
24 ombudsmen, because we don't use them so much in
25 this system, I'm not real sure. 13:49:21

1 Q. Are there any other folks involved 13:49:23
2 in the day-to-day monitoring of the group homes
3 from either the state or the county?

4 MR. SCHALTENBRAND: Outside of case
5 management? 13:49:38

6 MR. FORBES: Outside of case
7 management, thanks.

8 A. The licensure, state licensure.

9 Q. Do you understand what the state
10 licensure does? What's their role; can you 13:49:45
11 tell me?

12 A. To monitor the facilities, to --
13 they would do citations if things weren't up to
14 code.

15 Q. Do you know how often they monitor 13:50:07
16 the facilities?

17 A. I'm not sure.

18 Q. So these group homes then are
19 subject to your, or someone like you as case
20 manager, reviewing them and talking to 13:50:14
21 residents as well as separate folks from the
22 state who are making inquiries and
23 investigations in the licensure?

24 A. Right.

25 Q. And the state then has the option, 13:50:25

1 they can cite homes, correct?

13:50:27

2 A. Uh-huh. Uh-huh.

3 Q. Is it a progressive type of
4 discipline, they begin with citations and then
5 end with revoking of the license?

13:50:37

6 A. Yes.

7 Q. Do you know of any homes within
8 Lake County who have had their license revoked?

9 A. No.

10 Q. You do know homes, though, that
11 have been cited, correct?

13:50:50

12 A. Yes.

13 Q. From your working knowledge in your
14 day-to-day job do you have any understanding of
15 the levels of that progressive discipline
16 beginning with citation and going towards
17 licensure revocation, can you give my anymore
18 detail as to how that works?

13:51:04

19 A. Having never experienced the latter
20 part I would have no idea. I know that when
21 there was a citation they'd have a certain
22 amount of time, ten days, 30 days, to make a
23 correction and to provide that to the state.

13:51:19

24 Q. When there's a citation followed by
25 a plan of action from the home, as a monitor do

13:51:36

1 you follow-up to see if the plan of action is
2 being implemented?

13:51:42

3 A. If we're aware of them.

4 Q. So if a plan of action came to you
5 saying we're going to do X, Y and Z to address
6 a problem, then it would be your job to make
7 sure X, Y and Z was done or to follow-up and
8 see if X, Y and Z were done?

13:51:51

9 A. If licensure would have asked to us
10 to do that we would have done that.

13:52:06

11 Q. Are there any federal regulations
12 for the group homes that aren't necessarily
13 Medicaid?

14 A. Not that I'm aware of.

15 Q. How were the group homes funded; do
16 you know?

13:52:17

17 A. There's a number of different
18 sources. I believe the majority of it is
19 Medicaid funding now through the waiver
20 services, state waiver.

13:52:37

21 Q. Is it fair to say they're
22 exclusively funded by some level of government?

23 A. I don't know about exclusive.

24 Q. It's your understanding the
25 majority of funding is governmental?

13:52:52

1 A. I think so. I don't know for sure. 13:52:57

2 Q. Fair enough.

3 A. I don't know for sure.

4 Q. Can you describe for me how

5 abundant the housing is for mentally retarded 13:53:07

6 folks in Lake County? Is there difficulty

7 placing people? Do you have an excess? Can

8 you tell me about it?

9 A. We don't have an excess, we have a
10 very long wait list. 13:53:17

11 Q. How long is the wait list?

12 A. Pages, years.

13 Q. If someone is found by a court to
14 be mentally retarded, unable to take care of
15 themselves, the county has an obligation to 13:53:33
16 place them in housing, correct?

17 A. I don't know if we have an
18 obligation.

19 Q. Is there a governmental
20 responsibility to provide housing for the 13:53:50
21 mentally retarded?

22 A. Yes.

23 Q. If I understand correctly, your
24 level, the way these homes are regulated would
25 be either some sort of sanction that requires a 13:54:13

1 response or a license suspension or revocation?

13:54:16

2 A. I'm sorry, say that again.

3 Q. I'm looking for a complete list of
4 the tools that are available to the government
5 regulators to modify behavior from the group
6 homes. Do you understand what I'm saying?

13:54:25

7 MR. SCHALTENBRAND: On the state
8 level or county level?

9 MR. FORBES: State and county.

10 Q. To the extent you know. Let me try
11 that again. If you see a situation you don't
12 like, what are the tools that are available to
13 you to change it?

13:54:37

14 A. We could make recommendations to
15 the facilities and that was generally based on
16 what we generally believed to be best practice.
17 We did not have any ability to do citations.

13:54:54

18 Q. If a facility didn't follow a
19 recommendation what options do you have?

20 A. Licensure could be made aware, they
21 could go out, they could do citations.

13:55:15

22 Q. So if you confronted a home that
23 didn't take a recommendation that you thought
24 was important you then had the option of going
25 to the state?

13:55:28

1 A. Uh-huh. Yes.

13:55:29

2 Q. As you sit here today are there any
3 other options available to you?

4 A. Not that I can think of.

5 Q. Other than case management was
6 there any other person who residents or their
7 family members could complain to if there was a
8 problem?

13:55:41

9 A. I don't -- well, they can go up the
10 ladder, they could, you know, talk to the
11 superintendent here, they could talk to the
12 administrators at the group homes.

13:56:04

13 Q. As far as your supervision here as
14 a case manager, what's the structure, who's
15 over you and then who's next?

13:56:26

16 A. There was a director of case
17 management services.

18 Q. Who is that?

19 A. At the time his name was David
20 Miller.

13:56:33

21 Q. When did Mr. Miller leave from that
22 position?

23 A. A year ago.

24 Q. Who is it now?

25 A. There's no case management

13:56:44

1 department as of January 2nd, 2003.

13:56:45

2 Q. What happened to the case
3 management department?

4 A. We were laid off and there's a new
5 department called service and support
6 administration.

13:56:54

7 Q. How is service and support
8 administration different from case management?

9 A. I would defer that to someone else.

10 Q. How did that affect your individual
11 job?

13:57:05

12 A. I was laid off.

13 Q. Do you have any understanding as to
14 why that decision was made?

15 A. I would defer that.

13:57:12

16 Q. Did the level of staffing change,
17 to your knowledge? Are there fewer folks now
18 doing the same job?

19 A. I would defer that to the
20 administration.

13:57:26

21 Q. Fair enough.

22 MR. SCHALTENBRAND: I could give
23 you that information if you need it.

24 Q. If there was a violation of the
25 Bill of Rights for mentally retarded people how

13:57:36

1 would that be handled if that came to your
2 attention?

13:57:40

3 A. If there was a rights violation the
4 case manager would talk to the person involved,
5 the consumer involved, they would talk to the
6 facility staff and if there was no resolution
7 they would bring it to the major unusual
8 incident specialist, which at the time was me,
9 and then I would go out and interview the
10 consumer, then I would write a major unusual
11 incident report that would go to the state.

13:57:56

13:58:26

12 Q. What time period were you the major
13 unusual incident specialist?

14 A. Probably the last five to six
15 years.

13:58:52

16 Q. What did that job -- can you
17 describe that job for me or position?

18 A. It was pretty much what I just
19 described, for any major unusual incident, and
20 the state determined what the major unusual
21 incidents were, there were rights violations,
22 abuse, neglect, let's see, there was seven I
23 believe, hospitalizations, those would all be
24 reported to the state.

13:59:06

25 Q. The purpose of them being reported

13:59:31

1 to the state was what?

13:59:33

2 A. I'm not sure how to answer that.

3 Q. Is it fair to say the state had a
4 fairly -- had a fair number of resources and
5 folks like yourself and others who when a major
6 unusual incident was reported they could
7 investigate to make sure the home was handling
8 it appropriately, and the requirement to report
9 it meant that it got reviewed by folks to make
10 sure things were being done the right way in an
11 acceptable manner; fair enough?

13:59:54

14:00:07

12 A. Yeah.

13 Q. I mean, if I'm wrong let me know,
14 but that seems to me to be the reason you'd
15 have it; does it make sense to you as someone
16 who does this or did it?

14:00:19

17 A. There is, and I don't know the
18 revised code number, but that specifies that
19 the state is responsible for reviewing all the
20 major unusual incidents. I don't know that
21 number.

14:00:32

22 Q. I'm not looking for the code
23 section or for what it says in those rules.
24 I'm looking for your understanding as someone
25 in the trenches and as a major unusual incident

14:00:45

1 specialist as to why the home would have to
2 report things to you and the state, what the
3 purpose of that was.

4 A. I believe that was for the state's
5 ability to monitor. 14:00:55

6 Q. When did you first come to know
7 Lorna Moeller?

8 A. Oh, geez, I've known Lorna for
9 years.

10 Probably the late 70s, early 80s. 14:01:22

11 Q. In the late 70s, early 80s where
12 was Lorna residing?

13 A. She was at Eastwood -- well it was
14 Meridian I think at the time.

15 Q. Same physical location, same
16 building? 14:01:37

17 A. Right, exactly.

18 Q. Prior to 1997, which was when we
19 had the major unusual incident with her, the
20 questions about Lorna smoking, prior to that
21 smoking incident had you ever met Carol
22 Zoelbel? 14:01:49

23 A. No, I don't believe I had.

24 Q. Since the late 70s, early 80s when
25 you first met Lorna how often did you come into 14:02:05

1 contact with her?

14:02:09

2 A. It was infrequent prior to my
3 becoming a case manager, you know, I'd run into
4 her at the workshop or whatever. There was no
5 direct contact, my job was not to work with
6 Lorna at that time, it was just passing in the
7 hall.

14:02:21

8 When I became a case manager I was
9 assigned to monitor the consumers that lived at
10 Eastwood and then I had more direct contact
11 with Lorna. That would have been 1990, '91.

14:02:36

12 Q. You say "more direct contact", can
13 you describe that contact in any way once
14 you're a case manager and you're monitoring the
15 home and her condition?

14:02:56

16 A. Again, I would be out there
17 probably on a monthly basis, not necessarily
18 always -- not necessarily to work directly with
19 Lorna but I would be responsible for doing the
20 quality reviews for all of the ladies that
21 resided in the home.

14:03:13

22 Q. So you were doing quality reviews
23 for the Eastwood residents from approximately
24 1990 until whenever?

25 A. '95 -- '95, '94. I'd really have

14:03:27

1 to look at all those dates.

14:03:34

2 Q. I understand it's a while back, I'm
3 looking for a very rough understanding --

4 A. Okay.

5 Q. -- just to get an understanding.

14:03:40

6 Then in 1995, '94 you stopped doing
7 the quality reviews?

8 A. Right. Our department, case
9 management department then had specific people
10 to do the monitoring and specific -- we divided
11 out the workload basically, specific people to
12 do intake, major unusual incidents, placement.

14:03:53

13 Q. So '94, '95 is when you assumed,
14 about the time you assumed the major unusual
15 incidents specialist?

14:04:11

16 A. I believe so.

17 Q. From '95 until Lorna died what was
18 your contact with her then?

19 A. Limited at that point because I
20 wasn't out at the house.

14:04:23

21 Q. You would have had contact with her
22 at least if there was any major unusual
23 incident involving her?

24 A. Right, or if there was major
25 unusual incidents involving the home, certainly

14:04:31

1 I would say hello to her.

14:04:35

2 Q. From '95 until 1997 with regard to
3 the smoking, do you remember any major unusual
4 incidents that involved Lorna?

5 A. No.

14:04:50

6 Q. From the time that you knew her
7 going past her in passing when she was here
8 working all the way until she died, do you
9 remember any complaints from Lorna about the
10 home?

14:05:10

11 A. Smoking was an issue. The only
12 other thing I can think of off the top of my
13 head were sometimes there were other consumers
14 that she wasn't real pleased with their
15 behavior.

14:05:36

16 Q. So she had complaints about other
17 residents in the home?

18 A. Occasionally. Lorna wasn't one to
19 complain about anything, I mean, her first
20 sentence to everybody and anybody was honey, I
21 don't want to bother you, so, I mean, that's
22 who Lorna was.

14:05:45

23 Q. Did Carol Zoelbel have any
24 complaints to you prior to Lorna's death?

25 A. The only thing I remember with

14:06:03

1 Carol prior was the smoking, that smoking
2 thing.

14:06:05

3 Q. And Carol's position, Carol wanted
4 Lorna to stop?

5 MR. SCHALTENBRAND: You're
6 referring to the smoking?

14:06:15

7 MR. FORBES: Smoking.

8 A. Uh-huh.

9 Q. Yes?

10 A. As far as I know.

14:06:20

11 Q. Well you had a meeting with LuAnne
12 Busch and Carol and you were present --

13 A. Yes.

14 Q. -- and was there a Linda Henry, is
15 that someone --

14:06:28

16 A. Yes.

17 Q. Who was she?

18 A. She was the case manager who took
19 over for me.

20 Q. So all of these folks would have
21 been present at a meeting, and at that meeting
22 didn't Carol say Lorna doesn't smoke when she
23 sees me, I prefer she not smoke when she's at
24 the home; do you remember that?

14:06:33

25 A. I do not remember that. I do know

14:06:45

1 that they taped it.

14:06:46

2 Q. "They", was that Ms. Busch?

3 A. Yes.

4 Q. Is that standard, to tape a meeting
5 like that?

14:06:54

6 A. That hadn't been before.

7 Q. What's your recollection of that
8 meeting?

9 A. My recollection is that we reviewed
10 the client rights, that she does have the right
11 to smoke. The family was very angry. LuAnne
12 was somewhat angry that she had the right to
13 smoke when it wasn't in her best interest.

14:07:09

14 Q. The family's anger was not about
15 her being deprived of the right to smoke, the
16 family's anger was that she was using her
17 Social Security money on cartons of cigarettes
18 and then smoking?

14:07:29

19 A. My recall is that the anger was in
20 relation to the client rights.

14:07:45

21 Q. So your recollection was that Carol
22 Zoelbel was upset about --

23 A. I don't recall Carol Zoelbel being
24 upset.

25 Q. Who in the family was angry?

14:07:54

1 A. Her husband was angry. 14:07:56

2 Q. He was angry because the home was

3 restricting Lorna's smoking?

4 A. No, because I filed a report that

5 said she had the right to smoke. 14:08:05

6 Q. Is it fair to say that both the

7 family and the home wanted to limit Lorna's

8 smoking?

9 A. Yes.

10 Q. Based on your interpretation of the 14:08:15

11 client rights this is an individual who had the

12 right to do what she wanted, including smoking?

13 A. Correct.

14 Q. Did the home take any action

15 consistent with the Bill of Rights and Lorna's 14:08:24

16 rights to attempt to steer her and limit her

17 smoking?

18 A. Yes, I do believe that they did try

19 to limit it.

20 Q. What did they do; do you know? 14:08:37

21 A. There was a doctor's order, and I

22 believe that there were times -- I'm not sure

23 on that. I believe there were times that she

24 could smoke, but I don't --

25 Q. I'm sorry. Do you know if they 14:08:58

1 took steps to help Lorna limit her smoking with
2 her agreement?

14:09:00

3 A. I'm not sure.

4 Q. During the time when you were a
5 case manager interacting with Eastwood was
6 their licensure ever brought into question?

14:09:17

7 A. There was something with financial
8 years ago, there was a state auditor that had
9 come out.

10 Q. When you say "years ago", when was
11 that?

14:09:40

12 A. I knew you were going to ask me
13 that. I'm not sure. '92, '93. I really don't
14 know.

15 Q. When you say something financial,
16 do you have any understanding of what that was?

14:10:01

17 A. I remember that there was a state
18 auditor that came out, there was allegation of
19 impropriety with client monies being spent on
20 household items, personal like hygiene items
21 that should have been supplied by the facility.

14:10:21

22 Q. Anything else?

23 A. I don't know. I'd have to go look.

24 Q. Do you remember who the

25 administrator was at the time? Was it before

14:10:45

1 or after LuAnne Busch took over?

14:10:48

2 A. Oh, before.

3 Q. Other than using client funds to
4 buy items for the residents but that should
5 have been purchased by the home, any other
6 citations that you remember that stand out from
7 '90 until 2000?

14:11:03

8 A. You know, I'd really have to look.
9 To stand out for me to think of right now off
10 the top of my head --

14:11:25

11 Q. I'm looking for something that
12 jumps out as you remember in your job as being
13 the person who would visit the home and take
14 statements on quality of life from residents,
15 anything as you're sitting here that stands out
16 that they were cited for that you remember in
17 any way?

14:11:36

18 A. You know, I'd have to look, I
19 really don't. There was a number of -- I don't
20 know if there were citations. There was a
21 number of concerns regarding things like food,
22 snacks, staffing levels.

14:12:01

23 Q. What do you mean by food and snack
24 concerns? Regardless of whether there's a
25 citation, tell me about those.

14:12:19

1 A. There was an ongoing, and I think
2 it was a licensure, there was an ongoing thing
3 about the snacks, the client, the consumer
4 snacks being locked up and that they shouldn't
5 have been locked up. It was like a -- it was
6 an ongoing thing for a long time. From time to
7 time there would be complaints that there was
8 no food at the home.

14:12:21

14:12:31

9 Q. No food in between meals?

10 A. No, that their supply -- their
11 supplies were low.

14:12:53

12 Q. Anything else? Forgetting any
13 questions that may go to citations that may
14 stand out, but any concerns other than this
15 concern over snacks being locked up and
16 financial issues, anything else during your
17 years that you were charged as a monitor to
18 look at the home and talk to the residents?

14:13:14

19 A. I'd have to really think about it
20 at this point.

14:13:27

21 Q. Well at any time during the
22 question asking if anything jumps out just let
23 us know.

24 A. Okay.

25 Q. We do know the citations are public

14:13:36

1 record. Aside from what you remember whatever
2 else was there we could look up and judge the
3 home's record for ourselves; is that fair?
4 Yes?

5 A. Are you asking --

6 Q. When I'm asking about these
7 citations, if the home was cited for behavior
8 that affected licensure, those citations or any
9 sanctions that are available to the state would
10 be -- somebody has those records, correct?

11 A. I imagine so; maybe not at this
12 level.

13 Q. During your time when you were
14 doing the assessments and the questionnaire
15 that Lorna would fill out, anything in that
16 questionnaire that caused you concern to move
17 her to another facility?

18 A. Not that I recall.

19 Q. There was an option if either Lorna
20 no longer qualified for group home services or
21 was unhappy she could move to another home
22 within the system, or at least request it?

23 A. She could request it, that's
24 better.

25 Q. Neither Lorna nor her sister Carol

1 or anyone in the family requested a change as 14:14:49
2 you remember?

3 A. No, not that I recall.

4 Q. Were there ever, that you remember,
5 any problems with the number of staff manning 14:15:09
6 the homes at Eastwood?

7 A. There were some concerns about
8 that.

9 Q. Do you remember what those concerns
10 were? 14:15:21

11 A. Just that the numbers were low.
12 There was I think one or two staff on second
13 shift with 21 ladies in the big house.

14 Q. There are regulations that -- are
15 there regulations that spell out the number of 14:15:40
16 care-giving employees to residents at a home?

17 A. They were -- Eastwood actually did
18 not have that regulation at the time, they were
19 a purchase of service home, and I don't know
20 about all that funding, I just remember it's a 14:16:00
21 POS home.

22 Q. What's a purchase of service home?

23 A. Again, it's federal money but they
24 didn't have all the regulations that the
25 Medicaid did. Maybe it's not federal, it might 14:16:10

1 be state, I'm not sure.

14:16:14

2 Q. But if Eastwood was violating the
3 regulations regarding staffing --

4 A. There was no numbers. Here in the
5 ICFMRs there's a one day ratio; the group homes
6 never had those ratios. What we were saying
7 that best practice, they didn't have the
8 manpower to maintain everybody's needs.

14:16:23

9 Q. So, first off, they weren't
10 violating any rule?

14:16:39

11 A. They were not violating any rule.

12 Q. The second, if you had concerns do
13 you remember if those concerns were addressed?

14 A. I'm sure that we've talked -- that
15 we had talked about it.

14:16:50

16 Q. What would be -- when you talk
17 about "best practice", what's the best practice
18 in your mind?

19 A. Number wise?

20 Q. Yes.

14:16:59

21 A. You know what? I couldn't give it
22 a number. I could not say one to eight, the
23 state says that, but one to 16 with, you know,
24 people needing X number of services, probably
25 not enough.

14:17:19

1 Q. Second shift is what hours? 14:17:19

2 A. Generally three to 11. All of

3 those homes are different, though, it could be

4 2:30 to 10:30.

5 Q. Did you know what the staffing was 14:17:27

6 in 2000 when Lorna Moeller died?

7 A. No.

8 Q. It would be whoever the monitor

9 was, if the monitor had complaints, concerns

10 about staffing it would be his or her 14:17:55

11 responsibility to talk to the home to address

12 those problems?

13 A. Yes.

14 Q. Certainly if they were serious

15 enough to affect resident care that would be 14:18:03

16 the county and state's job to fix?

17 A. (Nodding head affirmatively.)

18 Q. Yes?

19 A. Yes.

20 Q. Are group homes like Eastwood 14:18:14

21 required to have a licensed practical nurse on

22 staff?

23 A. I don't believe so.

24 Q. Are there group homes within Lake

25 County like Eastwood that don't have licensed 14:18:30

1 practical nurses on staff?

14:18:32

2 A. There's only one other and I don't
3 know if they have a nurse or nurse consultant,
4 I'm not sure.

5 Q. What is the one other?

14:18:46

6 A. Brittany Residential.

7 Q. Is there any attempt to get more
8 group homes within the area?

9 A. I'm not sure.

10 Q. In your tenure as case manager and
11 monitor do you know if Eastwood was ever cited
12 for having the staff inappropriately trained?

14:19:14

13 A. I don't remember.

14 Q. Nothing stands out as we sit here
15 today?

14:19:36

16 A. I'm trying to think when I did some
17 of those exit interviews and I don't remember.

18 Q. It would be the county's job
19 through the case management and the monitors as
20 well as the state licensure to make sure that
21 the homes have folks who are adequately
22 trained, correct?

14:19:45

23 A. That would be more licensure.

24 Q. So any problems with training would
25 affect what, the license or status with the

14:20:00

1 home? Could?

14:20:02

2 A. It could.

3 Q. Can you describe the type of
4 resident who is eligible for a group home?

5 A. Anybody with mental retardation,
6 there's individual policies or there were
7 individual admission policies with the homes.

14:20:26

8 Q. To qualify as mentally retarded, to
9 qualify for government-funded housing -- do you
10 know what the definition of mentally retarded
11 is?

14:20:53

12 A. IQ below 70, deficits in three or
13 more areas of daily living skills. There's a
14 state assessment called an OEDI, Ohio
15 Eligibility Determination Instrument, and that
16 would show deficits.

14:21:14

17 Q. As part of your investigation into
18 a major unusual -- I'll start again.

19 When there's a major unusual
20 incident and you're required to investigate it
21 tell me about what you do.

14:21:43

22 A. We would go out and interview the
23 consumer and the involved parties. If it's an
24 abuse/neglect, it would require police
25 interview also, we would go out together

14:22:00

1 generally, under the age of 22 we would go out 14:22:02
2 with the Department of Human Services, Jobs and
3 Family Services now, and we would conduct
4 interview with the parties involved. A lot of
5 times it would be compiling a lot of paper, 14:22:15
6 incident reports, shift notes, staff notes,
7 those kinds of things. Then we would write a
8 report to the state.

9 Q. In general would you take notes of
10 your interviews as part of this process? 14:22:37

11 A. Generally, yes.

12 Q. Do you ever retain those? Do you
13 retain those notes?

14 A. Not after I write the reports for
15 the state. 14:22:51

16 Q. As a general practice are any
17 documents maintained after the report is
18 written that were gathered as part of the
19 process?

20 A. Are any documents -- 14:23:05

21 Q. Other than the documents that you
22 would obtain, like medical records, any
23 documents you generate other than the report do
24 you retain?

25 A. No. 14:23:14

1 Q. I'm going to show you -- I guess 14:23:15
2 we'll just mark it as exhibit 1.

3 - - - - -

4 (Thereupon, Defendant's Deposition
5 Exhibit 1 was marked for purposes of 14:23:19
6 identification.)

7 - - - - -

8 MS. TOSTI: Would you just tell us
9 what you're using?

10 MR. FORBES: Yes. This is the May 14:23:25
11 9th letter from William Angel to Alfie Romain.

12 Q. Did you see this document as part
13 of your investigation into Lorna Moeller's
14 death?

15 A. Yes. 14:24:17

16 Q. If you could describe for me as
17 best, before we go to the documents, your best
18 recollection of your involvement with the
19 events that led up or an investigation
20 following Lorna Moeller's death? 14:24:32

21 A. Would you repeat that?

22 Q. What did you do, what was your role
23 after Lorna Moeller died with regard to an
24 investigation by the county and state?

25 A. I was informed by another case 14:24:46

1 manager the morning that Lorna passed away that 14:24:49
2 she had died. I called out to LuAnne Busch and
3 set up a time to go out there to the facility
4 and compile the information as to what
5 happened. 14:25:08

6 Q. Do you remember when you did go out
7 to the facility?

8 A. It was the morning that she -- it
9 was probably closer to afternoon.

10 Q. So if she died on February 4th this 14:25:19
11 would be the afternoon of February 4th?

12 A. Yeah, I'm thinking so.

13 Q. When you got there what did you do?

14 A. I sat down with LuAnne, Julie
15 Warner, Lisa Schubert, I believe there was one 14:25:31
16 other person, I'd have to look and see who it
17 was, I don't recall.

18 Q. Do you remember the person's role?

19 A. If I -- it was the home manager.

20 Q. Stacey Reigert? 14:25:55

21 A. Stacey, thank you. Went out, met
22 with them and asked them, you know, what
23 happened basically.

24 Q. How long was this meeting?

25 A. I'm guessing one to two hours, 14:26:16

1 again.

14:26:23

2 Q. Was it at Eastwood?

3 A. Yes.

4 Q. Did you talk to the individuals
5 separately?

14:26:26

6 A. No, they were all in that office
7 area.

8 Q. Do you remember what information
9 you obtained at this meeting?

10 A. I believe that they gave me the
11 time lines. I remember Julie telling me that
12 she'd been paged through the night, and that's
13 when they told me that -- they pretty much
14 described the scenario of when Lorna had thrown
15 up and that Julie went to get the medication
16 from the pharmacy -- from the drugstore and
17 they pretty much recounted what happened that
18 morning.

14:26:41

14:27:03

19 Q. When you said they gave you the
20 time lines, was this something that was written
21 out or they just described for you the time
22 frames?

14:27:15

23 A. I don't believe it was written out.
24 At one point Julie looked at her pager and gave
25 the specific times that she had been paged the

14:27:31

1 prior evening.

14:27:35

2 Q. Did they provide you with any
3 written documents at that meeting?

4 A. I don't believe at that particular
5 meeting they did.

14:27:49

6 Q. Do you remember anything else about
7 that meeting?

8 A. No.

9 Q. Did you ask for major unusual
10 incident reports at that meeting?

14:28:09

11 A. I'm sure I asked for incident
12 reports.

13 Q. Help me with the terminology:
14 What's the difference?

15 A. Major unusual incident report is a
16 report that goes to the state.

14:28:20

17 The incident report is the report
18 that was generated at the facility written by
19 the direct care staff or whoever was involved
20 in the incident.

14:28:29

21 Q. When there are incident reports are
22 those necessarily given to anyone outside the
23 facility if there's no problem? If they just
24 generate their own reports are those typically
25 shared with you as someone -- as a case manager

14:28:42

1 or not?

14:28:46

2 A. Usually for a major incident the
3 incident reports are always shared -- generally
4 shared. The state has a right to review those,
5 the licensure will review those on a consistent
6 basis, I believe.

14:28:53

7 Q. Who makes a determination as to
8 whether something is a major unusual incident?

9 A. The state.

10 Q. So I just want to understand the
11 way we're labeling those reports. There would
12 be an incident report for whatever requires
13 those to be generated. At that point it would
14 go to someone like you who would decide whether
15 they're going to make a major unusual incident
16 report to the state?

14:29:04

17 A. Yes, correct.

18 Q. You leave this meeting on the 4th
19 after talking to the folks at Eastwood, what do
20 you do?

14:29:36

21 A. From there I -- LuAnne had informed
22 me that she had made an appointment at Potti
23 Funeral Home that I needed to attend because
24 she couldn't, and I went to the funeral home to
25 make arrangements for Lorna.

14:29:55

1 Q. When a resident of a group home or 14:30:06
2 an ICFMR dies, what is the procedure to
3 determine whether an autopsy should be done; do
4 you know?

5 A. I don't know. 14:30:27

6 Q. Do you know whether or not an
7 autopsy was done in Ms. Moeller's case?

8 A. I do know one was not.

9 Q. Do you know why?

10 A. I spoke with the coroner and he 14:30:34
11 said it was a natural death.

12 Q. Which coroner did you speak with?

13 A. The Ashtabula County.

14 Q. Do you remember his or her name?

15 A. I'm thinking Jeff, but that may not 14:30:56
16 be it.

17 Q. It was a man?

18 A. It was a man.

19 Q. Do you know if anybody else
20 consulted with the coroner with regard to the 14:31:05
21 decision as to whether or not to get an
22 autopsy?

23 A. I have no idea.

24 Q. Do you know if Ms. Zoelbel was
25 consulted? 14:31:14

1 A. I'm not sure. 14:31:17

2 Q. Did you talk to the coroner on the

3 phone or were you in person with him?

4 A. On the phone.

5 Q. How did it come that you were 14:31:25

6 talking with the coroner?

7 A. There was some mix-up and -- there

8 was some mix-up that occurred. I originally

9 had been informed that Lorna was being

10 transported to Lake East Hospital and I 14:31:44

11 contacted Lake County coroner I believe at the

12 request of the MUI, we have a consultant or had

13 a consultant through the state and at some

14 point in all of that I spoke with her, she

15 thought an autopsy was necessary, and I called 14:32:10

16 Lake County coroner.

17 They had no record of Lorna, they

18 have didn't know anything about it. When I

19 presented, and I don't remember the lady's

20 name, to her, she said that she thought it was 14:32:20

21 suspect enough that Lake County would do an

22 autopsy.

23 I then found out that Lorna, in

24 fact, was not in Lake County, that she had gone

25 to Geneva Hospital and that it would be the 14:32:35

1 Ashtabula County coroner. The state consultant
2 that we had at that time for the MUI suggested
3 that we get the autopsy and that's when I made
4 the request.

14:32:38

5 Q. Who was the state consultant?

14:32:53

6 A. Roxanne Smith.

7 Q. What's her job?

8 A. She was the MUI -- they divided
9 into districts at the state level and Roxanne
10 would be the MUI contact person, kind of our
11 consultant for is this an MUI, is it not an
12 MUI, those kinds of things. I'm blanking out
13 here.

14:33:10

14 Q. That's all right. When did you
15 first contact Ms. Smith regarding Lorna
16 Moeller?

14:33:27

17 A. It would have been the 4th.

18 Q. After you met with the folks at
19 Eastwood?

20 A. Yes.

14:33:34

21 Q. So you meet with the folks at
22 Eastwood. At that meeting one of the things
23 Ms. Busch tells you is she asks you to help
24 with the funeral arrangements, correct?

25 A. She let me know that I needed to

14:33:47

1 make them, that she wasn't available. 14:33:48

2 Q. You agree to do that?

3 A. I went over.

4 Q. You called for a consultation with
5 your MUI consultant with the state? 14:33:58

6 A. Yes.

7 Q. That consultant says get an
8 autopsy?

9 A. Yeah.

10 Q. And this may have come out in your 14:34:04
11 answer but just so I'm clear now, and her
12 rationale for the autopsy was what?

13 A. A bowel obstruction did not seem to
14 be a natural cause of death to her.

15 Q. You then you are told Lorna's going 14:34:25
16 to Lake County, you speak with someone in the
17 Lake County coroner's office?

18 A. Uh-huh.

19 Q. Yes?

20 A. Yes. I'm sorry. 14:34:36

21 Q. Was that a physician, somebody who
22 answered the phones? Do you know who you
23 talked to, the category of the person you
24 talked to?

25 A. I don't remember the lady's name. 14:34:42

1 Q. Do you know if that lady was a doc
2 or if that lady was someone who answered the
3 phone?

14:34:44

4 A. I'm not sure.

5 Q. All she told did you was no Ms.
6 Moeller here?

14:34:53

7 A. Right.

8 Q. Then you contact the Ashtabula
9 County coroner?

10 A. Yes.

14:35:03

11 Q. And you speak with a physician,
12 male physician in Ashtabula, correct?

13 A. I'm not sure if he was a physician.

14 Q. That person tells you we don't
15 think there's a need for an autopsy?

14:35:16

16 A. Correct.

17 Q. When you're told that information,
18 which is contrary to the state consultant's
19 advice, what do you do?

20 A. There wasn't much I could do, he
21 said he wasn't going to do an autopsy.

14:35:27

22 Q. Do you know if he had talked to
23 anyone prior to making that decision about no
24 autopsy?

25 A. I don't know.

14:35:39

1 Q. At this point we're still on
2 February 4th, correct?

14:35:42

3 A. Yes.

4 Q. Have you spoken with Carol Zoelbel?

5 A. There was like a three-way

14:35:52

6 conversation. Carol and her husband were in
7 Texas, they were out of state, and there was
8 difficult -- they had trouble getting a hold of
9 them to notify them of Lorna's death, and they
10 -- well actually at the time they had trouble
11 getting a hold of her regarding Lorna being at
12 the hospital and on a respirator and they
13 finally got a -- I believe LuAnne finally got a
14 hold of Mr. Zoelbel and then she somehow set up
15 a three-way conversation so we could discuss
16 what they wanted to do in terms of the
17 respirator. But that was the only conversation
18 -- there was no conversation with Carol that
19 particular day, it was with Hank and it was
20 regarding --

14:36:19

14:36:41

14:36:57

21 Q. You were part of that three-way
22 conversation with Hank when you informed LuAnne
23 to have a DNR, to take her off the ventilator?

24 A. Yes.

25 Q. The autopsy was not discussed at

14:37:14

1 that point?

14:37:16

2 A. No.

3 Q. When was Lorna's funeral?

4 A. Oh, a couple days later.

5 Q. After making the funeral

14:37:38

6 arrangements, talking to the various coroners,

7 did you do anything else with regard to your

8 investigation on the 4th of February?

9 A. No.

10 Q. Tell me about the remainder of your
11 investigation.

14:37:48

12 A. I filed the initial report with the
13 state.

14 Q. Let me just get a handle on
15 terminology. The initial report, would that be
16 the initial major unusual incident report?

14:37:57

17 A. Yes. Yes.

18 Q. Would Eastwood be copied on that?

19 A. No.

20 Q. Do you remember what was in that
21 report?

14:38:07

22 A. That Lorna had passed away, pretty
23 much that, I mean, the initial report that's --
24 that she had been vomiting and that she had
25 passed away and then had the times.

14:38:25

1 Q. When you say "the times" you mean
2 what?

14:38:26

3 A. The time of death, the time that
4 the paramedics were called, those kinds of
5 things.

14:38:34

6 Q. After submitting that initial
7 report and prior to responding to the questions
8 that are set forth in the exhibit in front of
9 you what does your investigation consist of?

10 A. I believe -- I believe this was the
11 next part of the investigation.

14:38:50

12 Q. Are there any conversations between
13 February 4th and May 9th, 2000 with anybody
14 from Eastwood regarding Lorna Moeller?

15 A. Oh, I went out and spoke with the
16 third shift staff, was that the next night? It
17 was either -- I believe it was the next night,
18 I'm not completely sure on that, after Lorna
19 died.

14:39:11

20 Q. Do you remember who was on the
21 third shift staff?

14:39:31

22 A. Marquita and there was one other
23 lady whose name I don't remember.

24 Q. Marquita Burton?

25 A. Yes.

14:39:45

1 Q. Prior to this incident with Ms. 14:39:46
2 Moeller had you met Ms. Burton?

3 A. I may have met her, I don't know, I
4 mean, working out there, you know?

5 Q. Right, you may have passed her. 14:39:58
6 I'm looking for: Did you have a relationship
7 with her where you would have known who she was
8 and dealt with her on any other incident?

9 A. No.

10 Q. Do you remember what Ms. Burton 14:40:08
11 told you?

12 A. Well it's in my report, I believe
13 it is. She reported that Lorna had been up
14 vomiting, most of the night she was pretty
15 uncomfortable, that the bedding and her 14:40:26
16 clothing was changed two, three times. She had
17 contacted the nurse on several occasions to
18 report Lorna's condition. I remember her
19 saying that Lorna kept coming out saying that
20 this was it, she was going to meet her maker, 14:40:43
21 some term like that.

22 Q. Did you take notes of this meeting?

23 A. I probably took some notes.

24 Q. Was anyone else present?

25 A. No. 14:41:04

1 Q. So this was with the two resident 14:41:10
2 care workers?

3 A. Just Marquita. The other staff
4 left, they went somewhere.

5 Q. Did you subsequently talk with the 14:41:20
6 other staff members?

7 A. No.

8 Q. Did you interview, other than Ms.
9 Burton, Ms. Warner, Ms. Busch, Ms. Reigert and
10 Ms. Schubert, did you interview anyone else 14:41:41
11 from Eastwood?

12 A. There was a second shift staff Rita
13 that took her to the hospital or took her to
14 the Urgent Care.

15 Q. Rita Freeborn? 14:41:54

16 A. Yes.

17 Q. What did Rita tell you?

18 A. I believe she told me that she
19 was -- that Lorna was very uncomfortable and
20 that she had taken her to the Urgent Care. 14:42:05

21 Q. Did you interview Ms. Freeborn
22 while she was still working with Eastwood?

23 A. Yes.

24 Q. Did she tell you anything else in
25 that first interview? 14:42:20

1 A. Not that I recall. 14:42:25

2 Q. Was anyone else present at that
3 interview?

4 A. I don't -- I don't remember anybody
5 else. 14:42:36

6 Q. As far as being an administrator of
7 one of these homes, are there any county,
8 state, federal regulations regarding
9 qualifications?

10 A. To be an administrator? 14:42:46

11 Q. Yes.

12 A. I don't know.

13 Q. You never cited Ms. Busch regarding
14 her qualifications? As far as you know Ms.
15 Busch was never cited for being unqualified as
16 an administrator? 14:43:02

17 A. Oh, yeah, that did come up once.

18 Q. When?

19 A. I believe it was right after she
20 had started. 14:43:15

21 Q. She was there for eight years when
22 Lorna passed away; is that your understanding?

23 A. I wouldn't remember that.

24 Q. Was she there when you became the
25 major unusual incident specialist? 14:43:28

1 A. You know, that's difficult because
2 there was a period of time where there was a
3 lot of people.

14:43:34

4 Q. Tell me about the qualifications
5 issue.

14:43:42

6 A. My supervisor and myself were
7 meeting with Jim Victor and LuAnne, and from
8 what I remember it was the first time -- she
9 had like just come on, my supervisor had
10 questioned the qualifications, her
11 qualifications.

14:44:00

12 Q. And Mr. Victor was present with Ms.
13 Busch and they set forth what her
14 qualifications were and your supervisor asked
15 questions about it; fair enough?

14:44:13

16 A. What I recall is that Jim said that
17 he was going to be the administrator for the
18 year that it took for her to get whatever
19 qualifications, what she needed.

20 Q. Following that meeting were there
21 ever any questions from the folks in charge of
22 regulating, state, county, federal, regarding
23 Ms. Busch's qualifications that you recall?

14:44:34

24 A. Not that I'm aware of. That's not
25 something I personally would --

14:44:49

1 Q. Right. I'm looking for your
2 knowledge.

14:44:51

3 So after the meeting with Ms.
4 Freeborn did you meet with any folks at
5 Eastwood prior to May 9th when Mr. Angel
6 submitted a list of questions?

14:45:06

7 A. I don't believe so.

8 Q. In that time period, February 4th
9 to May 9th, did you review Eastwood's incident
10 reports?

14:45:27

11 A. Which incident reports?

12 Q. The incident reports involving the
13 events leading up to Lorna Moeller's death.

14 A. I would have reviewed those. That
15 would have been part of the initial.

14:45:42

16 Q. Either on that first meeting or
17 when you came out again to talk to Ms. Burton
18 and Ms. Freeborn?

19 A. Somewhere in there.

20 Q. Other than your sending off the
21 major unusual incident report to the state
22 shortly after Ms. Moeller's death did you
23 prepare any other written document prior to
24 getting a list of questions from Mr. Angel?

14:45:58

25 A. I believe there was one other major

14:46:14

1 unusual incident report that was filed 14:46:16
2 regarding -- gosh, I got to think about that.
3 There was another incident -- a major unusual
4 incident report filed regarding the amount of
5 time, I think, that was different, the amount 14:46:45
6 of time in between when she got medical care
7 and when she passed away, there was some
8 additional information.

9 Q. That was filed by you?

10 A. Yes. 14:46:59

11 Q. When you say that was different,
12 what do you mean?

13 A. There were a couple consumers that
14 had reported to one of the staff, one of the
15 case management staff that Lorna was 14:47:09
16 uncomfortable, she was crying out for help,
17 nobody would help, and we had to check into
18 that.

19 Q. How did that information make its
20 way to you? 14:47:22

21 A. The consumers reported to the other
22 case manager.

23 Q. And the other case manager?

24 A. Came back to me.

25 Q. I need her name or his name. 14:47:31

1 A. Her name, Judy Ketchum. 14:47:34

2 Q. Did you investigate the information

3 that was relayed to you by Ms. Ketchum?

4 A. Yes.

5 Q. How did you investigate it? 14:47:43

6 A. I spoke with the two ladies.

7 Q. What did the two ladies tell you?

8 A. Pretty much what I just told you,

9 that they reported that she was screaming out,

10 that nobody would help her, that she was in a 14:48:00

11 lot of pain.

12 Q. Who are these two ladies?

13 A. Anna Pressern.

14 Q. How do you spell Anna's last name?

15 A. P-R-E-S-S-E-R-N. 14:48:18

16 MR. KRAUSE: I'm sorry, I don't

17 mean to interrupt. It sounded like there were

18 two questions and I don't know if I looked down

19 and I missed the answer to the first. You

20 asked what night and then what ladies; was 14:48:25

21 there an answer that I missed?

22 MR. FORBES: No.

23 MR. KRAUSE: I'm sorry, okay.

24 MR. FORBES: That's fine, I just

25 may have -- 14:48:35

1 MR. KRAUSE: That's fine. 14:48:36

2 Q. And the second lady?

3 A. Ruth Fineman.

4 Q. Do you know where these ladies'

5 rooms were, are? 14:48:49

6 A. I don't know where they are now.

7 Q. Where were they at the time?

8 A. I'm not -- let me think.

9 I don't know where their rooms are.

10 Q. Did you include that in the second 14:49:12

11 major unusual incident report?

12 A. Yes.

13 Q. When did you go out to talk to

14 these two residents?

15 A. It would have been probably the 14:49:25

16 next day after I got the original report -- the

17 original statement -- report from Judy.

18 Q. Do you know when that was?

19 A. I don't remember.

20 Q. Is Judy still around? 14:49:39

21 A. Yes.

22 Q. Where does Judy work?

23 A. She works at the residence,

24 Deepwood Center Residence.

25 Q. How do you spell her last name? 14:49:50

1 A. K-E-T-C-H-U-M. 14:49:52

2 Q. Did you speak with anyone at

3 Eastwood -- let me start again.

4 Did you speak to these folks, Ms.

5 Pressern and Ms. Fineman, prior to May 9th of 14:50:05

6 2000?

7 A. Yeah, I believe it was before that.

8 Q. Do you have any idea of when you

9 spoke to them?

10 A. I'm not sure. 14:50:20

11 Q. Do you know when they were claiming

12 Lorna was calling out?

13 A. Before she died. Before she died

14 is what they're saying, that they --

15 Q. Do you know when? 14:50:30

16 A. Do you want a date? February 3rd.

17 Q. I want to know somewhere within the

18 time frame of when she died when these folks

19 were saying they heard the yelling.

20 A. It would have been within a couple 14:50:47

21 days after Lorna's death, maybe within a week,

22 I'm not sure.

23 Q. So sometime within a week before

24 Lorna passing away?

25 MR. KRAUSE: Objection. You're not 14:51:04

1 connecting --

14:51:08

2 A. Yeah.

3 Q. When did the folks tell you Lorna
4 was yelling out for help?

5 A. It would have been within a week
6 after she died.

14:51:13

7 MR. KRAUSE: You're still
8 not connecting them.

9 MR. FORBES: I understand. I
10 understand. I was connecting on that question.

14:51:21

11 Q. Now when did the folks say what
12 time was Lorna yelling out?

13 A. They wouldn't say a time but they
14 were saying from the time she returned from the
15 hospital to the time she died.

14:51:40

16 Q. When you received this information
17 did you talk to the people at Eastwood about
18 it?

19 A. I don't remember.

20 Q. As part of a normal investigation
21 if you were hearing information that people
22 were ignoring cries for help it would be part
23 of your practice to talk to folks and get a
24 response?

14:51:59

25 A. Yes.

14:52:09

1 Q. But you don't specifically remember
2 talking to them?

14:52:09

3 A. After I went out and spoke to
4 Marquita --

5 Q. Correct.

14:52:18

6 A. -- I always want to say Margarita
7 -- I received a page the following morning from
8 Marquita saying that no one was allowed to talk
9 to me anymore, that LuAnne was very upset that
10 I'd come out and spoken with her, so it kind of
11 got -- I don't know what word to use -- I don't
12 know what -- I'm not sure what to say, what
13 word to use, but it kind of got -- the staff
14 weren't going to talk to me and I was aware of
15 that so there might not -- it got weird.

14:52:38

14:53:04

16 Q. Did you talk to Ms. Busch before
17 going out to see Ms. Burton to speak with her?

18 A. I spoke to her earlier in that day.
19 Did I tell you I was going out to --

20 Q. Yes.

14:53:24

21 A. No.

22 Q. Did you communicate to anyone that
23 Ms. Burton had told you Ms. Busch had said that
24 staff couldn't talk to you?

25 A. Anyone --

14:53:33

1 Q. Anybody above you who could help 14:53:34
2 you with your investigation if people were not
3 going to respond to you.

4 A. I probably notified my supervisor,
5 I don't know. 14:53:43

6 Q. A statement like that, we're not
7 going to cooperate, would that usually be
8 documented somewhere?

9 A. I don't know. I don't have it
10 documented. 14:54:03

11 Q. In response to Ms. Burton telling
12 you that she was told by Ms. Busch not to speak
13 with you, what did you do to continue your
14 investigation?

15 A. Well, it was about that time that 14:54:21
16 I -- well, no, it would have been earlier.

17 Q. Do you know when Ms. Burton made
18 this call?

19 A. To me?

20 Q. To you. 14:54:31

21 A. The day after I interviewed her.

22 Q. So sometime still early February?

23 A. Yeah, it was the day after I
24 interviewed her.

25 Q. And you said she paged you? 14:54:46

1	A.	Uh-huh.	14:54:47
2	Q.	Then you called her back?	
3	A.	Yes.	
4	Q.	Where was she when you called her	
5		back?	14:54:56
6	A.	I believe it was a home number. It	
7		was not an Eastwood number.	
8	Q.	Did you ever visit any of the	
9		Eastwood folks outside the Eastwood home, meet	
10		them at their houses or some other places?	14:55:10
11	A.	Staff? (Shaking head negatively.)	
12	Q.	No?	
13	A.	No.	
14	Q.	Prior to that February 9th list of	
15		questions did you ever talk to Rita Freeborn	14:55:29
16		outside of Eastwood?	
17	A.	No.	
18	Q.	After talking -- were any Eastwood	
19		people present when you spoke with the	
20		residents?	14:55:58
21	A.	You mean Anna and --	
22	Q.	Ruth.	
23	A.	-- Ruth? No.	
24	Q.	What time of day was that meeting?	
25	A.	I'm guessing afternoon, I don't	14:56:14

1 really remember.

14:56:15

2 Q. And you relayed that information as
3 part of a major unusual incident report to the
4 state?

5 A. Yes.

14:56:23

6 Q. What was their response?

7 A. I don't recall a response.

8 Q. Did it concern you that there was
9 no response to these allegations?

10 A. No.

14:56:35

11 Q. How long did you meet with the two
12 residents?

13 A. Maybe 20, 30 minutes.

14 Q. Did you ever talk to them again
15 about this incident?

14:56:56

16 A. No.

17 Q. Did you speak with them separately
18 or together?

19 A. Separately.

20 Q. And no one else was present but you
21 and the resident?

14:57:10

22 A. Correct.

23 MR. SCHALTENBRAND: Steve, is this
24 a good time to take a break?

25 MR. FORBES: If you want one you

14:57:21

1 can have one, yes.

14:57:22

2 MR. SCHALTENBRAND: How much longer
3 do you have?

4 MR. FORBES: It's going to be a
5 while.

14:57:25

6 MR. SCHALTENBRAND: Why don't we
7 take a break?

8 (Discussion had off record.)

9 (A recess was taken.)

10 Q. I just want to make sure I clarify
11 because I think my questioning wasn't crystal.

15:09:16

12 The folks were telling you they
13 heard Lorna crying out sometime during the
14 night: Was it the night before she died, was
15 it the night before that? Were they specific
16 in any way?

15:09:29

17 MR. KRAUSE: Objection.

18 You can answer.

19 A. I'm sorry?

20 Q. He objected.

15:09:38

21 MR. KRAUSE: From time to time I
22 might object, it has nothing to do with how you
23 should respond. Go ahead, please.

24 THE WITNESS: Okay.

25 A. Would you repeat your question?

15:09:52

1 Q. I'll try to do better. Can you
2 specify for me when these folks were saying
3 Lorna was crying out?

15:09:54

4 A. As I recall, Ruth reported that
5 from the time she came home from the hospital
6 until the time she died she was saying that she
7 was crying, that she was in pain.

15:10:09

8 Q. What about --

9 A. Anna.

10 Q. Anna, thank you.

15:10:27

11 A. I don't remember that Anna gave a
12 specific.

13 Q. Is Ruth still at the home?

14 A. Yes.

15 Q. Did Ruth talk to any of the
16 resident care workers about it, did she relate
17 that to you?

15:10:38

18 A. I don't know.

19 Q. Do you have an understanding of
20 Ruth's level of mental retardation?

15:10:46

21 A. I believe it's mild or moderate
22 retardation.

23 Q. How many residents were at Lorna's
24 home at that time; do you know?

25 A. How many people lived there?

15:11:02

1 Q. Yes. 15:11:03

2 A. There was ten in the front part of
3 the house and 11 in the back part.

4 Q. Did you talk to any of the other
5 residents about this? 15:11:14

6 A. No.

7 Q. Why not?

8 A. Either based on functioning level,
9 they wouldn't have known, and the other people
10 hadn't reported anything. 15:11:28

11 Q. Of the people who were functioning
12 -- the people you assessed who would have a
13 functioning level that would know, did you talk
14 to any of those folks?

15 A. No, only the two that made the
16 original statements. 15:11:37

17 Q. Do you have a recollection as you
18 sit here today where Anna and Ruth's rooms were
19 in relation to Lorna's?

20 A. You know, I really don't remember. 15:11:47

21 Q. Did you take that into
22 consideration in assessing their statements?

23 A. Yes. I believe at that time Anna
24 was up a lot during the night and she would sit
25 in that living room which is right off -- 15:12:06

1 Lorna's bedroom is right off from the living
2 room and Anna would be up watching TV or
3 whatever during the night because for some
4 reason she wasn't sleeping a lot from what I
5 recall and Ruth -- I really don't remember.

15:12:10

15:12:21

6 Q. With regard to Anna, did you talk
7 with her, well she's up late at night in the
8 middle of the night hearing Lorna complain or
9 hearing Lorna indicate she's in pain, did you
10 ask Anna what she did, did she go talk to
11 somebody?

15:12:34

12 A. I don't recall.

13 Q. I asked this with regard to the
14 other folks: Did you take notes of these
15 conversations with Anna and Ruth?

15:12:54

16 A. I don't recall.

17 Q. So other than the time you're out
18 there on the day of Lorna's death and then I
19 think we have three other visits, once to talk
20 to Ms. Burton and the other care worker, once
21 to talk to Ms. Freeborn and once to talk to the
22 two other residents, other than those trips did
23 you go out to see anyone of these four prior to
24 May 9th of 2000 when you get the list of
25 questions to respond to?

15:13:20

15:13:38

1 A. I don't recall going out. 15:13:39

2 Q. Is there any kind of log or record

3 that you keep that would keep track of what you

4 did on your investigations? Are you required

5 to fill anything out that says I went here, 15:13:57

6 here, here, did this, that?

7 A. That would be in our case notes.

8 Q. Do you maintain those case notes?

9 Does Deepwood maintain the case notes?

10 A. Thank you. Yes. 15:14:08

11 Q. To your knowledge do those case

12 notes still exist?

13 A. Yes.

14 Q. Typically what would be in case

15 notes? 15:14:16

16 A. The time, the service provided.

17 Q. What's the purpose of maintaining

18 the case notes?

19 A. Other than being good practice it's

20 also -- they were also used for billing. 15:14:39

21 Q. Why is it good practice?

22 A. For scenarios like this.

23 Q. So the purpose is you would have a

24 record so if anybody else wanted to look in and

25 assess what was done they don't have to rely on 15:14:53

1 people's recollections or what they say in 15:14:56
2 retrospect, they'd have something to look at in
3 records that were contemporaneous that are
4 accurate, right?

5 A. Right. Correct. It's more for us, 15:15:13
6 but --

7 Q. Well if you for any reason had to
8 look back to assess what happened you can look
9 back and rely on your notes to help folks; fair
10 enough? 15:15:21

11 A. That's fair.

12 Q. This exhibit 1, I just want to try
13 to identify the players here. Alfriede Roman
14 is also known as Alfie Roman?

15 A. Yes. And it's also Ms., not Mr. 15:15:30

16 Q. That I knew.

17 A. Okay.

18 Q. Proving the state is fallible. Is
19 she still around?

20 A. Yes. 15:15:41

21 Q. What's her current position?

22 A. Superintendent.

23 Q. And then who's Mr. Angel?

24 A. The assistant deputy director for
25 the Ohio Department. 15:15:52

1 Q. Do you know if he's still around? 15:15:53
2 A. I believe so.
3 Q. What is the community MUI registry
4 unit?
5 A. That's the department at the state 15:16:02
6 level that does all the follow through with
7 MUIs.
8 Q. They refer in the first paragraph
9 to a major unusual incident case. What would
10 the folks at the state be reviewing typically 15:16:25
11 in an MUI situation? Do you understand what
12 I'm asking for?
13 A. No.
14 Q. They would have your report or
15 reports, correct? 15:16:40
16 A. Correct.
17 Q. What other stuff do they gather
18 before getting back to you like they did?
19 A. They would -- actually they would
20 request of us any additional information that 15:16:52
21 they needed.
22 Q. Now were these 25 questions
23 communicated to you by Ms. Roman?
24 A. This was sent to the director, the
25 case management director, David Miller, who 15:17:09

1 gave them to me.

15:17:11

2 Q. Did he give them to you with any
3 instructions?

4 A. No.

5 Q. Did he give them to you with any
6 other information?

15:17:18

7 A. No.

8 Q. If you go to the bottom here, can
9 we just identify --

10 A. The bottom?

15:17:25

11 Q. The cc.

12 A. Oh, okay.

13 Q. Do you know who the folks
14 identified here are?

15 A. Only by --

15:17:42

16 Q. Let me just stop you. Do you know
17 who Dr. Eddy is?

18 A. He's the medical director.

19 Q. Do you know him?

20 A. No, I don't know him personally.

15:17:50

21 Q. As part of your job would you ever
22 have any contact with these folks that are
23 copied here?

24 A. No.

25 Q. You get these questions, you're

15:18:01

1 charged with the responsibility of getting
2 answers?

15:18:05

3 A. Correct.

4 Q. What do you do?

5 A. I set up an appointment with LuAnne
6 to go out there and review these questions.

15:18:09

7 Q. Did LuAnne agree to meet with you?

8 A. Yes, she did.

9 Q. Did you ever talk to LuAnne about
10 her purported instruction not to have her folks
11 speak with you?

15:18:19

12 A. No, I did not.

13 Q. Why not?

14 A. The staff person was concerned when
15 she paged me that she would lose her job if
16 LuAnne knew that she had spoken to me.

15:18:37

17 Q. As an employee of the county
18 charged with the responsibility of monitoring
19 group homes did you tell her -- did you give
20 her any reassurance that you could act to
21 prevent that from happening?

15:18:51

22 A. No, because I couldn't.

23 Q. Could you give anyone who was
24 concerned about reporting information to you
25 any reassurance that the state wouldn't let

15:19:03

1 someone fire them for simply talking to a
2 regulator?

15:19:07

3 A. No, I couldn't give them that.

4 Q. What happens after you talk to
5 LuAnne, she agrees to meet with you?

15:19:20

6 A. We set up an appointment and I went
7 out and spoke with her and Julie. I let her
8 know that most of the questions were questions
9 that Julie would probably have answers to.

10 Q. Was anyone else there?

15:19:37

11 A. I'm thinking Lisa. Lisa and
12 Stacey, I think.

13 Q. I'll show you what we'll mark as
14 exhibit 2.

15 - - - - -

16 (Thereupon, Defendant's Deposition
17 Exhibit 2 was marked for purposes of
18 identification.)

19 - - - - -

20 Q. Can you identify exhibit 2 for me?

15:20:21

21 A. This was my response to Bill Angel
22 regarding his questions.

23 Q. In answering these questions you
24 met with the people at Eastwood on one
25 occasion, the 23rd of May, correct, people

15:20:41

1 still working at Eastwood?

15:20:46

2 A. Yes.

3 Q. The people identified as Julie

4 Warner, Lisa Schubert, Stacey Reigert and

5 LuAnne Busch --

15:20:56

6 A. Yes.

7 Q. -- are those all the people you met

8 with at Eastwood?

9 A. Yes.

10 Q. Did you ask to meet with Ms.

15:21:00

11 Burton?

12 A. No.

13 Q. Why not?

14 A. For this question --

15 Q. Yes.

15:21:10

16 A. -- or when I went out that night?

17 Q. Now that we're in May and you're

18 charged with the responsibility of answering

19 the questions did you ask to meet with Ms.

20 Burton?

15:21:19

21 A. No.

22 Q. Why not?

23 A. I don't know.

24 Q. Did you ask to meet with Ms.

25 Freeborn?

15:21:31

1 A. No. 15:21:32

2 Q. And of this meeting I assume -- did

3 you take notes, the May 23rd meeting?

4 A. Yes.

5 Q. And you don't have those notes? 15:21:42

6 A. Well they'd be in here, they would

7 be answers to these questions.

8 Q. The handwritten notes that you took

9 actually when you were listening to the people

10 talk, you didn't save those? 15:21:53

11 A. No.

12 Q. And a day before --

13 A. I'm sorry.

14 Q. I'm sorry, go ahead.

15 A. Once these reports were written 15:22:00

16 then it's just extra paper.

17 Q. A day before you had met with Ms.

18 Irwin and --

19 A. Yes.

20 Q. -- the nurse? 15:22:18

21 A. I don't know how to pronounce it.

22 Q. Man or woman?

23 A. Woman.

24 Q. What did they tell you? Do you

25 remember independently as you sit here today 15:22:26

1 what those folks told you about Ms. Moeller?

15:22:28

2 A. I would refer to my notes.

3 Q. Did Nurse Dieglio --

4 MR. KRAUSE: Alaki Dieglio.

5 Q. Did Nurse Dieglio explain to you
6 what specific after-care instructions she told
7 the nurse at Eastwood?

15:22:48

8 A. No.

9 Q. Did you ask?

10 A. I believe I asked for a copy of it,
11 of whatever they had written.

15:23:07

12 Q. Do you remember if Nurse Dieglio
13 ever explained to you if there were ever any
14 communications different or in addition to what
15 was written or provided to you?

15:23:30

16 MR. KRAUSE: Objection to form.

17 A. I remember her being concerned that
18 there was nobody there at the hospital and that
19 she had called to the nurse because of Lorna's
20 functioning, she didn't want to send it home
21 with her without communication.

15:23:45

22 Q. So she wasn't concerned and she
23 called and told the nurse what?

24 A. Whatever the instructions were
25 written out.

15:23:57

1 Q. So it's your recollection Nurse
2 Dieglio told you that she informed Ms. Warner
3 what the instructions were by referring to the
4 document and what was already written out?

15:23:59

5 A. I believe so.

15:24:08

6 Q. Was there any reason if Nurse
7 Dieglio -- let me try again.

8 Did you ask Nurse Dieglio if she
9 was concerned about no one from Eastwood being
10 there why she didn't wait for someone?

15:24:22

11 MR. KRAUSE: Objection to form.

12 A. Say it again.

13 Q. Nurse Dieglio told you she was
14 concerned that there was no one from Eastwood
15 at the hospital, correct?

15:24:31

16 A. Correct.

17 Q. Did you ever ask her if she
18 considered waiting for someone from Eastwood to
19 be there?

20 A. I believe that they understood that
21 no one was going to come from Eastwood.

15:24:44

22 Q. Did you ask her --

23 A. There would be no reason for her to
24 wait, she knew that they weren't coming.

25 Q. Did you ask her if she ever called

15:24:58

1 back and asked if anyone would be there if they
2 could have someone there, expressed her concern
3 to anyone at Eastwood?

15:25:00

4 MR. KRAUSE: Objection.

5 A. Not that, I wouldn't know.

15:25:04

6 Q. Do you remember anything else that
7 those two, Ms. Irwin and Ms. Dieglio, told you
8 at this meeting?

9 A. No. I remember Ms. Irwin being
10 very helpful in getting all the records
11 together.

15:25:24

12 Q. Anything else?

13 A. (Shaking head negatively.)

14 Q. No?

15 A. No.

15:25:33

16 Q. The meeting with Ms. Warner, Ms.
17 Busch, Ms. Schubert and Ms. Reigert, do you
18 remember anything? What did they communicate
19 to you?

20 A. We went pretty much straightforward
21 down answering these questions.

15:25:46

22 Q. Did you meet with Ms. Freeborn at
23 home or did you call her?

24 A. Now I'm -- I think that Rita may
25 have called me.

15:26:22

1 Q. Where did she call you? 15:26:28

2 A. At my office.

3 Q. How many times did you speak with

4 Rita after the interview at the home and prior

5 to -- 15:26:43

6 A. It wouldn't have been more than

7 once or twice.

8 Q. -- before preparing exhibit 2?

9 Do you remember what Rita told you?

10 A. Not per se. 15:27:06

11 Q. Did you talk about Rita's

12 resignation from Eastwood?

13 A. No.

14 Q. You understood that she had

15 resigned, though, when you spoke with her, 15:27:21

16 correct?

17 A. I don't know.

18 Q. Page one says: "Note: Rita

19 resigned from Eastwood at the end of February"?

20 A. Okay, then I did know. 15:27:32

21 Q. You say: "She was contacted at

22 home by this worker. She is willing to help in

23 any way she can."

24 A. Okay. She must have -- I wouldn't

25 have her number, she must have called me. 15:27:42

1 Q. You don't remember anything she may 15:27:49
2 have said to you in that conversation?

3 A. I really don't right now.

4 Q. Just going through these questions
5 I just want to identify some people. 15:27:58

6 In your response one you say "the
7 hospital nurse reports": Who is that?

8 A. That would have been the name we
9 can't pronounce.

10 Q. Dieglio? 15:28:14

11 A. Dieglio.

12 Q. Two, you identify "an Eastwood
13 nurse reports": Is that Julie Warner?

14 A. That would be Julie.

15 Q. In response to number four you 15:28:46
16 refer to documentation about Lorna's condition
17 throughout the night of the 3rd and the morning
18 of the 4th. Are there any federal, state
19 regulations with regard to things that have to
20 be documented by group homes? 15:29:14

21 A. I don't know if they are
22 regulations -- I don't know if there's
23 regulations.

24 Q. Did this documentation issue result
25 in any kind of censure whatsoever with regard 15:29:34

1 to Eastwood's licensure?

15:29:38

2 A. I'm sorry?

3 Q. Did this documentation issue,
4 whether or not things were documented through
5 the night of the 3rd and into the morning of
6 the 4th, did that result in any inquiries into
7 Eastwood's licensure and any citations?

15:29:47

8 A. I don't know if there were any
9 citations.

10 Q. Number five there, the sentence in
11 the middle that says: "Reportedly, this was
12 after Lorna had vomited 'a large amount of
13 brownish matter.'" This refers to the nurse
14 contacting the doctor's office at six p.m. on
15 2-3?

15:30:10

16 A. Correct.

17 Q. Where did you get the information
18 that Lorna had vomited a large amount of
19 brownish matter?

15:30:30

20 A. From Julie Warner.

15:30:37

21 Q. Is that part of this meeting --

22 A. I believe there's some staff note,
23 too.

24 Q. So it's your recollection that
25 there's a staff note which indicates that

15:30:56

1 sometime before 6:00 on February 3rd a large 15:31:00
2 amount of brownish matter had been --

3 A. I believe there was a staff note.

4 Q. When you prepared answers to these
5 25 questions did you have access to Eastwood's 15:31:14
6 incident reports as well as their records?

7 A. Yes.

8 Q. Is it fair to say that all
9 references throughout these answers that refer
10 to the Lake Hospital nurse refer to Nurse 15:32:02
11 Dieglio?

12 A. Yes. I hadn't spoken to anyone
13 else.

14 Q. Sometimes my question comes from
15 sometimes folks are referred to by their name 15:32:15
16 and sometimes they're given different titles,
17 so I just want to make sure that I know who's
18 talking or being referred to.

19 What was your understanding with
20 regard to question nine as to what that 15:32:58
21 question was asking for?

22 A. What's my understanding?

23 Q. Yes. It says: "Were the staff
24 made aware of signs and symptoms which would
25 indicate a return visit to the hospital was 15:33:15

1 warranted?" Made aware of by whom?

15:33:17

2 A. I'm thinking that that was in
3 relation to Julie having received the after-
4 care reports from the nurse and then there not
5 being any documentation from Julie to the
6 direct care staff.

15:33:37

7 Q. So you answered it -- you were
8 answering the question did Julie make the
9 direct care staff aware of things that would
10 warrant a return trip to the hospital?

15:33:56

11 A. My answer was that there was no
12 documentation available.

13 Q. I know, I'm trying to get a handle
14 on what question you were answering. "Were the
15 staff made aware": "Staff" refers to whom?

15:34:12

16 A. The direct care staff.

17 Q. And that would be different than
18 Julie Warner? Or would Julie Warner be part of
19 the direct care staff?

20 A. No, Julie would be the nurse.

15:34:23

21 Q. Number 13 you refer to residential
22 staff?

23 A. Yes.

24 Q. Who were you referring to there?

25 MR. SCHALTENBRAND: Which?

15:34:54

1 Q. "Residential staff felt that Lorna
2 should've returned to the hospital on 2-3 when
3 vomiting continued."

15:34:56

4 A. That would have been Rita or
5 Marquita.

15:35:07

6 Q. Neither Rita nor Marquita are at
7 the meeting?

8 A. Correct.

9 Q. So is it fair to say then you were
10 answering these questions with information
11 other than information that was provided at the
12 February 23rd meeting with the Eastwood staff
13 and your February --

15:35:16

14 A. That sentence --

15 Q. I butchered my question.

15:35:28

16 Is it fair to say you're answering
17 these questions with information other than
18 information that was supplied to you in meeting
19 with Barbara Irwin and Nurse Dieglio on May
20 22nd and with the Eastwood people the next day,
21 on May 23rd?

15:35:45

22 A. It could have also been either
23 Stacey -- I remember Stacey being more verbal
24 than Lisa, it may have been Stacey also that
25 issued that concern.

15:36:05

1 Q. But you're not sure which of the 15:36:07
2 residential staff?

3 A. Right now, no.

4 Q. In responding to 14 you note that:
5 "Eastwood completes a census check every three 15:36:31
6 hours."

7 What's your understanding of what a
8 census check is?

9 A. That they physically need to see
10 the consumer, that they physically go and check 15:36:40
11 and see that the person is awake, asleep,
12 whatever.

13 Q. Is that a state requirement, they
14 do that kind of census check?

15 A. I don't know if it is for Eastwood. 15:36:53

16 Q. When the folks at Eastwood told you
17 that they had done the check every three hours
18 and their response was okay, sleeping, did you
19 then say that conflicts with what two of your
20 residents have told me about what was going on 15:37:10
21 that night?

22 A. I don't know that the census check
23 conflicts.

24 Q. Did you, in answering this question
25 to the people at the state, indicate that in 15:37:31

1 addition, when they were asking what was going
2 on, in addition to the notes from Eastwood
3 about the condition of Ms. Moeller residents
4 had indicated that she was in pain?

15:37:34

5 A. Did I --

15:37:47

6 Q. In answering this question -- I
7 guess I'm trying to figure out if their things
8 are okay and sleeping, did you ever ask them at
9 all about whether they'd heard these cries of
10 help that the residents had heard?

15:38:01

11 A. Those four people weren't on duty,
12 they wouldn't have heard it.

13 Q. Did you ask them if they had talked
14 to any resident care worker about this issue of
15 someone crying out through the night?

15:38:17

16 A. No.

17 Q. Why not?

18 A. I don't know.

19 Q. Going down to 17 and 18. There's a
20 description from Ms. Freeborn that on the 1st,
21 2nd and 3rd Rita was vomiting -- excuse me,
22 Lorna was vomiting large amounts of brownish
23 bile that was like any vomit.

15:38:52

24 Do I understand what you're saying
25 correctly, is that what's going on? I'm just

15:39:12

1 trying to figure out if there's going to be any 15:39:19
2 ambiguity in some of the things in your report.

3 The way that I read this is that
4 Rita said Lorna's vomiting large amounts of
5 brownish, I'm on the 1st, 2nd and 3rd, that had 15:39:30
6 an odor like any vomit; do I have it right?

7 A. Right.

8 Q. Then Julie reports brownish bile on
9 2-4 and reports a large amount coming out of
10 Lorna's nose and mouth. Do you know what time 15:39:53
11 Julie is saying this is happening?

12 A. She's reporting 2-4. 2-4, it was
13 the day Lorna died. I believe it was somewhere
14 between seven and nine a.m.

15 Q. So if I'm reading your report 15:40:23
16 correctly, and correct me if I'm wrong, the way
17 that I read this is the first time there was
18 obvious fecal matter is when the vomit came out
19 of Lorna's nose and mouth between what you
20 just -- your best estimate is between seven and 15:40:51
21 nine in the morning?

22 A. That's what Julie reported, that's
23 what she observed.

24 Q. And there's some dispute as to when
25 Julie arrived that morning, correct? 15:40:51

1 A. I believe there was.

15:40:53

2 Q. Julie told you it was sometime
3 around seven or a little after, right?

4 A. Right.

5 Q. And then I believe your review of
6 the payroll records show that she punched in at
7 eight?

15:40:58

8 A. I believe there was a discrepancy.

9 Q. And this wouldn't be, my
10 understanding of the payroll, I don't show up
11 and sign a sheet, I would show up and do a time
12 card; is that right?

15:41:08

13 A. I don't know how they do it there.

14 Q. Let me see if I can find it.

15 If we go back to question number
16 six. You note that she, being Julie Warner,
17 reports that it was seven a.m. arrival time.
18 Sign in/payroll records show that she worked
19 eight a.m. to three p.m.?

15:41:27

20 A. Okay.

15:41:44

21 Q. Do you have a recollection what
22 you're referring to as the "sign in/payroll
23 records"?

24 A. Geez, I don't -- I don't remember
25 what it was now.

15:41:55

1 Q. In getting answers -- you reported 15:42:01
2 that Julie reported a large amount of brownish
3 matter prior to calling the physician on
4 February 3rd, 2000, correct?

5 A. February 3rd -- 15:42:55

6 Q. Yes. Let's go back --

7 A. -- 4th?

8 Q. -- to question number five, your
9 response.

10 A. Okay. 15:43:16

11 Q. Did you inquire into if this was
12 just like any other vomit odor or whether it
13 had any peculiar, distinct odor?

14 A. I don't remember.

15 Q. What did you do, you complete this 15:44:03
16 report, you send it off to Mr. Angel?

17 A. Yes.

18 Q. Is there a response from the state
19 to this report?

20 A. Yes. I believe it was actually 15:44:15
21 from Dr. Eddy.

22 Q. We'll mark this, if you could take
23 a look at it, take a look to identify it, and
24 I'll be right back.

25

1 (Thereupon, Defendant's Deposition
2 Exhibit 3 was marked for purposes of
3 identification.)

4

5 (Discussion had off record.)

6 Q. I gave you exhibit 3. Can you
7 identify that for me, please?

8 A. It was the response from Dr. Eddy.

9 Q. Were you given a copy of this
10 response when Dr. Eddy sent it? 15:47:48

11 A. I'm sorry?

12 Q. Did you ever see this?

13 A. Yes.

14 Q. Did you use it in preparing a
15 response to Eastwood? 15:48:13

16 A. Yes.

17 Q. Do you see a date on the memorandum
18 prepared by Dr. Eddy? If not, do you know when
19 he sent it?

20 A. Off the top of my head, no, I 15:48:26
21 don't.

22 Q. Would it have come -- I'm going to
23 show you 4.

24

25 (Thereupon, Defendant's Deposition

1 Exhibit 4 was marked for purposes of
2 identification.)

15:48:31

3 - - - - -

4 A. Yeah, it did come with that, that's
5 what I was looking for.

15:48:41

6 Q. So exhibit 4 then really is part of
7 exhibit 3, I mean they go together?

8 A. Yeah, right, those came together.

9 Q. After you receive the information
10 from Dr. Eddy do you do any further
11 investigation and speak to anyone at Eastwood
12 or the hospital?

15:49:29

13 A. When I received this I wrote up the
14 MUI synopsis letter for Eastwood and scheduled
15 a time to meet with LuAnne to review this
16 report.

15:49:48

17 Q. Did Ms. Busch agree to meet with
18 you?

19 A. She did.

20 Q. Do you have any disagreement with
21 the information conveyed by Dr. Eddy?

15:50:06

22 A. I don't -- no. No, I don't.

23 Q. If we go down, his comments on the
24 responses to question five, he notes: "The
25 staff had documented what I believe to be

15:50:48

1 emesis of fecal material, and I cannot tell if
2 this was communicated to the nurse or to the
3 physician."

15:50:50

4 As you review this do you have an
5 understanding as to what Dr. Eddy is referring
6 to, what staff note he's talking about?

15:51:00

7 A. No, I do not.

8 Q. Did you ever talk with Dr. Eddy
9 about this report?

10 A. No, I did not.

15:51:16

11 Q. Did you ever talk to anyone other
12 than LuAnne Busch about this report?

13 A. Jim Victor was with her and my
14 supervisor was in on that meeting, too.

15 Q. Who's your supervisor?

15:51:27

16 A. It was David Miller.

17 Q. When did Mr. Miller get his
18 position with the county?

19 A. When?

20 Q. Yes.

15:51:45

21 A. I don't know.

22 Q. I guess I'm just looking for very
23 rough ball park. Was it relatively recent or
24 did he have the job a long time before stepping
25 in?

15:52:00

1 MR. SCHALTENBRAND: His position
2 within case management?

15:52:01

3 MR. FORBES: Yes.

4 A. Yeah, I'm not -- maybe -- he may
5 have been there a year, a year and a half, I
6 don't know for sure.

15:52:09

7 Q. Now let's move to the conclusions.
8 The first four conclusions, other than
9 conclusion number three which has to do with
10 the nurse's assessment of the 90 over 60 blood
11 pressure, is it fair to say the other three
12 have to do with improving communication between
13 the nurse at Eastwood and the staff at Eastwood
14 as well as the hospital and Eastwood?

15:52:36

15 A. Yes.

15:52:54

16 MR. KRAUSE: Objection to form.

17 Q. Number one would have to do:

18 "Discharge from the hospital was not
19 coordinated with the direct care staff who
20 would be monitoring Ms. Moeller."

15:53:09

21 Did you take this conclusion to
22 mean that the communication that was at issue
23 here was from people at the hospital to the
24 direct care staff, or Julie Warner and then
25 Julie Warner to the direct care staff?

15:53:20

1 A. I took it to mean that it was
2 fragmented before the direct care -- she came
3 home via ambulance, there was no direct care
4 staff that picked her up to get that
5 information, there was no communication from
6 Julie in the nurse's log to the staff as to
7 what needed to be done.

15:53:23

15:53:38

8 Q. Where would Julie get the
9 information about what needed to be done?

10 A. From the nurse. From the hospital
11 nurse.

15:53:50

12 Q. Do you know what -- regardless of
13 whether it was documented, what did Julie tell
14 you she told the direct care staff?

15 A. I don't know that she -- I don't
16 know that she answered that.

15:54:02

17 Q. Did you ask her?

18 A. I believe so.

19 Q. What did the direct care staff tell
20 you?

15:54:17

21 A. Basically that they kept paging
22 her.

23 Q. I'm talking about the communication
24 after discharge about what the discharge
25 instructions were: Did the direct care staff

15:54:27

1 tell you anything about what Julie told her?

15:54:30

2 A. That was fuzzy. All along that was
3 fuzzy.

4 Q. What do you mean?

5 A. That there was no communication in
6 the log, and that's what we were all relying on
7 in the nursing log, there was no communication
8 from Julie which is what they rely on because
9 they're a 24/7 operation and Julie's not there
10 all of those hours.

15:54:36

15:54:53

11 Q. I'm trying to just look for what
12 they told you with regard to what Julie told
13 them on the discharge.

14 A. I don't believe that -- other than
15 the one reference where Julie was paged and she
16 said she'd check with them in the morning I
17 don't believe there was any other conversation
18 regarding staff and Julie's communication.

15:55:10

19 Q. If we go to number eight on your
20 responses to the questions.

15:55:35

21 MR. SCHALTENBRAND: Which exhibit,
22 Steve?

23 MR. FORBES: I'm sorry, it's 2.

24 A. The staff did not recall receiving
25 anything from the driver. Yeah, they received

15:55:54

1 it verbally from Julie.

15:55:57

2 Q. What I'm trying to distinguish is
3 the form versus oral communications, okay? So:
4 "Staff when interviewed did not recall
5 receiving any after-care forms from the
6 ambulance driver upon Lorna's return. Staff
7 believed they received this information from
8 Julie verbally."

15:56:09

9 So what the staff told you was
10 Julie told them what the after-care
11 instructions were; is that correct?

15:56:22

12 A. Yes.

13 Q. So we have then a chain of events
14 that is Nurse Dieglio calls Nurse Warner, tells
15 the after-care instructions, Nurse Warner tells
16 the staff what the after-care instructions
17 were; is that your understanding?

15:56:35

18 A. That's my understanding.

19 Q. And that chain of oral
20 communication, that didn't violate any county,
21 state or federal regulation with regard to how
22 group homes are supposed to handle discharges
23 from hospitals?

15:56:51

24 A. Not to my knowledge.

25 Q. Conclusion number five, that had

15:57:26

1 nothing to do with Eastwood, correct?

15:57:28

2 MR. SCHALTENBRAND: That's exhibit
3 3?

4 MR. FORBES: I'm back to exhibit 4,
5 I apologize.

15:57:35

6 A. Correct.

7 MS. TOSTI: Exhibit number 4 I
8 think was identified as the medical director's
9 mortality review, so are you referring to
10 another exhibit?

15:57:49

11 MR. FORBES: I'm referring to
12 the --

13 MS. TOSTI: Why don't you read the
14 title off of it or give a date or something so
15 we --

15:57:57

16 MR. FORBES: Lorna Moeller
17 mortality review.

18 THE WITNESS: It's the memo.

19 MS. TOSTI: So you're referring to
20 the memo from Dr. Andy Eddy, M.D. --

15:58:03

21 MR. FORBES: Correct.

22 MS. TOSTI: -- to Mick Ihlenfeld?

23 MR. FORBES: Correct.

24 MS. TOSTI: I think we've marked
25 that as exhibit number 3.

15:58:11

1 MR. FORBES: All right.

15:58:13

2 Q. So on exhibit number 3, number five
3 has nothing to do with Eastwood, correct?

4 A. Correct.

5 Q. On the recommendations that were
6 made is it fair to say that the first three
7 recommendations involve improving communication
8 between the various individuals involved in
9 care when a resident has to be hospitalized?

15:58:39

10 MS. TOSTI: Can I ask what exhibit
11 we're looking at? Because I think there's a
12 difference in recommendations between Dr.
13 Eddy's report and the MUI synopsis.

15:58:55

14 MR. FORBES: I'm on exhibit 3.

15 MS. TOSTI: Okay.

15:59:10

16 Q. Do I need to try my question again?

17 A. Oh, I'm sorry, I was waiting for
18 you to ask a question.

19 Q. Is it fair to say that
20 recommendations one, two and three involve
21 recommendations geared to improve communication
22 between physicians, hospital, resident care
23 workers, Eastwood nurse?

15:59:49

24 A. I believe the intent was to improve
25 the communication with the Eastwood nurse,

16:00:13

1 direct care staff and coordination with the
2 hospital.

16:00:20

3 Q. So as we go to the bottom of three,
4 after outlining all that's in three, what Dr.
5 Eddy says: "This will improve communication
6 between the home and outside medical
7 consultants"?

16:00:29

8 A. Uh-huh.

9 Q. So in addition to improving
10 communication between resident care workers and
11 the nurse, another key recommendation is to
12 improve communication between the home and
13 outside medical consultants; do I got that
14 right?

16:00:36

15 A. That's what he has here.

16:00:49

16 Q. I know that's what he has here, but
17 as you reviewed this and acted upon it that's
18 what you understood it to say, correct?

19 A. Yes.

20 Q. I lost it in the pronoun so I'm
21 just going to clarify. By "that" I meant a key
22 recommendation was to improve communication
23 between the home and outside medical
24 consultants --

16:00:58

25 MR. KRAUSE: Objection to form.

16:01:09

1 Q. -- right? 16:01:10

2 A. Yes.

3 Q. So I'm going to try again.

4 A key recommendation made by Dr.

5 Eddy was to improve communications between the 16:01:14
6 home and outside medical consultants, correct?

7 A. Yes, that's what he has here.

8 Q. Can you give me your understanding
9 of what the fourth recommendation means?

10 A. Dr. Eddy's requesting additional 16:01:47
11 training for the staff. There was a lack of
12 documentation at Eastwood regarding input
13 and -- intake and output. Even though
14 everybody was reporting she was vomiting large
15 amounts, there was nobody that really was able 16:02:07
16 to say, there was no written documentation to
17 support exactly what was happening, what was
18 occurring with her. So there was nothing for
19 the nurse to review, there was nothing for the
20 nurse to send to the doctor. 16:02:23

21 Q. I'm looking for your understanding
22 of what Dr. Eddy meant by: "Direct care staff
23 should be trained in providing basic medical
24 care for persons with specific conditions, on
25 an as needed basis." 16:02:36

1 A. He was looking for additional
2 training or the nurse, as an example, to say
3 this is what we need to do, we need to take her
4 blood pressure every hour, we need to do an
5 input -- an intake and output chart.

16:02:39

16:02:50

6 Q. Is it your understanding here that
7 direct care staff here includes the nurse?

8 A. No.

9 Q. I'm just trying to get an
10 understanding what this sentence means.

16:03:06

11 A. Direct care staff means the staff
12 that works hands-on with the consumers.

13 Q. Right, and we agree with that. So
14 this first recommendation -- he's not talking
15 about something that should be done for the
16 nurse, he's talking about something that should
17 be done for the direct care staff, right?

16:03:19

18 A. Yes.

19 Q. Do you have an understanding of
20 when -- would this training be ongoing
21 depending on a resident gets a specific
22 condition, it's identified, the training comes
23 in and the folks are trained on it as the
24 conditions develop; was that your
25 understanding?

16:03:29

16:03:42

1 A. That specific to client need on an
2 as needed basis.

16:03:43

3 Q. So you might not be able to
4 anticipate that until the clients had the
5 problem?

16:03:53

6 A. Correct.

7 Q. Other than the conclusions and
8 recommendations that are listed in exhibit 3,
9 do you know of any other conclusions and
10 recommendations that the state made with regard
11 to Lorna Moeller's death?

16:04:16

12 A. That the state made, no. I made
13 three or four additional recommendations.

14 Q. Correct. Can the state fine group
15 homes for violations?

16:04:46

16 A. "Fine" as in?

17 Q. Monetary penalty.

18 A. I'm not sure.

19 Q. Do you know if Eastwood was
20 sanctioned in any way as a result of your and
21 the state's investigation into Lorna Moeller?

16:04:58

22 A. I don't know.

23 Q. The form that came that is exhibit
24 4, are you familiar with that form?

25 A. This is the first time I've seen

16:05:18

1 it. This case was the first time I'd seen it.

16:05:20

2 Q. Have you seen it since?

3 A. No.

4 Q. I'll show you number 5.

5 - - - - -

6 (Thereupon, Defendant's Deposition
7 Exhibit 5 was marked for purposes of
8 identification.)

9 - - - - -

10 Q. Can you identify exhibit number 5
11 for me, please?

16:05:55

12 A. This was my report back to LuAnne.

13 Q. Between May 25th and September
14 14th, 2000 did you conduct any additional
15 investigation into Lorna Moeller's death?

16:06:25

16 A. No.

17 Q. Did you provide any other
18 additional information to the state?

19 A. I don't know.

20 Q. Any information you provided would
21 be maintained in your file, though, correct?

16:06:46

22 A. Yeah. Yes.

23 Q. Do you know: To your knowledge did
24 Eastwood -- after this incident and after your
25 MUI synopsis did you continue to be the case

16:07:00

1 manager for Eastwood?

16:07:03

2 A. I wasn't the case manager.

3 Q. I'm sorry. Correct my terminology,
4 whatever you were did your responsibilities
5 toward Eastwood change after your MUI synopsis?

16:07:13

6 A. No.

7 Q. Were you aware of any complaints
8 that Eastwood had made with regard to your
9 potential bias?

10 A. Yes, I was.

16:07:28

11 Q. What was your involvement in those
12 complaints?

13 A. I received a call from legal
14 counsel that they had received a letter.

15 Q. Any communications from an attorney
16 representing you, I'm sorry, you're
17 represented, I don't have to say that, I will
18 say I'm not looking for that, so outside of
19 communications with counsel tell me about this
20 investigation into bias, alleged bias.

16:07:41

16:07:58

21 A. Yeah, that's what I was telling
22 you. The legal counsel called --

23 MR. SCHALTENBRAND: Pat, without
24 saying what you discussed with Joe, are you
25 aware of any investigation into whatever

16:08:09

1 allegations they were?

16:08:12

2 THE WITNESS: No.

3 Q. Do you know what the basis of what
4 the complaint was?

5 A. I was unprofessional -- or I don't
6 know, I never saw anything written on it.

16:08:27

7 Q. After that one conversation you
8 never heard about it again?

9 A. No. I received a copy of a letter
10 that LuAnne had written to Alfie.

16:08:47

11 Q. Was that after you submitted your
12 MUI synopsis?

13 A. Yes.

14 Q. Under "Findings" you basically here
15 repeat what is in exhibit 4, you say: "It was
16 determined that Lorna's death was possibly
17 preventable, if 'bowel obstruction had been
18 diagnosed and treated when present.'"

16:09:20

19 Were you repeating Dr. Eddy's
20 conclusion?

16:09:40

21 A. Yeah, it's in quotations.

22 Q. I understand. I didn't say from
23 whom, that's what I'm trying to sort out.

24 So whatever was meant by "possibly
25 preventable" and "bowel obstruction had been

16:10:01

1 diagnosed and treated when present" we'd have
2 to ask Dr. Eddy about that, correct?

16:10:05

3 A. Correct.

4 Q. Again with the next sentence, "It
5 was determined", you're again relying upon Dr.
6 Eddy's investigation?

16:10:27

7 A. Correct.

8 Q. So it's fair to say then that that
9 conclusion and finding beginning with "It was
10 determined" is not your conclusion and finding,
11 but it's Dr. Eddy's?

16:10:31

12 A. Correct.

13 Q. The first five recommendations,
14 you're basically reiterating Dr. Eddy's
15 recommendations?

16:11:02

16 A. Yes. The first line, number one
17 through five as recommended through the Ohio
18 Department of MR/DD.

19 Q. I understand. But what we're
20 talking about there is Dr. Eddy's
21 recommendations?

16:11:12

22 A. Correct.

23 Q. Then you add three recommendations
24 of your own; is that fair?

25 A. Correct.

16:11:28

1 Q. Number six refers to additional 16:11:39
2 in-service training. Did you receive notice of
3 this -- I'm sorry, yes, it does?

4 A. Yes, it does.

5 Q. Did you receive additional notice 16:11:49
6 of this in-service training as requested?

7 A. As I recall, LuAnne reported that
8 they already received that training in their
9 orientation.

10 Q. Did you question her on that? 16:12:05

11 A. No, I didn't.

12 Q. So in number six then you took
13 LuAnne's -- LuAnne responded that they had
14 received the training, and in your job as
15 investigator for the county you accepted that 16:12:16
16 statement from Ms. Busch, correct?

17 A. I accepted that statement from
18 Busch, from Ms. Busch that they received
19 training during orientation.

20 Q. And you didn't do any additional 16:12:32
21 follow-up to make sure number six was
22 implemented because it already had been?

23 A. Correct. Licensure would follow-up
24 on that also.

25 Q. Correct. So if there were problems 16:12:43

1 with number six and with the training that the 16:12:44
2 staff was receiving there would be some -- it
3 would raise a red flag with licensure?

4 A. Yes.

5 Q. To your knowledge there was, 16:12:54
6 following your MUI synopsis in September of
7 2000, there was no further red flag with
8 licensure --

9 A. I don't know.

10 Q. -- with regard to training? 16:13:02

11 A. I don't know.

12 Q. I'm just looking for your
13 knowledge. To your knowledge there hasn't been
14 any?

15 A. To my knowledge I don't know 16:13:08
16 there's been anything.

17 Q. And you would have been someone
18 involved in monitoring the home from September
19 of 2000 until just recently?

20 A. I would not have been monitoring 16:13:17
21 the home. Another case manager would have.

22 Q. Who is that case manager?

23 A. At the time it would have been --

24 Q. September 2000 until the change at
25 the beginning of the year. 16:13:35

1 A. Yeah. I believe that was Judy
2 Ketchum.

16:13:37

3 Q. What about number seven: "The
4 nurse receive additional training in the
5 handling of medical emergencies and potentially
6 compromising situations"?

16:13:50

7 A. You know, I don't remember.

8 Q. Would you have any responsibility
9 to follow-up on your recommendations or would
10 Ms. Ketchum have that responsibility?

16:14:08

11 A. That actually might be more of a
12 licensure. I don't remember what LuAnne's
13 response was on that either, on that particular
14 issue either.

15 Q. You would have a copy of LuAnne's
16 response in your file, though, correct?

16:14:20

17 A. We should have, sure.

18 Q. After receiving LuAnne's response
19 did you contact her for any additional response
20 and place any additional obligation on her to
21 make any additional changes?

16:14:33

22 A. I don't believe so.

23 Q. "Case management will be notified
24 of any hospitalizations and discharge plans."

25 Does that now happen?

16:14:43

1 A. Yes, that happens.

16:14:58

2 Q. In your tenure at Deepwood are you
3 aware of any other lawsuits that involved
4 Eastwood?

5 A. I'm sorry?

16:15:05

6 Q. In your tenure at Deepwood involved
7 in regulating Eastwood are you aware of any
8 other lawsuits that involved Eastwood?

9 A. No.

10 Q. Following your recommendations made
11 in September of 2000 are you aware of any
12 additional problems that Eastwood had with
13 residents that had to be hospitalized?

16:15:15

14 A. I'm not aware of any, but I wasn't
15 doing the direct day-to-day monitoring at that
16 point.

16:15:34

17 Q. You were still the MUI specialist,
18 correct?

19 A. Right. There was nothing that was
20 MUI that I am aware of.

16:15:42

21 Q. You would be --

22 A. Other than the hospitalizations in
23 and of themselves are reported to the state.

24 Q. Hospitalizations require an
25 incident report which you would review to see

16:15:52

1 if it qualified as a major unusual incident 16:15:54
2 report, correct?

3 A. Correct.

4 Q. Following September of 2000 when
5 you have made your recommendations as to how 16:15:59
6 Eastwood should modify its behavior with regard
7 to hospitalizations and improve communication,
8 are you aware of any incident reports involving
9 an Eastwood resident who was improperly --
10 where Eastwood didn't follow the instructions 16:16:13
11 that you had given?

12 A. I don't recall.

13 Q. Did you speak with Carol Zoelbel
14 after February 4th of 2000?

15 A. Yes. 16:16:36

16 Q. How many times?

17 A. I don't know.

18 Q. Did you meet with her in person?

19 A. Yes, I did.

20 Q. Tell me about that. More than 16:16:43
21 once?

22 A. I believe it was once.

23 Q. Tell me about that meeting.

24 A. I met with her to give her the
25 findings from Dr. Eddy's report. 16:17:04

1 Q. Where did you meet with her? 16:17:07
2 A. Somewhere up by where she lives.
3 Q. Was anyone else present?
4 A. Her husband.
5 Q. So you had to travel about an hour 16:17:18
6 to see her?
7 A. I was on my way to another group
8 home out in Toledo.
9 Q. Tell me about this meeting with Ms.
10 Zoelbel: What was discussed? 16:17:30
11 A. I gave them the report involving
12 Dr. Eddy's conclusion.
13 Q. Did either Mrs. Zoelbel or her
14 husband have questions?
15 A. From what I remember, Mrs. Zoelbel 16:17:47
16 just cried. It was pretty -- it was pretty
17 emotional for her. If they had -- I don't
18 remember if they had specific questions.
19 Q. Other than what was in the report
20 did you tell them anything? 16:18:18
21 A. Anything? I'm not sure what you're
22 referring to.
23 Q. Did you tell them anything about
24 Eastwood, about the care provided, anything
25 whatsoever? 16:18:28

1 A. No. 16:18:28

2 Q. Do you remember when this meeting
3 with the Zoelbels was?

4 A. It would have been after all of
5 this (indicating). I don't recall an exact
6 date. 16:18:46

7 Q. I just want to clarify. Exhibits 3
8 and 4, exhibit 3 is the one that's not dated,
9 correct?

10 A. Yes. 16:19:14

11 Q. This is my mistake, but it couldn't
12 have come with exhibit 4 because exhibit 4 is
13 dated April 12th, correct? Or would it? It
14 would have -- see, because it says --

15 A. I saw these two together. 16:19:29

16 Q. But that just means they sent them
17 to you together. I'm trying to figure out when
18 he sent -- when this letter from Dr. Eddy came
19 to you, I mean exhibit 3.

20 A. This (indicating). 16:19:47

21 Q. Correct.

22 A. I'm not sure.

23 MS. TOSTI: Can I interject
24 something here? The first line indicates that
25 he reviewed her responses dated May 25th of 16:20:08

1 2000.

16:20:13

2 MR. FORBES: All that tells me it's
3 after May 25th.

4 MS. TOSTI: It had to be after May
5 25th, 2000, if that's of any help.

16:20:18

6 A. Yeah, this is definitely after May
7 25th.

8 Q. I got that.

9 A. Right.

10 Q. I'm looking for --

16:20:23

11 A. Yes, you're looking for June, July,
12 August, I know.

13 Q. Correct.

14 A. I'm not sure. I remember it taking
15 a long time.

16:20:31

16 Q. Do you remember when you met
17 with -- did you meet with the Zoelbels prior to
18 doing your MUI synopsis?

19 A. I don't believe so.

20 Q. Do you have any recollection of the
21 season of the meeting with the Zoelbels?

16:20:53

22 A. You know, I don't know. I remember
23 this report took a really long time.

24 Q. By "this report" you're talking
25 about Dr. Eddy's?

16:21:12

1 A. Yeah, 3. 16:21:13

2 Q. Do you remember how long it took

3 you to turn around yours after you got Dr.

4 Eddy's?

5 A. Not long. 16:21:17

6 Q. So we can, we're now down to --

7 A. Somewhere between May and

8 September -- June and September.

9 Q. You received Dr. Eddy's report not

10 long before September 14th, 2000? 16:21:28

11 A. I'm sorry?

12 Q. So if I understand you correctly,

13 you received your report not long before your

14 MUI synopsis on September 14th, 2000?

15 A. Yeah, I'm guessing September. 16:21:39

16 Q. So you would have seen the Zoelbels

17 then sometime in September of 2000, at best

18 guess we realize?

19 A. Yeah, I think so.

20 Q. Do you remember calling Ms. Burton 16:22:02

21 at her home in September of 2000?

22 A. Yes, that was after the meeting

23 with the Zoelbels.

24 Q. When you met with the Zoelbels had

25 they filed a lawsuit? 16:22:23

1 A. No, not that I was aware of. 16:22:25

2 Q. When you called Ms. Burton had the

3 Zoelbels filed a lawsuit?

4 A. Not that I was aware of.

5 Q. So you didn't tell Ms. Burton that 16:22:37

6 the Zoelbels had sued Eastwood?

7 A. No.

8 Q. Why did you call Ms. Burton after

9 meeting with the Zoelbels?

10 A. Mrs. Zoelbel was extremely upset 16:22:49

11 and had requested to be able to talk to the

12 people who spent the last hours of Lorna's life

13 with her and I told her that I would contact

14 the staff to see if they would agree to do

15 that. 16:23:07

16 Q. When you contacted staff -- strike

17 that.

18 What did staff say -- who did you

19 contact besides Ms. Burton?

20 A. No one. 16:23:29

21 Q. What did Ms. Burton say when you

22 contacted her?

23 A. Geez, I don't remember.

24 Q. Did you contact Sharon Stifler?

25 A. Sharon -- I don't know who that is. 16:24:00

1 Q. At this point after meeting with 16:24:03
2 the Zoelbels did you contact Rita Freeborn?

3 A. I don't think so.

4 Q. Do you have any understanding as to
5 why you chose Ms. Burton who was still working 16:24:25
6 at Eastwood as someone who could console Ms.
7 Zoelbel as opposed to Ms. Freeborn who had
8 left?

9 A. I wasn't looking at somebody to
10 console Ms. Zoelbel. She had made a request 16:24:36
11 that somebody who had spent the last hours of
12 Lorna's life with her, and that's why.

13 Q. I used the wrong verb. Someone to
14 help Ms. Zoelbel by talking with her about the
15 last hours of Lorna's life; have I got what the 16:24:53
16 request was?

17 A. That was the request.

18 Q. Right. Why Ms. Burton over Ms.
19 Freeborn?

20 A. Because she was the person that had 16:25:05
21 spent the last hours of Lorna's life with her.

22 Q. So it mattered to Ms. Zoelbel that
23 it was time on the 4th as opposed to time on
24 the 3rd?

25 A. She didn't specify that. 16:25:19

1 Q. Other than this meeting with Ms.
2 Zoelbel did you talk to her on the phone at
3 all?

16:25:26

4 A. With?

5 Q. Ms. Zoelbel.

16:25:30

6 A. Yes.

7 Q. About how often?

8 A. Gosh, I don't know. She'd call --
9 rough guess maybe once a month, I don't know.

10 Q. What kind of things did you guys
11 talk about once a month?

16:25:44

12 A. It was basically assisting her
13 through grief.

14 Q. What once a month time period? Is
15 this from February 4th on or is it -- what time
16 period?

16:26:01

17 A. February 4th, I don't know how
18 long. I remember sending her a card at the one
19 year anniversary, so within that year.

20 Q. Did you advise anyone that in
21 addition to conducting the investigation into
22 Eastwood and other folks providing care to
23 Lorna you were also maintaining contact with
24 Ms. Zoelbel and consoling her and helping her
25 through her grief?

16:26:31

16:26:54

1 A. Say it again.

16:26:59

2 Q. We can agree two things were going
3 on: One, you were investigating the
4 circumstances surrounding Lorna's death,
5 correct?

16:27:02

6 A. Correct.

7 Q. Two, you were speaking with Ms.
8 Zoelbel monthly, hand delivering the report and
9 helping her through her grief, correct?

10 A. Yeah. Yes.

16:27:20

11 Q. Did you inform anyone at the state
12 or anyone who was your supervisor that you were
13 involved in these two tasks: One,
14 investigating the care provided; and, two,
15 providing assistance to Ms. Zoelbel as she
16 dealt with her grief?

16:27:34

17 A. No, that would not be unusual.

18 Q. Had it ever happened to you before?

19 A. Had what?

20 Q. Investigating the death of a
21 resident while you are simultaneously consoling
22 a grieving family?

16:27:50

23 A. I don't know.

24 Q. Why do you say those two --
25 performing those two roles wouldn't be unusual?

16:28:10

1 A. It's not unusual for people to call
2 us and talk about whatever the issues are, that
3 is not an unusual thing.

16:28:19

4 Q. I'm talking specifically now
5 investigations into deaths or injuries of
6 residents. Have you ever had another
7 circumstance where you were simultaneously
8 investigating the circumstances around a death
9 or serious injury and helping someone affected
10 by that death or serious injury cope with their
11 grief?

16:28:33

16:28:52

12 A. No.

13 Q. Is it fair to say, though, as you
14 sit here today and look back on the dual role
15 that you see no conflicts of interest?

16:29:03

16 A. I don't see it as a dual role.

17 Q. So as you sit here today you don't
18 see as a dual role consoling a grieving family
19 member who's dealing with the death of her
20 sister and investigating the care provided that
21 may or may not have been involved in that
22 death?

16:29:16

23 A. I don't see it as a dual role.

24 Q. We can agree then because you
25 didn't see it as a dual role or any conflicts

16:29:32

1 of interest whatsoever that you felt no
2 obligation to tell your supervisor?

16:29:34

3 A. Why would I tell my -- well, I
4 didn't tell my supervisor.

5 Q. And then Dr. Eddy, we can agree
6 that the information that Dr. Eddy is relying
7 upon to reach his conclusions and to make
8 recommendations is solely filtered through you,
9 correct?

16:29:48

10 A. No. Filtered through me?

16:30:01

11 Q. Let me try it this way: Dr. Eddy
12 got information from you with regard to two
13 major unusual incidents, correct, after Lorna's
14 death between February 4th and May 9th?

15 A. Yes.

16:30:19

16 Q. Is it fair to say you were the
17 primary source of information as to Dr. Eddy
18 and the state regarding Lorna Moeller?

19 A. I compiled the information for Dr.
20 Eddy.

16:30:30

21 Q. And then when Dr. Eddy asked
22 questions that he thought of after he reviewed
23 the major unusual incident reports, you were
24 the person who interviewed the people,
25 collected the information and communicated with

16:30:45

1 Dr. Eddy, correct?

16:30:47

2 A. I communicated with the state, with
3 Roxanne.

4 Q. And then Roxanne communicated with
5 Dr. Eddy, to your understanding?

16:30:55

6 A. To my understanding.

7 Q. Then Dr. Eddy based his
8 conclusions -- to the best of your knowledge
9 Dr. Eddy based his conclusions on the
10 information you had provided him, correct?

16:31:06

11 A. On the information he received,
12 yes.

13 Q. And that information he received
14 was from you?

15 A. And, yeah, from wherever I compiled
16 it from.

16:31:12

17 Q. We can agree when Dr. Eddy reached
18 his conclusions that you were both consoling
19 Ms. Zoelbel and collecting information
20 regarding Lorna's death?

16:31:29

21 A. No, he didn't -- I guess I'm taking
22 exception with the consoling. It is not
23 unusual when somebody calls that we would
24 listen.

25 Q. You talked to her monthly and you

16:31:43

1 sent her a sympathy card, didn't you?

16:31:44

2 A. Yes, I did.

3 Q. Did you ever talk to her about the
4 advisability of filing a lawsuit?

5 A. No, I did not. She asked me that
6 at that meeting and I said I could not answer
7 or direct her.

16:31:55

8 Q. Have you ever delivered an MUI
9 synopsis --

10 A. Yes.

11 Q. -- personally to family?

12 A. Yes.

13 Q. I'm going to show you what we'll
14 mark as 6.

15 - - - - -

16 (Thereupon, Defendant's Deposition
17 Exhibit 6 was marked for purposes of
18 identification.)

19 - - - - -

20 Q. Can you identify exhibit 6 for me?

16:33:28

21 A. Client Bill of Rights.

22 Q. Was Eastwood ever advised that it
23 had violated any of Lorna Moeller's client
24 rights in the events surrounding leading up to
25 her death?

16:33:41

1 A. I don't believe it was a rights
2 violation.

16:33:49

3 Q. So as you sit here today you don't
4 believe there was an issue regarding a
5 violation of client rights?

16:33:58

6 A. Involving her death?

7 Q. Yes.

8 A. Was that the second report? I
9 don't remember.

10 Q. The second report?

16:34:25

11 A. The second MUI. You know what? I
12 really don't remember.

13 Q. If we talk about the first MUI
14 being smoking, that was a rights issue,
15 correct?

16:34:44

16 A. Correct.

17 Q. And then the second --

18 A. Was the death.

19 Q. -- was the death.

20 A. It was filed as a death.

16:34:50

21 Q. Correct.

22 MR. FORBES: Mark these as 7.

23 - - - - -

24 (Thereupon, Defendant's Deposition

25 Exhibit 7 was marked for purposes of

16:35:04

1 identification.)

2 - - - - -

3 (Discussion had off record.)

4 Q. Ms. Fishley, can you identify
5 exhibit 7 for me, please?

16:36:37

6 A. It appears that it's the three or
7 four incidents written by Eastwood staff.

8 Q. The first one is on February 1st.
9 Do you see any -- if this by itself came to you
10 would this constitute a major unusual incident?

16:36:55

11 A. Yes, because there was a
12 hospitalization.

13 Q. So this by itself would require a
14 report to the state?

15 A. Yes.

16:37:30

16 Q. So all hospitalizations require a
17 major unusual incident report?

18 A. Yes.

19 Q. Based on your experience in
20 training staff and in monitoring homes and in
21 assessing major unusual incidents, is there
22 anything that Ms. Freeborn did wrong as
23 reflected in this report?

16:37:30

24 A. Based on this report she got
25 medical attention.

16:37:58

1 Q. So Ms. Freeborn assessed the 16:38:01
2 problem, got her to the emergency room, did the
3 right thing?

4 A. Yes.

5 Q. You could go to the third page. 16:38:17

6 In preparing your report to the
7 state, these incident reports that are exhibit
8 7 are things that you reviewed, correct?

9 A. Yes.

10 Q. Is your understanding of what 16:38:38
11 happened consistent with the note that Ms.
12 Warner wrote on page three here regarding her
13 follow-up with Ms. Moeller when she got to the
14 hospital?

15 A. I'm sorry, what was your question? 16:39:01

16 Q. Is the note written by Ms. Warner
17 here on page three of exhibit 7 consistent with
18 your understanding of what happened?

19 A. When she was sent home from the
20 hospital? 16:39:18

21 Q. Correct.

22 A. Yes, Julie's reported this.

23 Q. But based on your investigation is
24 that consistent with what happened?

25 A. That she came home with the ambu -- 16:39:35

1 that she spoke to the nurse, yes.

16:39:39

2 Q. The nurse called Julie --

3 A. Right.

4 Q. -- and indicated that Lorna had a
5 bad case of gastroenteritis?

16:39:46

6 A. Yes.

7 Q. And that she was coming home and
8 there was an order for Colace, that was --

9 A. That's what Julie reported, yes.

10 Q. So there is within the incident
11 report a documentation of what the diagnosis
12 was and what the doctor's recommendations for
13 treatment were?

16:40:10

14 A. Yes.

15 Q. If you look at the next page, which
16 is dated 2-4, if you could read through that
17 and I have the same question: Is this
18 consistent with your understanding of what
19 happened based upon your investigation?

16:40:31

20 MS. TOSTI: Steve, which report are
21 we looking at, the date?

16:41:06

22 MR. FORBES: The date of the
23 incident is 2-3 and this is the one with the
24 crossed out 4th at the bottom and the time
25 change.

16:41:17

1 MS. TOSTI: Okay. 16:41:17

2 A. Yes, this was reported.

3 Q. I know it was reported, I'm

4 looking --

5 A. Is it similar to what I was told? 16:41:55

6 Q. Is it consistent with the factual

7 conclusions that you drew after your

8 investigation? Let's try it this way: You

9 investigated and came to some understanding as

10 to what happened; fair enough? 16:42:08

11 A. Fair enough.

12 Q. Is the information conveyed by Ms.

13 Burton in this incident report consistent with

14 the conclusions that you reached after your

15 investigation? 16:42:21

16 A. Yes. There was a little bit more

17 information I think verbally than there is

18 written at any given time.

19 Q. Yes. I'm looking not for did they

20 tell you additional stuff, but is there 16:42:42

21 anything that you understand that's different

22 or wrong as related by Ms. Burton here?

23 A. I believe this to be accurate.

24 Q. If we go to the next page, which is

25 an incident report from Tracey Cherry dated 16:42:57

1 February 4th, I'd ask you to review it and I
2 have the same question, which is: Is Ms.
3 Cherry's rendition of what happened consistent
4 with the conclusions you reached after your
5 investigation?

16:43:01

16:43:14

6 A. This is what was referred to.

7 Q. I know that. In addition, though,
8 to just taking what people wrote and gave you,
9 you interviewed various people at different
10 times and then reached a conclusion as to your
11 best understanding what happened as a post-fact
12 investigator. Are the conclusions reached --
13 are the statements made by Ms. Cherry in the
14 incident report dated February 4th consistent
15 with the factual conclusions you reached as
16 part of your investigation?

16:44:24

16:44:36

17 A. Yes.

18 Q. Now as someone who's been employed
19 by Deepwood since 1978 who has been a long-time
20 major unusual incident specialist and who has
21 been monitoring homes for at least the last ten
22 years, do you know of any federal, state or
23 county law or regulation that Eastwood violated
24 from February 1st of 2000 when they took Lorna
25 to the hospital to February 4th of 2000 when

16:45:09

16:45:33

1 Lorna died?

16:45:38

2 A. Any law that they violated?

3 Q. Any state law, federal regulation,
4 federal law, county rule --

5 A. No.

16:45:49

6 Q. You know of none?

7 MR. FORBES: I may have a couple
8 follow-ups, I doubt it, but I'll reserve that
9 after these folks ask questions.

10 (Discussion had off record.)

11 EXAMINATION OF PATRICIA FISHLEY

12 BY MR. KRAUSE:

13 Q. Ma'am, we met a few hours ago. My
14 name's David Krause. I represent Lake
15 Hospital.

16:46:27

16 I just have a few questions, and
17 hopefully I'll be brief. I'm going to try not
18 to go through the things Mr. Forbes did, he did
19 a pretty, I don't know what the word is,
20 thorough job.

16:46:40

21 (Discussion had off record.)

22 Q. You interviewed Barbara Irwin and
23 Alaki Dieglio at Lake Hospital as part of your
24 investigation in this case?

25 A. Yes.

16:46:53

1 Q. When you interviewed Barbara was 16:46:53
2 she cooperative and professional and courteous
3 to you?

4 A. Extremely.

5 Q. Did she facilitate the transfer of 16:47:01
6 information from the hospital to you?

7 A. Yes, she did.

8 Q. Did she ever tell you or refuse to
9 provide any information that you requested at
10 any point in time during your investigation? 16:47:13

11 A. No, not at all.

12 Q. Did she present and make available
13 Alaki Dieglio for you to interview?

14 A. Yes, she did.

15 Q. Did you ask Barb to interview any 16:47:26
16 other employees or any other staff at Lake
17 Hospital Systems as part of your investigation
18 in this case?

19 A. No, I did not.

20 Q. Did Barbara express to you that if 16:47:34
21 you want to interview anybody else or talk to
22 anybody else or had any other questions
23 whatsoever that she would be happy to so
24 provide those individuals or that information
25 to you? 16:47:44

1 A. Yes, she did. 16:47:44

2 Q. Do you know why Rita Freeborn
3 resigned?

4 A. I don't.

5 Q. You indicated when you spoke to 16:48:07
6 Mrs. Dieglio she indicated that she was
7 concerned because no one from Eastwood was
8 coming and the patient was being sent home in
9 an ambulance?

10 A. Yes. 16:48:19

11 Q. Was it your understanding having
12 talked to Ms. Dieglio that at the time of
13 Lorna's transfer she knew that the arrangements
14 had been made to transfer her via ambulance
15 because she already knew that no one was coming 16:48:32
16 from Eastwood to facilitate or accompany Ms.
17 Moeller in transit?

18 A. That's my understanding.

19 Q. Were there three MUIs regarding
20 Eastwood and Lorna Moeller? And I'm going to 16:48:51
21 track down in my mind what that was: Smoking,
22 the death and then was there a third MUI?

23 A. Yes.

24 Q. And this was following the death of
25 Ms. Moeller? 16:49:05

1 A. Correct. 16:49:05

2 Q. This third MUI was in regards to
3 problems you were having in your investigation?

4 A. The additional reporting from the
5 other two consumers -- 16:49:16

6 Q. I see, that's right.

7 A. -- and I really can't remember what
8 we put that under right now, I should know
9 that.

10 Q. That's right. 16:49:23

11 How are the findings of the state,
12 whether it be -- by state I'm including the
13 county and the state as well -- how are those
14 findings communicated to Eastwood?

15 A. I met with LuAnne and Jim Victor in
16 our office. 16:49:50

17 Q. And they're also communicated by
18 your report which is addressed to LuAnne Busch?

19 A. Correct.

20 Q. Now I recall that your MUI 16:50:05
21 synopsis -- I can't remember what we marked it
22 as -- I notice no one from Lake Hospital was
23 cc'ed on this report.

24 A. Correct.

25 Q. Did you talk to -- other than your 16:50:21

1 conversation with Barbara back around the same
2 time that you spoke to Alaki Dieglio as part of
3 your investigation, have you ever gone back and
4 spoken to Barbara or Ms. Dieglio about this
5 case?

16:50:23

16:50:34

6 A. No.

7 Q. Have you ever sent a copy of your
8 MUI synopsis or informed Barbara Irwin or Alaki
9 Dieglio or anyone from Lake Hospital of your
10 findings in this case?

16:50:46

11 A. I don't believe so.

12 Q. And that's because your findings in
13 this case are directed at the care of the
14 Eastwood facility, correct?

15 A. Correct.

16:50:57

16 Q. The changes that would need to be
17 made, if there are any, would need to be made
18 by the Eastwood facility and the care-givers
19 there, correct?

20 A. Correct.

16:51:08

21 Q. Do you have a copy of the letter
22 from LuAnne Busch to Alfie regarding this issue
23 after you issued your MUI synopsis that you
24 might be biased or that the investigation
25 wasn't fair?

16:51:32

1 A. I do have a copy of it. 16:51:33
2 Q. Where would that copy be located?
3 A. In my office.
4 Q. Is your office here?
5 A. No. Well, it's down the road. 16:51:38
6 Q. No, I don't want to go down the
7 road. If you could provide that to Mr.
8 Schalt --
9 MR. SCHALTENBRAND: Eric's fine.
10 Q. -- to Eric? 16:51:50
11 MR. KRAUSE: And I'd ask, Eric, if
12 you could just provide that to all of us or
13 send a copy to me and I'll disseminate it, that
14 way we don't have to come back.
15 MR. SCHALTENBRAND: I'll have to 16:52:01
16 get your card.
17 MR. KRAUSE: I'll get it for you
18 right now.
19 Q. To the best of your recollection
20 what was contained in that letter? 16:52:06
21 A. Gosh, LuAnne had written to Alfie
22 that based on whatever investigation Joe did
23 that it was a misunderstanding and that she
24 would hope for continued support or continued
25 being able to work with our agency, one of 16:52:34

1 those kinds of letters.

16:52:37

2 Q. Did it address your investigation
3 at all or concerns Ms. Busch had about bias or
4 the accuracy of your investigation?

5 A. I just remember it saying that it
6 was a misunderstanding.

16:52:50

7 Q. Did the letter come after you
8 received a phone call from the attorney who
9 told you -- I don't want to get into that --
10 where you learned that there was some concern
11 or some question regarding potential bias in
12 your investigation?

16:53:05

13 A. Yes.

14 Q. So this letter was after you got
15 that phone call?

16:53:14

16 A. Yes, correct.

17 Q. Up until the point in time when you
18 prepared your MUI synopsis -- strike that.

19 When were you informed by Ms.

20 Burton that LuAnne Busch had directed the
21 employees not to speak with you regarding Ms.
22 Moeller?

16:53:36

23 A. It was the day after I interviewed
24 Ms. Burton. She had paged me the following
25 morning.

16:53:50

1 Q. Was this before or after the other 16:53:51
2 residents, the two other residents came forward
3 and indicated to you that there were -- let me
4 finish my question --

5 A. I'm sorry. 16:54:01

6 Q. -- and indicated to you that Ms.
7 Moeller was in pain and asking for help which,
8 based on their observation, was not being
9 responded to at Eastwood?

10 A. It was before. 16:54:12

11 Q. It was before those people came
12 forward?

13 A. Yes.

14 Q. Is there a separate MUI synopsis
15 related to that incident? 16:54:41

16 MR. FORBES: Object to the form.

17 A. To which incident?

18 Q. Okay. In other words, we've gone
19 through the three MUIs, correct?

20 A. Uh-huh. 16:54:46

21 Q. I have an MUI synopsis and this one
22 obviously doesn't relate to the smoking, it
23 relates to the death, okay?

24 A. Uh-huh.

25 Q. Now the third MUI was the incident 16:54:53

1 where these residents came forward and informed
2 you of some facts and what their observations
3 were. Is there another MUI synopsis regarding
4 that?

16:54:56

5 A. No.

16:55:06

6 Q. Why not?

7 A. You know, I don't know, it's a good
8 question. I think we just lumped -- I think I
9 just lumped it all together.

10 Q. After you were informed by Ms. -- I
11 don't remember her name, who informed you that
12 LuAnne Busch had issued this directive that
13 employees were not to speak to you?

16:55:55

14 A. Marquita Burton.

15 Q. That's the name. After you spoke
16 to Marquita Burton, other than the meeting that
17 you had -- that was just going to be an awful
18 question so I'm going to start over.

16:56:16

19 After Ms. Burton informed you of
20 what LuAnne Busch had told the staff, did you
21 ever have an opportunity to speak to any
22 Eastwood employee outside the presence of
23 LuAnne Busch up until the point in time when
24 you issued your MUI synopsis?

16:56:35

25 A. I don't think so.

16:57:00

1 Q. Is that unusual? 16:57:01

2 MR. FORBES: Objection to the form.

3 Q. As you were --

4 MR. KRAUSE: I'll rephrase the

5 question. 16:57:12

6 MR. FORBES: Give me the time

7 frame.

8 MR. KRAUSE: I gave the time frame

9 in the first question.

10 Q. In the course of your investigation 16:57:17

11 after you learned that LuAnne Busch had issued

12 a directive to the employees of Eastwood not to

13 speak with you, did you find it unusual, as

14 compared to other investigations that you've

15 conducted, that you would not be allowed to 16:57:33

16 have access to the employees of Eastwood to

17 discuss with them what did or did not happen in

18 this case?

19 MR. FORBES: Objection to the form.

20 A. I don't know if it was unusual. 16:57:59

21 Q. Did it bug you?

22 A. Oh, sure.

23 Q. Did it cause -- did it make your

24 investigation more difficult?

25 A. I don't know that it did or didn't, 16:58:16

1 I don't know.

16:58:18

2 Q. And the only employee that you
3 spoke to in this time frame was an employee
4 that had left the Eastwood facility 25 days or
5 so after Ms. Moeller's death, that being Rita
6 Freeborn, correct?

16:58:30

7 MR. FORBES: Objection to the form.
8 You said "this time frame."

9 MR. KRAUSE: It's the same time
10 frame we've been talking about.

16:58:40

11 MR. FORBES: Can I just --

12 Q. Let me do it this way: Time frame,
13 we're going to talk about the time frame
14 between, once again, Ms. Burton told you that
15 LuAnne Busch issued a directive of Eastwood
16 employees not to speak to you and the time you
17 issued your MUI synopsis.

16:58:51

18 MR. FORBES: May I just clarify my
19 confusion?

20 MR. KRAUSE: Okay.

16:59:01

21 MR. FORBES: Which is they all met
22 on May 23rd to discuss and answer the questions
23 that Dr. Eddy issued, Stacey Reigert, all those
24 folks all met.

25 MR. KRAUSE: The questions that I'm

16:59:12

1 asking, and I said this, outside the presence
2 of LuAnne Busch.

16:59:13

3 MR. FORBES: Okay.

4 MR. KRAUSE: That was three
5 questions ago.

16:59:20

6 MR. FORBES: Right. That's my
7 confusion, that's why I --

8 MR. KRAUSE: That's fine. All
9 right.

10 Q. In this time period between when
11 Burton told you that LuAnne Busch had issued
12 the directive to employees of Eastwood not to
13 speak and the time that you issued your MUI
14 synopsis, you did not speak to any active
15 Eastwood employees outside the presence of
16 LuAnne Busch, correct?

16:59:26

17 A. Not that I recall.

18 Q. The only employee that you did
19 speak to outside the presence of LuAnne Busch
20 during this time frame was Rita Freeborn, if
21 I'm saying her name right, and that was the
22 employee that had left Eastwood 20 days or 25
23 days or so after Ms. Moeller's death, correct?

16:59:42

24 A. Yeah, I don't remember when I spoke
25 with Rita specifically.

16:59:54

17:00:11

1 Q. If the documents that you've -- 17:00:13
2 A. Right, yeah, I don't remember.
3 Q. -- indicate that you spoke to Ms.
4 Freeborn in that time frame, you wouldn't
5 disagree with that, correct? 17:00:22
6 A. Correct.
7 MR. FORBES: Objection to the form.
8 Q. When Rita Freeborn told you she
9 would help in any way she could, what did you
10 take that to mean? 17:00:44
11 A. She had some concerns about the
12 care and treatment that Lorna was receiving and
13 she had stated that she would help in any way
14 that she could.
15 Q. Do you know if she -- I'm sorry. 17:01:04
16 A. I don't know what specifically she
17 planned on doing.
18 Q. Do you know if she was fired?
19 A. I don't know.
20 Q. Has she ever communicated to you 17:01:14
21 the circumstances surrounding her leaving
22 Eastwood?
23 A. If she did I don't know, I don't
24 recall.
25 Q. Did she leave as a result of 17:01:24

1 anything that happened in this case dealing
2 with Lorna Moeller's death? If you know. If
3 you know.

17:01:25

4 A. I don't know.

5 Q. On page, I don't remember which
6 exhibit you were talking about, it's the memo
7 that you did to Bill Angel --

17:01:53

8 A. Okay.

9 Q. -- paragraph four on page two.

10 MR. SCHALTENBRAND: Exhibit 2.

17:02:04

11 MR. KRAUSE: Is it exhibit 2?

12 MR. SCHALTENBRAND: Yes.

13 A. Paragraph?

14 Q. It's the fourth numbered paragraph,
15 paragraph number four.

17:02:11

16 A. On page one?

17 Q. Page two, sorry. It starts: "The
18 Eastwood nurse, Julie Warner"?

19 A. Yes.

20 Q. In there I notice the sentence, and
21 I'm going to read an excerpt from it and ask
22 you if I read it the right way: "During the
23 initial interview with this worker", this
24 worker being Julie Warner, "on 2-4" --

17:02:21

25 A. Wait a minute, I'm sorry. Where

17:02:38

1 are you at?

17:02:38

2 MS. TOSTI: Third line of item
3 number four.

4 A. During the interview?

5 Q. "During the initial interview with
6 this worker on 2-4-00, Julie looked at her
7 pager and reported that she had been paged at
8 2:54 a.m., 3:15 a.m., 6:00 a.m. and 7:11 a.m."?

17:02:42

9 A. Yes.

10 Q. "On 2-4-00, Julie reported that
11 staff had paged to report that Lorna was
12 vomiting"?

17:02:53

13 A. Yes.

14 Q. "During the 5-22-00 interview Julie
15 reports that she was paged at the above
16 mentioned times and staff reported that 'Lorna
17 was tired.'" Okay?

17:03:03

18 A. Yes.

19 Q. Is that in your report because it's
20 a discrepancy between the facts as reported to
21 you by Julie Warner in your two meetings?

17:03:13

22 A. It's in my report because that's
23 what happened during the initial interview and
24 that's what happened on 5-22.

25 Q. Did you ask her why her story was

17:03:32

1 different?

17:03:34

2 A. No.

3 Q. Does it seem unusual to you as a
4 person who investigates homes such as Eastwood
5 that at 2:54 a.m. and 3:15 a.m. in the morning
6 resident staff would page a nurse to inform her
7 that a resident was tired?

17:03:47

8 A. That seems unusual.

9 Q. This 5-22-00 interview with Julie
10 Warner occurred after you were told by Ms.
11 Burton that LuAnne Busch had issued a directive
12 to Eastwood employees not to speak with you,
13 correct?

17:04:07

14 A. I'm sorry, say that again. I'm
15 starting to fade here.

17:04:23

16 Q. Yes. The second meeting with
17 Julie --

18 A. Yes,

19 Q. -- when she says that the staff
20 paged her because Lorna was tired, that was
21 after you had been informed by Ms. Burton that
22 LuAnne Busch had said -- had issued a directive
23 to the staff at Eastwood not to speak with you
24 anymore?

17:04:29

25 A. Correct.

17:04:45

1 Q. On, I forget what the exhibit was,
2 I'm talking about the bunch of incident
3 reports.

17:05:04

4 A. Yes.

5 Q. Page three, the third incident
6 report in that exhibit, it's the one by Julie
7 Warner.

17:05:12

8 A. Yes.

9 Q. That writing by Julie Warner
10 describes information that was relayed to her
11 by the nurse or the staff at Lake Hospital when
12 Ms. Moeller was discharged, correct?

17:05:30

13 A. Correct.

14 Q. So earlier when Mr. Forbes asked
15 you if you knew if anything in addition to
16 what's documented in the Lake Hospital
17 discharge instructions was communicated and you
18 indicated you had no information, would this
19 assist you in answering that question?

17:05:56

20 A. Could you say that again?

17:06:16

21 Q. Sure.

22 Earlier Mr. Forbes asked you a
23 question and said do you know if anything in
24 addition to what's contained in the Lake
25 Hospital records was communicated to Eastwood

17:06:27

1 on discharge, and I believe your answer was no,
2 you didn't know. Does this assist you in
3 determining what was communicated to Eastwood
4 on Ms. Moeller's discharge?

17:06:29

5 MR. FORBES: Objection to the form.

17:06:40

6 A. Yes.

7 Q. Do you know anything about this
8 change in the date in the bottom of the form on
9 the next page, February 4th?

10 A. You know, yes. My understanding
11 was that, and it's typical, it didn't surprise
12 me, third shift staff are always like a day
13 behind on their reports, that was my
14 understanding.

17:07:05

15 Q. So the date of the incident was
16 February 3rd as written in at the top in
17 section A?

17:07:24

18 A. Correct. The staff person would
19 have come in on the 3rd and would have, you
20 know, left on the 4th but in their -- it's
21 still the 3rd in their, yeah --

17:07:36

22 Q. I see.

23 A. -- in their shift. That was my
24 understanding.

25 Q. When were these incident reports

17:07:53

1 provided to you? And I'm referring --

17:07:54

2 MR. KRAUSE: What exhibit is the
3 incident?

4 MR. SCHALTENBRAND: 7.

5 MR. FORBES: 7.

17:08:02

6 A. Specific dates I don't know.

7 Q. Were any of these provided to you
8 on February 4th?

9 A. Boy, I don't remember. We always
10 ask for incident reports. I'm not sure that
11 they would have been written. Well I guess
12 some of them would have been written that
13 particular day. I don't recall if they were
14 that day or if they were faxed to me.

17:08:28

15 Q. If the times on the lines at the
16 bottom where it says "Date Completed" are
17 accurate, then all of these would have been
18 completed prior to your arrival to the Eastwood
19 facility to meet with the involved staff?

17:09:01

20 A. That's correct.

17:09:18

21 Q. Do you know if they were faxed out
22 or would you have a copy in your file of the
23 fax memo?

24 A. I'd have to look, I really don't
25 know. I can't recall if I picked them up, I

17:09:32

1 don't know.

17:09:37

2 MR. KRAUSE: I think that's all I
3 have. Thank you.

4 THE WITNESS: Thank you.

5 MS. ATKINSON: I just have a couple
6 questions

17:09:47

7 EXAMINATION OF PATRICIA FISHLEY

8 BY MS. ATKINSON:

9 Q. Ms. Fishley, my name is Kathleen
10 Atkinson. I'm here on behalf of Dr. Heng and
11 Dr. Oh.

17:09:51

12 Did you at any time have any
13 conversations with any of the physicians at
14 Lake East Hospital regarding the death of Lorna
15 Moeller?

17:10:00

16 A. I did not.

17 Q. Earlier you had stated to Mr.
18 Forbes that an MUI report was filled out
19 regarding the lapse of time between the medical
20 care that Lorna received from when she got home
21 from the hospital and when she died, and now
22 you're saying that you don't believe a report
23 was filled out; is that correct?

17:10:08

24 A. No, that was that second report, I
25 can't remember what -- the additional

17:10:21

1 information with the client, the client saying
2 that she was in pain or screaming out.

17:10:22

3 Q. That was from the two residents,
4 correct?

5 A. Correct.

17:10:37

6 Q. You're saying an incident report
7 was filled out?

8 A. Major unusual incident, the MUI,
9 not these forms, the MUI form, the state
10 reporting form.

17:10:40

11 Q. Originally that information came
12 from Judy Ketchum; is that correct?

13 A. Correct.

14 Q. Do you know how Judy got involved
15 with the investigation?

17:10:47

16 A. She didn't get involved in the
17 investigation, she was at least monitoring
18 talking to the ladies and the ladies reported
19 it to her and she brought it back to me. And,
20 again, that's typical.

17:11:04

21 MS. ATKINSON: I don't have
22 anything further.

23 MS. TOSTI: I don't have a copy of
24 the MUI report that she's --

25 MR. KRAUSE: Neither do I.

17:11:17

1 MS. TOSTI: -- mentioning in regard 17:11:19
2 to the two residents that were describing --
3 MR. FORBES: Nobody does.
4 MS. TOSTI: -- events. So if, in
5 fact, that is in the file, is that something 17:11:27
6 you could provide us?
7 MR. SCHALTENBRAND: I'll see if
8 it's in the file.
9 MS. TOSTI: If you want to give it
10 to me I'll be happy to disseminate it to 17:11:33
11 everyone.
12 MR. FORBES: I would just like
13 everything. Do we need a subpoena to get it?
14 MR. KRAUSE: I think that, we're on
15 the record, I know there are issues of 17:11:43
16 confidentiality, I think maybe Jeanne can
17 collect that and disburse it, although I think
18 that each of us might want to get our own copy
19 directly from the board, but maybe, Jeanne, if
20 you would authorize them to release copies to 17:11:58
21 us on the record probably expedite things.
22 MR. FORBES: I don't know if there
23 are confidentiality issues with reports to the
24 state. I'm willing to consider it.
25 MR. KRAUSE: You want the entire 17:12:10

1 file?

17:12:10

2 MS. TOSTI: I don't know what's in
3 the file so I can't say one way or the other.

4 MR. KRAUSE: Right.

5 MS. TOSTI: I have no problem with
6 him providing everything, a copy of the MUI.

17:12:15

7 MR. KRAUSE: That's fine.

8 MR. SCHALTENBRAND: I don't know
9 what's in the file.

10 MR. KRAUSE: I just don't want Eric
11 to be stuck later.

17:12:24

12 MR. FORBES: What I will do then is
13 just subpoena and then whatever is appropriate
14 under the subpoena then --

15 MR. SCHALTENBRAND: You can specify
16 to me what you want, what files we're talking
17 about.

17:12:33

18 MR. KRAUSE: Everything.

19 MR. SCHALTENBRAND: You got to be a
20 little more specific than that.

17:12:39

21 MR. FORBES: Everything plus two.

22 MR. SCHALTENBRAND: That's better.

23 EXAMINATION OF PATRICIA FISHLEY

24 BY MS. TOSTI:

25 Q. We were talking -- I am Jeanne

17:12:46

1 Tosti. I am representing the plaintiff, Carol
2 Zoelbel, in this case. I'll try to be brief
3 since we've been here a very long time already.

4 You had indicated that you had a
5 conversation I believe with Rita Freeborn and
6 that she had expressed some concerns to you
7 about the care that Lorna Moeller had. Was
8 there anything specific that Rita Freeborn
9 mentioned to you in regard to the care that
10 Lorna Moeller had?

11 A. Oh, gosh. I believe Rita felt that
12 Lorna should have been sent back to the
13 hospital, that she should have returned back to
14 the hospital, that she should have received
15 additional medical care.

16 Q. Was that during the period of time
17 when Rita Freeborn was on duty? I believe she
18 worked three to 11 or that evening shift?

19 A. Right, she was the one who took her
20 to the hospital on the 1st, February 1st, and
21 then I don't recall if she worked -- actually
22 I'm thinking she did work the 2nd or the 3rd or
23 2nd and 3rd.

24 Q. I believe if you would refer to
25 plaintiff's exhibit number 2 --

1 A. Okay.

17:14:11

2 MR. FORBES: Hey, wait a minute,
3 defendant's exhibit.

4 Q. I'm sorry, pardon me, defendant's
5 exhibit number 2.

17:14:17

6 A. I don't know which one it is, I'm
7 just look looking for a 2.

8 Q. Okay, number 2, and on page number
9 one --

10 A. Yes.

17:14:24

11 Q. -- down near the bottom of the page
12 it indicates "I spoke with Rita Freeborn", and
13 in that paragraph --

14 A. Yes.

15 Q. -- I believe you say Rita worked
16 the second shift on?

17:14:37

17 A. On 2-2 and 2-3, okay.

18 Q. And she also worked on 2-1 of 2000?

19 A. Right, I remembered 2-1 that she
20 was with her.

17:14:49

21 Q. And although you don't recall at
22 this time, at the time that you had filled out
23 defendant's exhibit number 2 this would have
24 been based on your interviews and whatever
25 notes you had at the time, correct, that

17:15:01

1 information that you've included in this
2 report?

17:15:03

3 A. Correct. Correct.

4 Q. Now aside from the Lorna Moeller
5 case have you ever investigated a death of a
6 resident where you were required to answer
7 questions posed by the medical director for the
8 Ohio Department of Mental Retardation and
9 Developmental Disabilities?

17:15:14

10 A. No, this was a first.

17:15:30

11 Q. So this was an unusual case, is
12 that correct, based on your experience?

13 A. Yes.

14 Q. Have you ever come across a report
15 from the state medical director, a mortality
16 review, that indicates that a resident's death
17 was possibly preventable in your experience
18 with your position at Lake County's board?

17:15:42

19 A. No.

20 Q. So that's an unusual situation,
21 too, at least from your experience?

17:16:00

22 A. It's the first time I saw that
23 form.

24 Q. Now when Marquita Burton informed
25 you that LuAnne Busch was angry and none of the

17:16:12

1 Eastwood staff was supposed to speak to you,
2 did you view that as an attempt to obstruct
3 your investigation in this case?

17:16:19

4 MR. FORBES: Objection to form.

5 A. Yes, and also a way for -- just for
6 LuAnne or Eastwood to be a part of whatever
7 interviews, just so that they would be there.

17:16:37

8 Q. I don't know that I'm understanding
9 your answer.

10 A. I saw it more as them wanting to be
11 involved as opposed to -- in addition to my not
12 being alone with the staff. It's -- I don't
13 know.

17:16:56

14 Q. You have done other investigations
15 of other major unusual incidents, is that
16 correct, in the course of your career here?

17:17:15

17 A. That's correct.

18 Q. Do you on occasion speak with
19 individual staff members privately away from
20 the administration of a group home?

17:17:28

21 A. Yes.

22 Q. Do you find sometimes that you
23 obtain information from the staff that is a
24 little more candid when they don't have an
25 administrator sitting there?

17:17:38

1 A. Yes. 17:17:39

2 Q. In this instance would it be
3 helpful to have spoken to the staff
4 individually to find out their perspective on
5 what happened rather than in the group? I 17:17:49
6 think you did meet in a group with Julie Warner
7 and the administrator and Lisa Schubert and
8 Stacey Reigert together?

9 A. (Nodding head affirmatively.)

10 Q. Did you ever have an opportunity to 17:18:04
11 speak with Julie Warner individually without
12 the administrator present?

13 A. You know, there was -- it was in
14 relation to this May 25th and I had asked -- I
15 called out to Eastwood so that I would be clear 17:18:20
16 when I was writing up my notes and asked them
17 to page Julie to give me a call so I could
18 clarify something that was in here, and LuAnne
19 called my supervisor as opposed to Julie
20 calling me back. I can't really remember what 17:18:42
21 happened after that. I believe they set up a
22 time and I don't know if LuAnne was present or
23 not when Julie did talk to me, when she did
24 clarify whatever I was asking.

25 Q. Now when Marquita Burton told you 17:19:01

1 that none of the staff was supposed to talk to
2 you, did you keep that confidence as far as
3 Marquita Burton, what she had told you?

17:19:04

4 A. Yes.

5 Q. And she expressed a concern to you
6 that if she talked with you individually and
7 they found out that she might lose her job; is
8 that correct?

17:19:15

9 A. Yes.

10 Q. Now when you conducted this
11 investigation did you conduct it in the same
12 manner that you would normally conduct an
13 investigation into a major unusual incident?

17:19:25

14 A. When I spoke with Marquita?

15 Q. No, I mean just in general --

17:19:41

16 A. I'm sorry.

17 Q. -- the procedures you follow in
18 talking with the staff and collecting the
19 information and developing your report.

20 A. Yes.

17:19:50

21 Q. And it was in accordance with the
22 department's usual procedures and policies; is
23 that correct?

24 A. Right.

25 Q. Did you prepare your MUI synopsis

17:19:58

1 in accordance with the usual policies and
2 procedures of the Lake County Board of Mental
3 Retardation and Developmental Disabilities?
4 Was this a format that you had used at other
5 times?

17:20:05

17:20:17

6 A. Yes.

7 Q. This was an acceptable format and
8 was prepared in the manner that you normally
9 did; is that correct?

10 A. Correct.

17:20:23

11 Q. And this MUI synopsis, is this kept
12 as a permanent record in the files here at
13 Deepwood?

14 A. Yes.

15 Q. Now, I believe we were looking at
16 defendant's exhibit number 2 a while ago and
17 item number four indicates, I believe, about
18 the fifth line down that during -- or the
19 fourth line down, that during the course of the
20 time that you spoke with Julie she looked at
21 her pager and reported to you that she'd been
22 paged at 2:45 a.m., 3:15 a.m., six a.m. and
23 7:11 a.m.; is that correct?

17:20:51

17:21:20

24 A. Yes.

25 Q. If she was paged at 7:11 a.m. by

17:21:36

1 When you spoke with those people
2 did you note there was a discrepancy between
3 the two things that Julie was telling you
4 versus what the staff was telling you?

17:24:54

5 A. Yes.

17:25:02

6 Q. Did you speak with Julie about
7 that, as to that discrepancy?

8 A. No, I'm assuming that that's why
9 Julie -- that last sentence is in there that
10 Julie reports she only saw Lorna on 2-4 because
11 I did ask Julie.

17:25:16

12 Q. And she denied seeing Lorna vomit
13 at six p.m. on February 3rd?

14 A. Julie would have responded --
15 reported that she only saw Lorna vomit on 2-4.

17:25:32

16 Q. Now you have reference here to the
17 staff and then you also told us that you spoke
18 with Rita Freeborn. Does that "staff" word
19 refer to Rita Freeborn?

20 A. Where are we looking?

17:26:10

21 Q. We're looking at that same notation
22 on page five --

23 A. Oh, "Staff reported that Julie did
24 witness Lorna vomit", that one?

25 Q. Yes. Are you referring to Rita

17:26:20

1 Freeborn there?

17:26:24

2 A. Yes.

3 Q. Now in the MUI synopsis, which has
4 been marked as defendant's exhibit number 5,
5 there are a number of recommendations. Do you
6 recall ever seeing a written copy of LuAnne
7 Busch's response to these recommendations?

17:27:11

8 A. I believe there was a written
9 response.

10 Q. Now we previously looked at item
11 number six and one of the recommendations was
12 Eastwood was to review/update policies and
13 procedures regarding the handling of medical
14 issues and emergencies, and I believe Mr.
15 Forbes spoke to you about all staff receiving
16 in-service training on handling of medical
17 emergencies and the response to that portion
18 was that they received that in their
19 orientation.

17:27:28

17:27:47

20 But in regard to that first
21 sentence, Eastwood was to review and update
22 policies and procedures regarding the handling
23 of medical issues and emergencies, do you
24 recall Eastwood ever doing that, reviewing
25 their policies and updating them?

17:27:58

17:28:11

1 A. No, I don't.

17:28:13

2 Q. Would Eastwood be required to
3 respond to you regarding these recommendations?

4 A. Yes.

5 Q. Do you know one way or the other
6 whether Eastwood ever reviewed and updated
7 their policies and procedures regarding the
8 handling of medical issues and emergencies?

17:28:25

9 A. I believe -- I believe that
10 Eastwood -- that's the part they said was
11 covered in the orientation, I believe. I'd
12 have to look at her response, her plan of
13 correction.

17:28:41

14 MS. TOSTI: Now I have requested
15 that response and haven't received it from
16 defense counsel as yet. I'm going to request
17 it again because I have not received that in
18 any of the production of documents that you've
19 given me. So I am going to request again that
20 you provide me with Eastwood's response to the
21 recommendations that were made on the MUI
22 synopsis.

17:28:56

17:29:09

23 MR. FORBES: Since you've already
24 requested that in writing I will forego my
25 usual request that you make it in writing and I

17:29:18

1 will get that to you, I have reviewed it and
2 will get it to you.

17:29:20

3 MR. KRAUSE: Can you cc me on that?

4 MR. FORBES: Yes, Mr. Krause.

5 Q. Now, number seven says: "The nurse
6 receive additional training in handling of
7 medical emergencies and potentially
8 compromising situations."

17:29:29

9 Is that a recommendation that you
10 formulated?

17:29:39

11 A. Yes.

12 Q. That wasn't one that came from Dr.
13 Eddy; is that correct?

14 A. One through five were from Dr.
15 Eddy.

17:29:47

16 Q. Why is it -- what was the basis for
17 you formulating number seven? Why did you feel
18 the nurse should receive additional training in
19 the handling of emergencies and potentially
20 compromising situations?

17:30:02

21 A. A blood pressure of 90 over 60, I
22 don't remember what Lorna's temperature was, it
23 was 97 or 99, the staff reports that she was
24 cool and clammy, the staff had paged her four
25 times in the course of the night, that seemed

17:30:21

1 pretty critical.

17:30:30

2 Q. Do you think that Julie Warner
3 should have responded during the night by
4 either telling the staff to take her to the
5 hospital or call 911 --

17:30:40

6 A. Yes.

7 Q. -- or contacting the physician?

8 A. Yes.

9 MS. TOSTI: I don't have any
10 further questions.

17:30:49

11 MR. FORBES: Unfortunately, I have
12 a few follow-ups.

13 EXAMINATION OF PATRICIA FISHLEY

14 BY MR. FORBES:

15 Q. First of all, prior to today did
16 you ever talk to Ms. Tosti or anyone from her
17 office other than to schedule the deposition?

17:30:55

18 A. That was it.

19 MS. TOSTI: I did call her to
20 schedule the deposition.

17:31:04

21 Q. Have you talked to anybody on
22 behalf of the Zoelbels?

23 A. No.

24 Q. My understanding, and correct me if
25 I'm wrong, is that the day of the accident --

17:31:14

1 the day of the death, Ms. Moeller's death, you 17:31:18
2 spoke with LuAnne Busch and Julie Warner
3 together, Stacey Reigert and Lisa Schubert all
4 there?

5 A. You know, I don't -- I think so. 17:31:32

6 Q. You spoke to a group of people at
7 the home?

8 A. Yes.

9 Q. The next day you spoke to Ms.
10 Burton? 17:31:37

11 A. I believe it was the next day, I
12 know it was close.

13 Q. And the following day or shortly
14 thereafter you spoke to Ms. Freeborn who was
15 still working at the home? 17:31:47

16 A. I believe so.

17 Q. So after speaking to Ms. Burton you
18 went to the home and spoke to Ms. Freeborn?

19 A. No, I didn't -- no.

20 Q. When did you speak to Ms. Freeborn? 17:32:03

21 A. I don't know. After that phone
22 call from Marquita I did not go out to the
23 house.

24 Q. But sometime in that time period
25 you spoke to Ms. Freeborn -- 17:32:10

1 MR. KRAUSE: Objection.

2 Q. -- in addition to Ms. Burton?

3 MR. KRAUSE: Objection to the time
4 frame without defining it.

5 A. Yes.

17:32:17

6 Q. Sometime between -- sometime in the
7 week following the death of Ms. Moeller you
8 spoke to Ms. Freeborn?

9 A. I do recall speaking to Ms.
10 Freeborn, I don't remember when in all of this.

17:32:26

11 Q. Did you ask to speak to any
12 hospital employees outside of Ms. Irwin's
13 presence?

14 A. No.

15 Q. To set up the meetings with Nurse
16 Dieglio, you spoke to Ms. Irwin to do that,
17 correct?

17:32:38

18 A. Correct.

19 Q. When you contacted Ms. Busch she
20 always produced each person you asked to speak
21 with, correct?

17:32:49

22 A. Yes.

23 Q. You never complained to Ms. Busch
24 or internally to a supervisor about Ms. Busch's
25 purported directive not to have folks speak to

17:33:08

1 you? 17:33:12

2 A. I did not talk to Ms. Busch about
3 that.

4 Q. And you did not talk to your
5 supervisor about that? 17:33:16

6 A. I may have.

7 Q. Is there any documentation of you
8 speaking to your supervisor about it?

9 A. I don't --

10 Q. Do you remember any advice your
11 supervisor gave you about how to deal with the
12 situation? 17:33:25

13 A. No.

14 Q. Going back to exhibit 2, the very
15 end of number 14, you don't -- is there a
16 reason you say "staff" as opposed to Ms.
17 Freeborn? 17:33:46

18 A. No.

19 Q. Could it have been somebody other
20 than Ms. Freeborn? 17:34:12

21 A. Could have been.

22 Q. Do you remember --

23 A. I don't know.

24 Q. Do you remember when this
25 information was conveyed to you by the staff 17:34:26

1 that is different than Ms. Warner's
2 recollection?

17:34:31

3 A. I don't know.

4 Q. It could have been in your initial
5 in-person meetings with Ms. Burton and Ms.
6 Freeborn or it could have been in a subsequent
7 phone call with Ms. Freeborn or it could have
8 been on the 23rd when you met with the folks?

17:34:46

9 A. I'm thinking it wasn't the 23rd,
10 but it could have been anywhere else. A
11 specific date I don't have right now.

17:35:04

12 Q. And you asked Julie straight on,
13 staff says this and your recollection is
14 different?

15 A. I'm not sure.

17:35:34

16 Q. So you don't know one way or
17 another whether you gave Julie an opportunity
18 to respond to what the staff was saying?

19 A. You know, I don't know right now.

20 Q. To your knowledge was this
21 information ever shared with Eastwood? The
22 "information" being this whole entire
23 exhibit 2.

17:35:49

24 A. I believe Eastwood got a copy after
25 the synopsis.

17:36:14

1 Q. They received a copy of your
2 response to the question?

17:36:16

3 A. Yes.

4 Q. And there was never -- with regard
5 to Eastwood's response to the recommendations
6 and conclusions, there was never any follow-up
7 by the county or the state needed to implement
8 those changes, correct?

17:36:27

9 A. I'm sorry, say it again.

10 Q. When Eastwood submitted its plan of
11 action there was never any action by the state
12 or the county saying you're not following
13 through any plan of action, correct?

17:36:45

14 A. Correct.

15 Q. Do you know where Lorna Moeller is
16 buried?

17:36:58

17 A. Arcola Cemetery.

18 Q. Since her death have you visited
19 her grave?

20 A. I did once.

17:37:18

21 Q. When did you do that?

22 A. I don't know.

23 Q. That's all right. Do you know if
24 it was before or after you spoke with Ms.
25 Zoelbel in that meeting when you delivered your

17:37:28

1 MUI synopsis? 17:37:31

2 A. It was after, I think. I don't

3 know.

4 Q. Fair enough.

5 A. Good. 17:37:46

6 Q. And after Ms. Freeborn said she

7 would help any way she can, did you ever speak

8 with her again?

9 A. No, not that I'm aware of. Not

10 that I recall. 17:38:02

11 MR. FORBES: Thank you.

12 THE WITNESS: Thank you.

13 MR. KRAUSE: Sorry.

14 EXAMINATION OF PATRICIA FISHLEY

15 BY MR. KRAUSE: 17:38:12

16 Q. I want to be very clear. When you

17 were made aware that something had happened

18 that would generate an MUI, you know, type

19 investigation, you wouldn't have known right

20 off the bat which employees were involved and 17:38:27

21 which weren't -- which employees and staff at

22 Eastwood were involved in the care and which

23 weren't, correct?

24 A. No.

25 MR. SCHALTENBRAND: Which MUI? 17:38:37

1 Which MUI?

17:38:38

2 MR. KRAUSE: Well we'll talk about
3 the MUI revolving around Lorna Moeller's death.

4 Q. You wouldn't have known which
5 employees were involved and which weren't,
6 correct?

17:38:45

7 A. Correct.

8 Q. And the person whom you would have
9 directed that request to to find out who was
10 involved would be LuAnne Busch, correct?

17:38:53

11 A. Correct.

12 Q. Did she ever give you the identity
13 of the employee who was sleeping on the couch?

14 A. Did LuAnne?

15 Q. LuAnne Busch.

17:39:02

16 A. No, but I never asked.

17 Q. And just so I'm clear about the
18 time frame for when this employee would have
19 been sleeping on the couch, would this have
20 been around the same time that the residents
21 reported to you Lorna Moeller was in her room,
22 unassisted and calling out for help?

17:39:09

23 MR. FORBES: Objection to the form.

24 Q. If you don't know, you don't know.

25 A. Yeah, I don't think so.

17:39:23

1 Q. What makes you not think so?

17:39:24

2 A. The clients were reporting that it
3 was an ongoing thing from the time she returned
4 from the hospital until her death, and Marquita
5 was the one that reported to the staff,
6 Marquita was with her that night, okay? The
7 other staff was there in the building, so they
8 wouldn't have known. I'm thinking it's two
9 separate things because they just reported it,
10 it was a more ongoing thing, the clients.

17:39:44

17:40:03

11 Q. All right. Do you recall if -- on
12 how many occasions did you speak or interview
13 Rita Freeborn, speak with or interview Rita
14 Freeborn?

15 A. I can only remember -- I think it
16 was only once.

17:40:26

17 Q. If your memo of May 25th, 2000
18 indicates that your conversation with Rita
19 Freeborn was on May 25th, 2000 and that she
20 resigned from Eastwood at the end of February
21 and that you contacted her at home and she was
22 willing to help any way she could, then that
23 would be the only time you spoke to her?

17:40:31

24 MR. FORBES: Objection to the form.

25 A. Well it would have been more than

17:40:42

1 once then, because I would have talked to her
2 around the 2nd, 1st or 2nd, so it would have
3 been more.

17:40:43

4 Q. When you talked to her around the
5 1st or 2nd of what?

17:40:50

6 A. February, I'm sorry.

7 Q. You wouldn't have spoke -- well
8 Lorna Moeller didn't die until the 4th.

9 A. Right.

10 Q. You spoke to her on the 1st or 2nd?

17:40:58

11 A. Oh, gosh, it had to be after that.
12 Thank you.

13 Q. Right.

14 A. It had to be the 4th.

15 Q. After the 4th, okay, and before the
16 25th of May, did you speak to Rita Freeborn or
17 conduct any other interviews with Rita
18 Freeborn?

17:41:09

19 A. You know, I'm thinking that she
20 called our office, that she called my office,
21 but I really don't -- I don't recall talking to
22 her more than once or twice.

17:41:26

23 Q. When she called your office was
24 this before or -- was this still in February?
25 In other words, was this before or after she

17:41:42

1 left Eastwood?

17:41:43

2 A. I don't know.

3 MR. KRAUSE: That's all I have,
4 thanks.

5 THE WITNESS: Thanks.

17:41:58

6 MS. TOSTI: I've got just one
7 little follow-up.

8 (Discussion had off record.)

9 EXAMINATION OF PATRICIA FISHLEY

10 BY MS. TOSTI:

17:42:11

11 Q. When you did your MUI synopsis --

12 A. Yes.

13 Q. -- you incorporated a number of the
14 findings from Dr. Eddy's report.

15 A. Yes.

17:42:22

16 Q. Is that a usual thing for you to do
17 when you receive information from the state
18 medical director, to incorporate it in an MUI
19 synopsis?

20 A. This is the first time I've
21 received anything from the state medical
22 director.

17:42:33

23 Q. Why is it that you incorporated
24 that information in this MUI synopsis, why did
25 you do that this time?

17:42:42

1 A. Based on his medical background,
2 his medical expertise and his evaluation of
3 this entire case.

17:42:45

4 Q. As an Ohio Department -- or Lake
5 County Department of Mental Retardation and
6 Developmental Disabilities was it typical for
7 you to rely upon the state medical director's
8 reports or findings, directives?

17:43:00

9 A. Not just medical director, but
10 anybody at the -- some people at the state we
11 would get direction from.

17:43:15

12 Q. Now we were talking about this
13 individual on item number 14 that is just
14 described as the staff reported that Julie did
15 witness Lorna vomiting at six p.m., it's on
16 page five of --

17:43:30

17 A. Yes.

18 Q. -- defendant's exhibit number 2
19 under item number 14. That information, even
20 if you can't specifically say it came from Rita
21 Freeborn, did that information come from
22 someone that actually was there at the time and
23 witnessed Lorna vomiting?

17:43:41

24 A. I can't -- I can't think of another
25 second shift staff person that I spoke with

17:44:04

1 other than Rita.

17:44:07

2 Q. But the person that you're
3 referring to here was giving you firsthand
4 information of what that person was observing
5 at the time?

17:44:16

6 A. Yeah.

7 Q. Yes? Is your answer yes?

8 A. Yes.

9 MS. TOSTI: I don't have any
10 further questions.

17:44:25

11 EXAMINATION OF PATRICIA FISHLEY

12 BY MR. FORBES:

13 Q. Do you have any training as a
14 nurse?

15 A. No, I do not.

17:44:30

16 Q. Do you have any medical training at
17 all?

18 A. Medical training?

19 Q. Training regarding how to care for
20 people who aren't feeling very well.

17:44:36

21 A. Other than basic first aid and
22 those things that --

23 Q. Would you say your training is
24 equivalent to a resident care worker, the
25 training they should receive?

17:44:48

1 A. Yes.

17:44:51

2 MR. FORBES: Okay, thanks. Thank
3 you for your patience.

4 (Discussion had off record.)

5 MR. FORBES: Eric, signature?

17:45:09

6 MR. SCHALTENBRAND: She's going to
7 waive. She'll waive signature.

8

9 (Deposition concluded.)

10

- - - - -

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Michelle A. Bishilany, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, PATRICIA FISHLEY, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

1 I do further certify that I am not
2 a relative, counsel or attorney for either
3 party, or otherwise interested in the event of
4 this action.

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 15th day of
8 January, 2003.

9
10
11
12
13 Michelle A. Bishilany

14 Michelle A. Bishilany, Notary Public
15 within and for the State of Ohio
16

17 My commission expires January 11, 2006.
18
19
20
21
22
23
24
25

I N D E X

1	
2	
3	EXAMINATION OF PATRICIA FISHLEY
4	BY MR. FORBES..... 4:6
5	
6	EXAMINATION OF PATRICIA FISHLEY
7	BY MR. KRAUSE..... 135:11
8	
9	EXAMINATION OF PATRICIA FISHLEY
10	BY MS. ATKINSON..... 154:7
11	
12	EXAMINATION OF PATRICIA FISHLEY
13	BY MS. TOSTI..... 157:23
14	
15	EXAMINATION OF PATRICIA FISHLEY
16	BY MR. FORBES..... 171:13
17	
18	EXAMINATION OF PATRICIA FISHLEY
19	BY MR. KRAUSE..... 177:14
20	
21	EXAMINATION OF PATRICIA FISHLEY
22	BY MS. TOSTI..... 181:9
23	
24	EXAMINATION OF PATRICIA FISHLEY
25	BY MR. FORBES..... 183:11

1	Exhibit 1 was marked.....	42:4
2	Exhibit 2 was marked.....	78:16
3	Exhibit 3 was marked.....	95:1
4	Exhibit 4 was marked.....	95:25
5	Exhibit 5 was marked.....	108:6
6	Exhibit 6 was marked.....	128:16
7	Exhibit 7 was marked.....	129:24
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

SIGNATURE OF WITNESS

The Deposition of PATRICIA FISHLEY, taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the reading and signing of the transcript of said deposition, be and the same is hereby waived.

Patricia Fishley

A	137:16	advise 123:20	169:19 176:9	78:21 94:16
ability 20:17 25:5	accordance	advised 128:22	177:8	148:7
able 105:15 107:3	163:21 164:1	affect 22:10 38:15	age 4:1 41:1	anger 30:14,16,19
121:11 140:25	accuracy 141:4	39:25	agency 8:17	angry 30:11,12,25
165:14	accurate 11:14	affected 35:8	140:25	31:1,2 160:25
about 7:16 18:23	74:4 133:23	125:9	ago 5:15 21:23	Anna 61:13 67:21
19:8 25:20	153:17	affirmatively	32:8,10 135:13	70:9,10,11
27:14 28:9,16	across 160:14	38:17 162:9	146:5 164:16	71:18,23 72:2,6
28:19 30:14,22	act 77:20	affixed 186:6	agree 50:2 77:7	72:10,15
33:25 34:3,19	acted 104:17	aforesaid 185:12	96:17 106:13	Anna's 61:14
35:6 36:7,20	action 17:25 18:1	after 5:18 6:16 7:9	121:14 124:2	anniversary
37:15,17 38:10	18:4 31:14	7:11,13 8:9	125:24 126:5	123:19
40:21 45:6	176:11,11,13	11:24 33:1	127:17	annual 10:14,14
48:18 51:23	186:4	41:14,17 42:23	agreed 189:12	14:2
53:10 58:4,15	active 146:14	46:19 49:18	agreement 32:2	another 35:17,21
60:2 64:17	actually 36:17	53:5 54:6,18	agrees 78:5	42:25 60:3
66:15 68:15	52:10 75:19	57:19 59:3,22	ahead 69:23	102:10 104:11
70:8,16 71:5	80:9 94:20	62:16 63:21	80:14	113:21 117:7
77:9,24 81:1	114:11 158:21	64:6 65:3 66:21	aid 183:21	125:6 143:3
82:9 84:11	182:22	66:23 67:18	ai 1:9	175:17 182:24
85:16 90:20	add 111:23	78:4 84:4 86:12	Alaki 81:4 135:23	answer 4:16,22
91:3,9,14 97:6,9	addition 81:14	88:3 93:3 96:9	136:13 139:2,8	14:6 24:2 50:11
97:12 99:9,23	91:1,2 104:9	99:24 104:4	Alfie 42:11 74:14	61:19,21 69:18
99:24 100:1	123:21 134:7	108:24,24 109:5	110:10 139:22	88:11 128:6
106:15,16	151:15,24	110:7,11 114:18	140:21	145:22 152:1
109:19 110:8	161:11 173:2	116:14 118:4	Alfriede 74:13	160:6 161:9
111:2,20 114:3	additional 60:8	119:3,4,6 120:3	allegation 32:18	183:7
116:20,23 117:5	75:20 105:10	120:22 121:8	allegations 68:9	answered 13:4
117:9,23,24	106:1 107:13	122:1 126:13,22	110:1	50:22 51:2 88:7
119:25 122:14	108:14,18 112:1	133:7,14 134:4	alleged 109:20	99:16
123:7,11 125:2	112:5,20 114:4	135:9 139:23	allowed 65:8	answering 78:23
128:3 129:13	114:19,20,21	141:7,14,23	144:15	79:18 83:21
139:4 141:3	115:12 133:20	142:1 143:10,15	alone 161:12	88:8,14 89:10
145:10,13	138:4 154:25	143:19 144:11	along 100:2	89:16 90:24
147:11 148:6	158:15 170:6,18	145:5 146:23	aloud 4:17	91:6 151:19
151:2 152:7	address 18:5	150:10,21	already 82:4	answers 4:18 77:2
157:17 158:7	38:11 141:2	162:21 165:17	112:8,22 137:15	78:9 80:7 87:4,9
164:17 167:6	addressed 37:13	172:17,21	158:3 169:23	94:1
168:15 173:24	138:18	175:24 176:24	although 156:17	anticipate 107:4
174:2,5,8,11	adequately 39:21	177:2,6 180:11	159:21	anybody 7:22
178:2,17 182:12	adjournment	180:15,25	always 26:18 46:3	14:5 28:20 40:5
above 66:1 149:15	185:22	afternoon 43:9,11	65:6 152:12	47:19 54:13
above-referenced	administration	67:25	153:9 173:20	57:4 66:1 73:24
185:13,18	22:6,8,20	afterwards 185:15	ambiguity 92:2	136:21,22
abundant 19:5	161:20	after-care 81:6	ambu 131:25	171:21 182:10
abuse 23:22	administrator	101:5,10,15,16	ambulance 99:3	anymore 17:17
abuse/neglect	32:25 57:6,10	again 20:2,11	101:6 137:9,14	65:9 150:24
40:24	57:16 58:17	26:16 36:23	amount 15:4	anyone 10:13
acceptable 24:11	161:25 162:7,12	40:18 44:1	17:22 60:4,5	36:1 45:22
164:7	administrators	59:17 63:3	86:12,18 87:2	51:23 55:24
accepted 112:15	21:12	68:14 82:7,12	92:9 94:2	56:10 57:2 63:2
112:17	admission 40:7	103:16 105:3	amounts 91:22	65:22,25 72:23
access 13:7 87:5	adult 5:24 6:1,14	110:8 111:4,5	92:4 105:15	77:23 78:10
144:16	advice 51:19	124:1 145:14	Andy 102:20	83:1,3 87:12
accident 171:25	174:10	150:14 151:20	Angel 42:11 59:5	96:11 97:11
accompany	advisability 128:4	155:20 169:17	59:24 74:23	117:3 123:20

124:11,12 139:9 165:5 171:16 anything 11:22 28:19 32:22 33:15 34:12,16 34:22 35:15 45:6 48:18 53:7 56:24 71:10 73:5 83:6,12,18 85:1 100:1,25 110:6 113:16 117:20,21,23,24 130:22 133:21 148:1 151:15,23 152:7 155:22 158:8 181:21 anywhere 175:10 apartments 9:4 apologize 102:5 166:10 APPEARANCES 2:1 3:1 appears 130:6 appointment 46:22 77:5 78:6 apprised 14:20 appropriate 157:13 appropriately 12:3 24:8 appropriateness 10:16 approximately 26:23 April 118:13 Arcola 176:17 area 39:8 44:7 areas 40:13 around 62:20 74:19 75:1 93:3 120:3 125:8 139:1 178:3,20 180:2,4 arrangements 46:25 49:24 53:6 137:13 arrival 93:17 153:18 arrived 92:25 Ashtabula 47:13 49:1 51:8,12 aside 35:1 160:4 asked 18:9 43:22 45:11 58:14 61:20 72:13 81:10 83:1	126:21 128:5 151:14,22 162:14,16 173:20 175:12 178:16 asking 34:22 35:5 35:6 75:12 87:21 91:1 142:7 146:1 162:24 asks 49:23 asleep 90:11 aspects 13:6 assess 73:25 74:8 assessed 71:12 131:1 assessing 71:22 130:21 assessment 12:25 13:2,9,10 40:14 98:10 assessments 13:24 35:14 assigned 26:9 assist 7:25 151:19 152:2 assistance 124:15 assistant 74:24 assisted 166:1,22 assisting 123:12 assists 9:2 assume 4:23 80:2 assumed 27:13 27:14 assuming 167:8 Atkinson 3:15 154:5,8,10 155:21 187:10 attempt 31:16 39:7 161:2 attend 46:23 attention 23:2 130:25 attorney 109:15 141:8 186:2 auditor 32:8,18 August 119:12 authorize 156:20 autopsy 47:3,7,22 48:15,22 49:3 50:8,12 51:15 51:21,24 52:25 available 20:4,12 21:3 35:9 50:1 88:12 136:12	Avenue 2:16 3:8 3:17 awake 90:11 aware 18:3,14 20:20 58:24 65:14 87:24 88:1,9,15 109:7 109:25 115:3,7 115:11,14,20 116:8 121:1,4 177:9,17 away 43:1 53:22 53:25 57:22 60:7 63:24 161:19 awful 143:17 a.m 92:14 93:17 93:19 149:8,8,8 149:8 150:5,5 164:22,22,22,23 164:25 <hr/> B <hr/> BA 5:12,13 bachelor's 5:8 back 27:2 60:24 67:2,5 71:3 74:8 74:9 75:18 83:1 93:15 94:6,24 102:4 108:12 125:14 139:1,3 140:14 155:19 158:12,13 162:20 174:14 background 182:1 bad 132:5 ball 97:23 Barb 136:15 Barbara 89:19 135:22 136:1,20 139:1,4,8 barn 11:24 based 9:21 12:21 20:15 31:10 71:8 127:7,9 130:19,24 131:23 132:19 140:22 142:8 159:24 160:12 182:1 basic 105:23 183:21 basically 14:15 27:11 43:23 99:21 110:14	111:14 123:12 basis 15:9 26:17 46:6 105:25 107:2 110:3 170:16 bat 177:20 became 26:8 57:24 Becker 2:4 become 5:6 becoming 26:3 bedding 55:15 166:2,23 bedroom 72:1 before 1:16 4:13 30:6 32:25 33:2 42:17 63:7,13 63:13,23 65:16 69:14,15 75:18 80:12,17 84:8 87:1 97:24 99:2 120:10,13 124:18 142:1,10 142:11 176:24 180:15,24,25 begin 17:4 beginning 17:16 111:9 113:25 behalf 2:3,11 3:3 3:12,21 4:11 15:16 154:10 171:22 behavior 20:5 28:15 35:7 116:6 behavioral 9:24 behind 152:13 being 4:3 18:2 23:25 24:10 30:15,23 32:19 33:12 34:4,15 48:9 52:11 57:6 57:15 73:19 81:17 82:9 83:9 87:18 88:5 89:23 93:16 129:14 137:8 140:25 142:8 145:5 148:24 161:12 175:22 believe 9:5 11:5 18:18 23:23 25:4,23 27:16 31:18,22,23 38:23 43:15 44:10,23 45:4	46:6 48:11 52:13 54:10,10 54:17 55:12 56:18 57:19 59:7,25 63:7 67:6 70:21 71:23 75:2 81:10 82:5,20 86:22 87:3 92:13 93:1,5,8 94:20 96:25 99:18 100:14,17 103:24 114:1,22 116:22 119:19 129:1,4 133:23 139:11 152:1 154:22 158:5,11 158:17,24 159:15 162:21 164:15,17 168:8 168:14 169:9,9 169:11 172:11 172:16 175:24 believed 20:16 101:7 below 40:12 besides 121:19 best 20:16 30:13 37:7,17,17 42:17,17 92:20 120:17 127:8 134:11 140:19 better 35:24 70:1 157:22 between 8:13 9:13 34:9 54:12 60:6 92:14,19,20 98:12 103:8,12 103:22 104:6,10 104:12,23 105:5 108:13 120:7 126:14 145:14 146:10 149:20 154:19 166:12 166:16 167:2 173:6 189:12 bias 109:9,20,20 141:3,11 biased 139:24 big 36:13 bile 91:23 92:8 Bill 22:25 31:15 78:21 128:21 148:7 billing 73:20 Bishilany 1:16
---	---	--	---	---

Patricia Fishley

185:6 186:14 bit 133:16 blanking 49:12 blood 98:10 106:4 170:21 board 1:19 3:21 8:15 156:19 160:18 164:2 both 31:6 127:18 bother 28:21 bottom 76:8,10 104:3 132:24 152:8 153:16 159:11 166:9 Boulevard 1:20 3:23 6:6 bowel 50:13 110:17,25 Boy 153:9 break 68:24 69:7 brief 135:17 158:2 bring 23:7 Brittany 39:6 Broadfield 9:10 brought 4:10 32:6 155:19 brownish 86:13 86:19 87:2 91:22 92:5,8 94:2 BS 5:10 bug 144:21 building 2:15 3:7 3:16 6:4,5 25:16 165:4 179:7 bunch 151:2 buried 176:16 Burton 54:24 55:2 55:10 56:9 59:17 65:17,23 66:11,17 72:20 79:11,20 120:20 121:2,5,8,19,21 122:5,18 133:13 133:22 141:20 141:24 143:14 143:16,19 145:14 146:11 150:11,21 160:24 162:25 163:3 172:10,17 173:2 175:5 Busch 29:12 30:2 33:1 43:2 49:23 56:9 57:13,15 58:13 65:16,23	66:12 79:5 83:17 96:17 97:12 112:16,18 112:18 138:18 139:22 141:3,20 143:12,20,23 144:11 145:15 146:2,11,16,19 150:11,22 160:25 172:2 173:19,23 174:2 178:10,15 Busch's 58:23 168:7 173:24 butchered 89:15 buy 33:4 C call 15:8 66:18 83:23 84:1 109:13 121:8 123:8 125:1 141:8,15 162:17 165:17 171:5,19 172:22 175:7 called 1:15 4:1 22:5 40:14 43:2 48:15 50:4 54:4 67:2,4 81:19,23 82:25 83:25 84:25 109:22 121:2 132:2 162:15,19 180:20,20,23 calling 63:12 94:3 120:20 162:20 178:22 calls 15:5,6 101:14 127:23 came 18:4 23:1 32:18 59:17 60:24 70:5 92:18 96:8 99:2 107:23 118:18 130:9 131:25 133:9 142:2,11 143:1 155:11 170:12 182:20 candid 161:24 caption 185:21 card 93:12 123:18 128:1 140:16 care 6:14,16 8:25 9:7 12:24 13:24 19:14 38:15 45:19 56:2,14	56:20 60:6 70:16 72:20 88:4,6,9,16,19 91:14 98:19,24 98:25 99:2,3,14 99:19,25 103:9 103:22 104:1,10 105:22,24 106:7 106:11,17 117:24 123:22 124:14 125:20 139:13 147:12 154:20 158:7,9 158:15 177:22 183:19,24 career 161:16 care-givers 139:18 care-giving 36:16 Carol 1:5 4:10,11 25:21 28:23 29:1,3,12,22 30:21,23 35:25 52:4,6,18 116:13 158:1 Carol's 29:3 cartons 30:17 case 1:8 6:18,20 7:15,16,18 11:5 11:25 12:6 16:4 16:6,19 21:5,14 21:16,25 22:2,8 23:4 26:3,8,14 27:8 29:18 32:5 39:10,19 42:25 45:25 47:7 60:15,22,23 73:7,8,9,11,14 73:18 75:9,25 98:2 108:1,25 109:2 113:21,22 114:23 132:5 135:24 136:18 139:5,10,13 144:18 148:1 158:2 160:5,11 161:3 182:3 categories 10:5 category 50:23 cause 50:14 144:23 185:12 caused 35:16 cc 76:11 170:3 cc'ed 138:23 Cemetery 176:17 censure 85:25	census 90:5,8,14 90:22 center 5:4,6,20,25 6:2,15 9:10 62:24 certain 17:21 certainly 27:25 38:14 CERTIFICATE 185:1 certification 7:5 certified 4:4 certify 185:8,19 186:1 chain 101:13,19 change 20:13 22:16 36:1 109:5 113:24 132:25 152:8 changed 6:9,12 55:16 changes 114:21 139:16 176:8 changing 166:1 166:22 charge 58:21 charged 34:17 77:1,18 79:18 chart 106:5 check 60:17 90:5 90:8,10,14,17 90:22 100:16 Cherry 133:25 134:13 Cherry's 134:3 chose 122:5 cigarettes 30:17 circumstance 125:7 circumstances 124:4 125:8 147:21 citation 17:16,21 17:24 33:25 citations 16:13 17:4 20:17,21 33:6,20 34:13 34:25 35:7,8 86:7,9 cite 17:1 cited 14:19 17:11 33:16 35:7 39:11 57:13,15 Civil 4:3 claiming 63:11 clammy 170:24	clarify 4:21 69:10 104:21 118:7 145:18 162:18 162:24 clear 50:11 162:15 177:16 178:17 Cleveland 2:8,17 3:9,18 5:17,18 186:7 client 9:21 30:10 30:20 31:11 32:19 33:3 34:3 107:1 128:21,23 129:5 155:1,1 clients 15:9 107:4 179:2,10 close 172:12 closer 43:9 clothing 55:16 166:2,23 code 16:14 24:18 24:22 Colace 132:8 collect 156:17 collected 126:25 collecting 127:19 163:18 come 7:24 25:6,25 32:9 48:5 50:10 57:17 58:9 65:10 82:21 95:22 96:4 118:12 140:14 141:7 152:19 160:14 182:21 comes 87:14 106:22 coming 55:19 82:24 92:9 132:7 137:8,15 comments 96:23 commission 186:17 commissioned 185:8 COMMON 1:1 communicate 65:22 83:18 communicated 75:23 97:2 126:25 127:2,4 138:14,17 147:20 151:17 151:25 152:3 communication 81:21 98:12,22
--	---	---	---	--

99:5,23 100:5,7 100:18 101:20 103:7,21,25 104:5,10,12,22 116:7 communications 81:14 101:3 105:5 109:15,19 community 9:3 13:7 75:3 compare 15:18 compared 144:14 compile 43:4 compiled 126:19 127:15 compiling 41:5 complain 21:7 28:19 72:8 complained 173:23 complaint 110:4 complaints 28:9 28:16,24 34:7 38:9 109:7,12 complete 20:3 94:15 completed 153:16 153:18 185:22 completely 54:18 completes 90:5 compromising 114:6 170:8,20 concern 34:15 35:16 68:8 83:2 89:25 141:10 163:5 concerned 77:14 77:24 81:17,22 82:9,14 137:7 concerns 33:21 33:24 34:14 36:7,9 37:12,13 38:9 141:3 147:11 158:6 concluded 184:9 conclusion 98:9 98:21 101:25 110:20 111:9,10 117:12 134:10 conclusions 98:7 98:8 107:7,9 126:7 127:8,9 127:18 133:7,14 134:4,12,15 176:6 condition 26:15	55:18 85:16 91:3 106:22 conditions 105:24 106:24 conduct 7:3 41:3 108:14 163:11 163:12 180:17 conducted 144:15 163:10 conducting 123:21 165:7 confidence 163:2 confidentiality 156:16,23 conflicts 90:19,23 125:15,25 confronted 20:22 confusing 4:20 confusion 145:19 146:7 connecting 64:1,8 64:10 consider 156:24 consideration 71:22 considered 82:18 consist 54:9 consistent 12:3 31:15 46:5 131:11,17,24 132:18 133:6,13 134:3,14 console 122:6,10 consoling 123:24 124:21 125:18 127:18,22 constitute 130:10 consultant 39:3 48:12,13 49:1,5 49:11 50:5,7 consultants 104:7 104:13,24 105:6 consultant's 51:18 consultation 50:4 consulted 47:20 47:25 consumer 10:4 13:4,9 23:5,10 34:3 40:23 90:10 consumers 26:9 28:13 60:13,21 106:12 138:5 contact 26:1,5,10 26:12,13 27:18	27:21 49:10,15 51:8 76:22 114:19 121:13 121:19,24 122:2 123:23 contacted 48:11 55:17 84:21 121:16,22 173:19 179:21 contacting 86:14 171:7 contained 140:20 151:24 contemporaneo... 74:3 continue 66:13 108:25 continued 3:1 89:3 140:24,24 contrary 51:18 conversation 52:6 52:15,17,18,22 85:2 100:17 110:7 139:1 158:5 179:18 conversations 54:12 72:15 154:13 conveyed 96:21 133:12 174:25 cool 170:24 cooperate 66:7 cooperative 136:2 coordinated 98:19 coordination 104:1 coordinator 10:10 cope 125:10 copied 53:18 76:23 copies 156:20 copy 81:10 95:9 110:9 114:15 139:7,21 140:1 140:2,13 153:22 155:23 156:18 157:6 168:6 175:24 176:1 coroner 47:10,12 47:20 48:2,6,11 48:16 49:1 51:9 coroners 53:6 coroner's 50:17 correction 17:23 169:13	correctly 19:23 91:25 92:16 120:12 couch 165:11 178:13,19 counsel 1:18 109:14,19,22 169:16 186:2 189:12 county 1:2,19 3:21 8:8,14,15 8:21 10:19 11:5 12:19,20,23 13:13 14:11,18 16:3 17:8 19:6 19:15 20:8,9 38:16,25 42:24 47:13 48:11,16 48:21,24 49:1 50:16,17 51:9 57:7 58:22 77:17 97:18 101:20 112:15 134:23 135:4 138:13 164:2 176:7,12 182:5 185:4 county's 39:18 160:18 county-run 8:17 couple 53:4 60:13 63:20 135:7 154:5 course 144:10 161:16 164:19 170:25 court 1:1 4:17 19:13 courteous 136:2 covered 169:11 cried 117:16 cries 64:22 91:9 critical 171:1 crossed 132:24 crying 60:16 69:13 70:3,7 91:15 crystal 69:11 current 5:1 74:21 Cuyahoga 185:4 CV 1:9 D D 187:1 daily 15:9 40:13 date 63:16 95:17	102:14 118:6 132:21,22 152:8 152:15 153:16 175:11 189:7 dated 118:8,13,25 132:16 133:25 134:14 dates 27:1 153:6 David 2:14 21:19 75:25 97:16 135:14 day 37:5 52:19 62:16 65:18 66:21,23 67:24 72:18 80:12,17 89:20 92:13 141:23 152:12 153:13,14 171:25 172:1,9 172:11,13 186:7 days 17:22,22 53:4 63:21 145:4 146:22,23 day-to-day 16:2 17:14 115:15 deal 174:11 dealing 125:19 148:1 dealt 55:8 124:16 death 28:24 42:14 42:20 47:11 50:14 52:9 54:3 59:13,22 63:21 72:18 107:11 108:15 110:16 124:4,20 125:8 125:10,19,22 126:14 127:20 128:25 129:6,18 129:19,20 137:22,24 142:23 145:5 146:23 148:2 154:14 160:5,16 172:1,1 173:7 176:18 178:3 179:4 deaths 125:5 decide 46:14 decision 9:19 10:1,12 22:14 47:21 51:23 decisions 11:17 Deepwood 1:20 3:23 5:4,6,20,23 6:5,17 7:7 8:4,14
--	---	---	--	--

Patricia Fishley

8:15,17 9:10 11:15 62:24 73:9 115:2,6 134:19 164:13 Defendant 2:11 3:3 Defendants 1:10 3:12 defendant's 42:4 78:16 95:1,25 108:6 128:16 129:24 159:3,4 159:23 164:16 165:21 166:8 168:4 182:18 defense 169:16 defer 22:9,15,19 deficits 40:12,16 defining 173:4 definitely 119:6 definition 40:10 delivered 128:8 176:25 delivering 124:8 denied 167:12 department 6:18 6:21 9:2 12:6 13:19,22,25 22:1,3,5 27:8,9 41:2 74:25 75:5 111:18 160:8 182:4,5 department's 163:22 depending 106:21 deposed 4:4,13 deposition 1:14 8:21 42:4 78:16 95:1,25 108:6 128:16 129:24 171:17,20 184:9 185:20 189:6,9 189:14 deprived 30:15 deputy 74:24 describe 19:4 23:17 26:13 40:3 42:16 described 23:19 44:14,21 182:14 describes 151:10 describing 156:2 description 91:20 detail 17:18 determination 40:15 46:7	determine 47:3 determined 23:20 110:16 111:5,10 determining 152:3 develop 106:24 developing 163:19 development 6:17 6:25 7:1,12,13 Developmental 160:9 164:3 182:6 diagnosed 110:18 111:1 diagnosis 132:11 die 180:8 died 27:17 28:8 38:6 42:23 43:2 43:10 54:19 63:13,13,18 64:6,15 69:14 70:6 92:13 135:1 154:21 Dieglio 81:3,4,5 81:12 82:2,7,8 82:13 83:7 85:10,11 87:11 89:19 101:14 135:23 136:13 137:6,12 139:2 139:4,9 173:16 dies 47:2 difference 45:14 103:12 different 13:6 18:17 22:8 38:3 60:5,11 81:14 87:16 88:17 133:21 134:9 150:1 165:3 175:1,14 difficult 52:8 58:1 144:24 difficulty 19:6 diploma 5:16 direct 6:14,15 26:5,10,12 45:19 88:6,9,16 88:19 98:19,24 98:25 99:2,3,14 99:19,25 104:1 105:22 106:7,11 106:17 115:15 128:7 directed 139:13	141:20 178:9 direction 182:11 directive 143:12 144:12 145:15 146:12 150:11 150:22 173:25 directives 182:8 directly 26:18 156:19 director 21:16 74:24 75:24,25 76:18 160:7,15 181:18,22 182:9 director's 102:8 182:7 Disabilities 160:9 164:3 182:6 disagree 147:5 disagreement 96:20 disburse 156:17 discharge 98:18 99:24,24 100:13 114:24 151:17 152:1,4 discharged 151:12 discharges 101:22 discipline 17:4,15 discrepancy 93:8 149:20 166:11 166:16 167:2,7 discuss 52:15 144:17 145:22 discussed 52:25 109:24 117:10 Discussion 69:8 95:5 130:3 135:10,21 165:20 181:8 184:4 dispute 92:24 disseminate 140:13 156:10 distinct 94:13 distinguish 9:13 101:2 districts 49:9 divided 27:10 49:8 DNR 52:23 doc 51:1 doctor 105:20 doctor's 31:21 86:14 132:12	document 42:12 59:23 82:4 documentation 10:20 85:16,24 86:3 88:5,12 105:12,16 132:11 174:7 documented 66:8 66:10 85:20 86:4 96:25 99:13 151:16 documents 41:17 41:20,21,23 42:17 45:3 147:1 169:18 doing 22:18 26:19 26:22 27:6 35:14 115:15 119:18 147:17 168:24 done 18:7,8,10 24:10 47:3,7 73:25 90:17 99:7,9 106:15 106:17 161:14 doubt 135:8 down 4:17 43:14 61:18 83:21 91:19 96:23 120:6 137:21 140:5,6 159:11 164:18,19 Dr 3:13,13,13 76:17 94:21 95:8,10,18 96:10,21 97:5,8 102:20 103:12 104:4 105:4,10 105:22 110:19 111:2,5,11,14 111:20 116:25 117:12 118:18 119:25 120:3,9 126:5,6,11,17 126:19,21 127:1 127:5,7,9,17 145:23 154:10 154:11 170:12 170:14 181:14 drew 133:7 driver 100:25 101:6 drugstore 44:16 dual 125:14,16,18 125:23,25 duly 4:3 185:7,10	during 32:4 34:16 34:21 35:13 69:13 71:24 72:3 112:19 136:10 146:20 148:22 149:4,5 149:14,23 158:16 164:18 164:19 171:3 duty 91:11 158:17 165:10 <hr/> E E 187:1 each 156:18 173:20 earlier 65:18 66:16 151:14,22 154:17 early 11:13 25:10 25:11,24 66:22 East 1:9 48:10 154:14 Eastwood's 59:9 86:1,7 87:5 169:20 176:5 Eddy 76:17 94:21 95:8,10,18 96:10,21 97:5,8 102:20 104:5 105:5,22 111:2 118:18 126:5,6 126:11,17,20,21 127:1,5,7,9,17 145:23 170:13 170:15 Eddy's 103:13 105:10 110:19 111:6,11,14,20 116:25 117:12 119:25 120:4,9 181:14 education 5:5 eight 37:22 57:21 93:7,19 100:19 either 8:5 9:3 16:3 19:25 35:19 54:17 59:16 71:8 89:22 114:13,14 117:13 171:4 186:2 elderly 9:18 Eligibility 40:15 eligible 40:4 emergencies
--	---	---	---	--

114:5 168:14,17 168:23 169:8 170:7,19 emergency 131:2 emesis 97:1 emotional 117:17 employed 134:18 employee 77:17 143:22 145:2,3 146:18,22 178:13,18 employees 7:4,5 36:16 136:16 141:21 143:13 144:12,16 145:16 146:12 146:15 150:12 173:12 177:20 177:21 178:5 employment 11:10 employment-wise 5:19 end 17:5 84:19 174:15 179:20 enforce 12:22 enough 19:2 22:21 24:11 37:25 38:15 48:21 58:15 74:10 133:10,11 177:4 entire 156:25 175:22 182:3 equivalent 183:24 Eric 3:22 140:10 140:11 157:10 184:5 Eric's 140:9 ESQ 2:5,14 3:6,15 3:22 estate 1:6 4:12 estimate 92:20 et 1:9 Euclid 3:8 evaluation 182:2 even 15:8 105:13 182:19 evening 45:1 158:18 event 186:3 events 42:19 59:13 101:13 128:24 156:4 ever 4:13 11:21 12:1 14:11	25:21 32:6 36:4 39:11 41:12 58:21 67:8,15 68:14 76:21 77:9 81:13,13 82:17,25 91:8 95:12 97:8,11 124:18 125:6 128:3,8,22 136:8 139:3,7 143:21 147:20 160:5,14 162:10 168:6,24 169:6 171:16 175:21 177:7 178:12 every 10:15 13:11 90:5,17 106:4 everybody 28:20 105:14 everybody's 37:8 everyone 156:11 everything 156:13 157:6,18,21 exact 118:5 exactly 25:17 105:17 examination 1:15 4:2,6 135:11 154:7 157:23 171:13 177:14 181:9 183:11 187:3,6,9,12,15 187:18,21,24 example 106:2 exception 127:22 excerpt 148:21 excess 19:7,9 exclusive 18:23 exclusively 18:22 excuse 91:21 Executrix 1:5 exhibit 42:2,5 54:8 74:12 78:14,17,20 84:8 95:2,6 96:1 96:6,7 100:21 102:2,4,7,10,25 103:2,10,14 107:8,23 108:7 108:10 110:15 118:8,12,12,19 128:17,20 129:25 130:5 131:7,17 148:6 148:10,11 151:1 151:6 153:2	158:25 159:3,5 159:23 164:16 165:22 166:8 168:4 174:14 175:23 182:18 188:1,2,3,4,5,6,7 Exhibits 118:7 exist 73:12 exit 14:16 39:17 expedite 156:21 experience 11:17 130:19 160:12 160:17,21 experienced 17:19 expertise 182:2 expires 186:17 explain 5:7 81:5 explained 81:13 express 136:20 expressed 83:2 158:6 163:5 extent 20:10 extra 80:16 extremely 121:10 136:4	fairly 24:4 fallible 74:18 familiar 107:24 families 8:11 family 10:10 21:7 30:11,25 31:7 36:1 41:3 124:22 125:18 128:11 family's 30:14,16 far 21:13 29:10 57:6,14 163:2 fax 153:23 faxed 153:14,21 February 43:10,11 52:2 53:8 54:13 59:8 63:16 66:22 67:14 84:19 87:1 89:12,13 94:4,5 116:14 123:15 123:17 126:14 130:8 134:1,14 134:24,25 152:9 152:16 153:8 158:20 166:3,24 167:13 179:20 180:6,24 fecal 92:18 97:1 federal 12:13 13:16 18:11 36:23,25 57:8 58:22 85:18 101:21 134:22 135:3,4 feel 170:17 feeling 183:20 felt 89:1 126:1 158:11 few 135:13,16 171:12 fewer 22:17 fifth 164:18 figure 91:7 92:1 118:17 file 108:21 114:16 153:22 156:5,8 157:1,3,9 filed 31:4 53:12 60:1,4,9 120:25 121:3 129:20 files 157:16 164:12 filing 128:4 fill 35:15 73:5 filled 154:18,23	155:7 159:22 filtered 126:8,10 finally 52:13,13 financial 32:7,15 34:16 find 93:14 144:13 161:22 162:4 178:9 finding 7:25 111:9 111:10 findings 110:14 116:25 138:11 138:14 139:10 139:12 181:14 182:8 fine 61:24 62:1 107:14,16 140:9 146:8 157:7 Fineman 62:3 63:5 finish 142:4 fire 78:1 fired 147:18 first 4:3,16 8:9 25:6,25 28:19 37:9 49:15 56:25 58:8 59:16 61:19 75:8 92:17 98:8 103:6 106:14 107:25 108:1 111:13,16 118:24 129:13 130:8 144:9 160:10,22 166:9 168:20 171:15 181:20 183:21 185:10 firsthand 183:3 Fishley 1:14 4:1,6 4:8 130:4 135:11 154:7,9 157:23 171:13 177:14 181:9 183:11 185:10 187:3,6,9,12,15 187:18,21,24 189:6 five 23:14 86:10 94:8 96:24 101:25 103:2 111:13,17 165:22 166:8 167:22 170:14 182:16 fix 38:16
--	---	---	--	--

Patricia Fishley

flag 113:3,7	179:24 183:12	177:6 179:13,14	given 45:22 87:16	grief 123:13,25
folks 10:6 16:1,21	184:2,5 187:4	179:19 180:16	95:9 116:11	124:9,16 125:11
19:6 22:17 24:5	187:16,25	180:18 182:21	133:18 169:19	grieving 124:22
24:9 29:20	forego 169:24	front 54:8 71:2	185:13,18	125:18
39:21 46:19	foregoing 185:16	function 12:1	giving 183:3	group 9:1,20 12:1
49:18,21 58:21	185:21	functioning 71:8	go 11:23 13:18	13:13,15 14:3
59:4 63:4,18	forget 151:1	71:11,13 81:20	14:8 20:21 21:9	14:12,18,23
64:3,11,23 67:9	Forgetting 34:12	functions 12:5	23:9,11 32:23	16:2,18 18:12
69:12 70:2	form 81:16 82:11	funded 9:16 18:15	34:13 40:22,25	18:15 20:5
71:14 72:14	98:16 101:3	18:22	41:1 42:17 43:3	21:12 35:20
74:9 75:10	104:25 107:23	funding 18:19,25	43:6 46:14	37:5 38:20,24
76:13,22 77:10	107:24 142:16	36:20	62:13 69:23	39:8 40:4 47:1
81:1 87:15	144:2,19 145:7	funds 33:3	72:10,23 76:8	77:19 85:20
90:16 106:23	147:7 152:5,8	funeral 46:23,24	77:6 80:14	101:22 107:14
123:22 135:9	155:9,10 160:23	49:24 53:3,5	90:10 93:15	117:7 161:20
145:24 173:25	161:4 178:23	further 96:10	94:6 96:7,23	162:5,6 172:6
175:8	179:24 189:11	113:7 155:22	100:19 104:3	guess 42:1 91:7
follow 20:18 75:6	format 164:4,7	171:10 183:10	131:5 133:24	97:22 120:18
116:10 163:17	forms 101:5 155:9	185:19 186:1	135:18 140:6	123:9 127:21
followed 17:24	formulated	fuzzy 100:2,3	172:22	153:11
following 42:20	170:10		goes 45:16	guessing 11:13
58:20 65:7	formulating	G	going 4:22 17:16	43:25 67:25
113:6 115:10	170:17	gastroenteritis	18:5 20:24 28:7	120:15
116:4 137:24	forth 54:8 58:13	132:5	32:12 42:1	guys 123:10
141:24 172:13	forward 142:2,12	gather 75:17	46:15 50:15	
173:7 176:12	143:1	gathered 41:18	51:21 55:20	H
follows 4:5	found 19:13 48:23	gave 44:10,19,24	58:17 65:14,17	H 2:14
follow-up 18:1,7	163:7	70:11 76:1 95:6	65:19 66:3,7	habilitation 10:9
112:21,23 114:9	four 72:23 85:15	117:11 134:8	69:4 73:1 82:21	11:6
131:13 176:6	91:11 98:8	144:8 174:11	85:4 90:20 91:1	half 98:5
181:7	107:13 130:7	175:17	91:19,25 92:1	hall 26:7
follow-ups 135:8	148:9,15 149:3	geared 103:21	95:22 104:21	hand 124:8 186:6
171:12	164:17 170:24	geez 25:8 93:24	105:3 124:2	handle 53:14
food 33:21,23	fourth 105:9	121:23	128:13 135:17	88:13 101:22
34:8,9	148:14 164:19	general 10:5	137:20 143:17	handled 23:1
Forbes 3:6 4:7,9	fragmented 99:2	15:20 41:9,16	143:18 145:13	handling 24:7
16:6 20:9 29:7	frame 63:18 144:7	163:15	148:21 169:16	114:5 168:13,16
42:10 61:22,24	144:8 145:3,8	generally 9:16,21	169:19 174:14	168:22 169:8
64:9 68:25 69:4	145:10,12,13	20:15,16 38:2	184:6	170:6,19
98:3 100:23	146:20 147:4	41:1,11 46:3	gone 48:24 139:3	hands-on 106:12
102:4,11,16,21	173:4 178:18	generate 41:23	142:18	handwritten 80:8
102:23 103:1,14	frames 44:22	45:24 177:18	good 68:24 73:19	Hank 52:19,22
119:2 129:22	Freeborn 56:15	generated 45:18	73:21 143:7	Hanna 3:7
132:22 135:7,18	56:21 59:4,18	46:13	177:5	happen 114:25
142:16 144:2,6	67:15 72:21	Geneva 48:25	gosh 60:2 123:8	144:17
144:19 145:7,11	79:25 83:22	gets 106:21	140:21 158:11	happened 22:2
145:18,21 146:3	91:20 122:2,7	getting 52:8,11	180:11	43:5,23 44:17
146:6 147:7	122:19 130:22	59:24 75:18	governed 12:12	74:8 124:18
151:14,22 152:5	131:1 137:2	77:1 83:10 94:1	government 18:22	131:11,18,24
153:5 154:18	145:6 146:20	give 17:17 22:22	20:4	132:19 133:10
156:3,12,22	147:4,8 158:5,8	37:21 76:2,5	governmental	134:3,11 148:1
157:12,21 159:2	158:17 159:12	77:19,23 78:3	18:25 19:19	149:23,24 162:5
161:4 166:5,10	167:18,19 168:1	102:14 105:8	government-fun...	162:21 177:17
168:15 169:23	172:14,18,20,25	116:24 144:6	40:9	happening 77:21
170:4 171:11,14	173:8,10 174:17	156:9 162:17	graduating 5:18	92:11 105:17
177:11 178:23	174:20 175:6,7	178:12	grave 176:19	happens 11:24

78:4 115:1 happy 13:5 15:4 136:23 156:10 having 15:23 17:19 39:12 88:3 137:11 138:3 head 28:13 33:10 38:17 67:11 83:13 95:20 162:9 heard 63:19 69:13 91:9,10,12 110:8 hearing 64:21 72:8,9 hello 28:1 help 32:1 45:13 49:23 60:16,17 61:10 64:4,22 66:1 74:9 84:22 91:10 119:5 122:14 142:7 147:9,13 177:7 178:22 179:22 helpful 83:10 162:3 helping 123:24 124:9 125:9 Heng 3:13 154:10 Henry 29:14 hereinafter 4:4 hereof 189:8 hereunto 186:5 Hey 159:2 him 48:3 76:19,20 127:10 157:6 hold 52:8,11,14 home 9:14,20 11:4 13:15 14:18 17:25 20:22 24:7 25:1 26:15,21 27:25 28:10,17 29:24 31:2,7,14 33:5 33:13 34:8,18 35:7,20,21 36:16,19,21,22 38:11 40:1,4 43:19 46:23,24 47:1 67:6,9 70:5 70:13,24 81:20 83:23 84:4,22 99:3 104:6,12 104:23 105:6 113:18,21 117:8	120:21 131:19 131:25 132:7 137:8 154:20 161:20 172:7,15 172:18 179:21 homes 9:1,4,18 12:1 13:13 14:3 14:12,23,23 15:20 16:2,18 17:1,7,10 18:12 18:15 19:24 20:6 21:12 36:6 37:5 38:3,20,24 39:8,21 40:7 57:7 77:19 85:20 101:22 107:15 130:20 134:21 150:4 home's 35:3 honey 28:20 hope 140:24 hopefully 135:17 hospital 1:9 2:11 48:10,25 52:12 56:13 64:15 70:5 81:18 82:15 85:7 87:10,25 88:10 89:2 96:12 98:14,18,23 99:10 103:22 104:2 131:14,20 134:25 135:15 135:23 136:6,17 138:22 139:9 151:11,16,25 154:14,21 158:13,14,20 171:5 173:12 179:4 hospitalization 130:12 hospitalizations 23:23 114:24 115:22,24 116:7 130:16 hospitalized 103:9 115:13 hospitals 101:23 hour 9:17,23 106:4 117:5 hours 15:10,12 38:1 43:25 90:6 90:17 100:10 121:12 122:11 122:15,21	135:13 house 27:20 36:13 71:3 172:23 household 32:20 houses 67:10 housing 8:19 15:21 19:5,16 19:20 40:9 Human 41:2 husband 31:1 52:6 117:4,14 hygiene 32:20 <hr/> I ICFMR 9:8,14,15 9:20 12:12 47:2 ICFMRs 12:2,9,11 37:5 idea 17:20 47:23 63:8 identification 42:6 78:18 95:3 96:2 108:8 128:18 130:1 identified 76:14 79:3 102:8 106:22 identify 74:13 76:9 78:20 85:5 85:12 94:23 95:7 108:10 128:20 130:4 identity 178:12 ignoring 64:22 Ihlenfeld 102:22 imagine 35:11 165:3 immediately 6:23 implement 176:7 implemented 18:2 112:22 important 20:24 improperly 116:9 impropriety 32:19 improve 103:21 103:24 104:5,12 104:22 105:5 116:7 improving 98:12 103:7 104:9 inappropriately 39:12 Inc 2:12 3:13 incident 23:8,11 23:13,19 24:6	24:25 25:19,21 27:23 40:20 41:6 45:10,11 45:15,17,20,21 46:2,3,8,12,15 53:16 55:1,8 57:25 59:9,11 59:12,21 60:1,3 60:4 62:11 68:3 68:15 75:9 87:6 108:24 115:25 116:1,8 126:23 130:10,17 131:7 132:10,23 133:13,25 134:14,20 142:15,17,25 151:2,5 152:15 152:25 153:3,10 155:6,8 163:13 incidents 23:21 24:20 27:12,15 27:25 28:4 126:13 130:7,21 161:15 include 62:10 included 160:1 includes 106:7 including 31:12 138:12 incorporate 181:18 incorporated 181:13,23 independently 80:25 indicate 72:9 87:25 90:25 147:3 indicated 91:4 132:4 137:5,6 142:3,6 151:18 158:4 indicates 86:25 118:24 159:12 160:16 164:17 179:18 indicating 118:5 118:20 indication 165:1 individual 22:10 31:11 40:6,7 161:19 182:13 individually 162:4 162:11 163:6 individuals 8:3,22	12:10 13:12 44:4 103:8 136:24 inform 124:11 150:6 information 7:19 22:23 43:4 44:8 51:17 60:8,19 61:2 64:16,21 68:2 75:20 76:6 77:24 86:17 89:10,11,17,18 96:9,21 99:5,9 101:7 108:18,20 126:6,12,17,19 126:25 127:10 127:11,13,19 133:12,17 136:6 136:9,24 151:10 151:18 155:1,11 160:1 161:23 163:19 174:25 175:21,22 181:17,24 182:19,21 183:4 informed 42:25 46:21 48:9 52:22 82:2 139:8 141:19 143:1,10,11,19 150:21 160:24 infrequent 26:2 initial 8:10 53:12 53:15,16,23 54:6 59:15 148:23 149:5,23 175:4 injuries 125:5 injury 125:9,10 input 105:12 106:5 inquire 94:11 inquiries 16:22 86:6 inspections 14:2 instance 162:2 instead 15:12 instruction 77:10 instructions 4:15 76:3 81:6,24 82:3 99:25 101:11,15,16 116:10 151:17 Instrument 40:15 intake 7:19 8:7,10 27:12 105:13
--	--	---	---	---

Patricia Fishley

106:5 intense 9:25 intent 103:24 interacting 32:5 interdisciplinary 10:2,6 interest 30:13 125:15 126:1 interested 186:3 interject 118:23 intermediary 15:16 intermediate 8:24 9:6,7 internally 173:24 interpretation 31:10 interrupt 61:17 interview 14:16 23:9 40:22,25 41:4 56:8,10,21 56:25 57:3 84:4 136:13,15,21 148:23 149:4,5 149:14,23 150:9 165:12,14,15 179:12,13 interviewed 66:21 66:24 101:4 126:24 134:9 135:22 136:1 141:23 interviews 39:17 41:10 159:24 161:7 166:15 180:17 investigate 24:7 40:20 61:2,5 investigated 133:9 160:5 investigates 150:4 investigating 124:3,14,20 125:8,20 investigation 40:17 42:13,19 42:24 53:8,11 54:9,11 64:20 66:2,14 96:11 107:21 108:15 109:20,25 111:6 123:21 131:23 132:19 133:8,15 134:5,16 135:24 136:10,17 138:3	139:3,24 140:22 141:2,4,12 144:10,24 155:15,17 161:3 163:11,13 165:7 177:19 investigations 16:23 73:4 125:5 144:14 161:14 investigator 112:15 134:12 involve 103:7,20 involved 7:21 12:8 14:11 16:1 23:4 23:5 28:4 40:23 41:4 45:19 103:8 113:18 115:3,6,8 124:13 125:21 153:19 155:14 155:16 161:11 177:20,22 178:5 178:10 involvement 42:18 109:11 involving 27:23 27:25 59:12 116:8 117:11 129:6 in-person 175:5 in-service 112:2,6 168:16 in/payroll 93:18 93:22 IQ 40:12 Irwin 80:18 83:7,9 89:19 135:22 139:8 173:16 Irwin's 173:12 issue 28:11 58:5 85:24 86:3 91:14 98:22 114:14 129:4,14 139:22 issued 89:25 139:23 143:12 143:24 144:11 145:15,17,23 146:11,13 150:11,22 issues 9:24 15:14 34:16 125:2 156:15,23 168:14,23 169:8 item 149:2 164:17	165:21,23,24 166:5,7 168:10 182:13,19 items 32:20,20 33:4 It'd 9:17 <hr/> J <hr/> J 3:6,22 January 1:21 22:1 186:17 Jeanne 2:5 156:16,19 157:25 Jeff 47:15 Jim 58:7,16 97:13 138:15 job 5:1 6:8,11,23 7:17,18 13:6 17:14 18:6 22:11,18 23:16 23:17 26:5 33:12 38:16 39:18 49:7 76:21 77:15 97:24 112:14 135:20 163:7 Jobs 41:2 Joe 109:24 140:22 judge 35:2 Judy 61:1 62:17 62:20,22 114:1 155:12,14 Julie 43:14 44:11 44:15,24 78:7,9 79:3 85:13,14 86:20 88:3,5,8 88:18,18,20 92:8,11,22,25 93:2,16 94:2 98:24,25 99:6,8 99:13 100:1,8 100:12,15 101:1 101:8,10 132:2 132:9 148:18,24 149:6,10,14,21 150:9,17 151:6 151:9 162:6,11 162:17,19,23 164:20 165:25 166:1,2,13,17 166:21,22,23 167:3,6,9,10,11 167:14,23 171:2 172:2 175:12,17 182:14	Julie's 100:9,18 131:22 July 119:11 jumps 33:12 34:22 June 119:11 120:8 just 4:15 23:18 26:6 27:5 34:22 36:11,20 42:2,8 44:21 45:23 46:10 50:11 53:14 56:3 58:9 61:8,24 69:10 74:12 76:9,16 80:16 85:4,5 87:17 91:25 92:20 94:12 97:22 100:11 104:21 106:9 113:12,19 117:16 118:7,16 134:8 135:16 140:12 141:5 143:8,9,17 145:11,18 154:5 156:12 157:10 157:13 159:7 161:5,7 163:15 178:17 179:9 181:6 182:9,13 <hr/> K <hr/> Kathleen 3:15 154:9 keep 73:3,3 163:2 Keeping 15:21 kept 55:19 99:21 164:11 Kessler 3:13 Ketchum 61:1,3 114:2,10 155:12 key 104:11,21 105:4 kind 49:10 65:10 65:13 73:2 85:25 90:14 123:10 165:16 kinds 15:14 41:7 49:12 54:4 141:1 knew 28:6 32:12 74:16 77:16 82:24 137:13,15 151:15 knowledge 12:21	17:13 22:17 59:2 73:11 101:24 108:23 113:5,13,13,15 127:8 175:20 known 25:8 55:7 71:9 74:14 177:19 178:4 179:8 Krause 2:14 61:16 61:23 62:1 63:25 64:7 69:17,21 81:4 81:16 82:11 83:4 98:16 104:25 135:12 135:14 140:11 140:17 144:4,8 145:9,20,25 146:4,8 148:11 153:2 154:2 155:25 156:14 156:25 157:4,7 157:10,18 170:3 170:4 173:1,3 177:13,15 178:2 181:3 187:7,19 K-E-T-C-H-U-M 63:1 <hr/> L <hr/> labeling 46:11 lack 105:11 ladder 21:10 ladies 26:20 36:13 61:6,7,12,20 62:4 155:18,18 lady 51:1,2 54:23 62:2 lady's 48:19 50:25 laid 22:4,12 Lake 1:2,9,19 2:11 3:21 8:21 13:13 14:18 17:8 19:6 38:24 48:10,11 48:16,21,24 50:16,17 87:10 135:14,23 136:16 138:22 139:9 151:11,16 151:24 154:14 160:18 164:2 182:4 Lakeland 9:11 lapse 154:19 large 86:12,18
---	---	---	---	---

87:1 91:22 92:4 92:9 94:2 105:14 larger 9:15,23 last 6:19 23:14 61:14 62:25 121:12 122:11 122:15,21 134:21 165:23 167:9 late 25:10,11,24 72:7 later 11:3 53:4 157:11 latter 17:19 law 134:23 135:2 135:3,4 lawful 4:1 lawsuit 4:10 120:25 121:3 128:4 lawsuits 115:3,8 leader 10:9 leading 59:13 128:24 learned 141:10 144:11 least 13:11 27:22 35:22 134:21 155:17 160:21 leave 21:21 46:18 147:25 leaving 147:21 led 42:19 left 11:9 56:4 122:8 145:4 146:22 152:20 181:1 legal 109:13,22 let 20:10 24:13 34:22 49:25 53:14 62:8 63:3 76:16 77:25 78:7 82:7 93:14 126:11 142:3 145:12 letter 42:11 96:14 109:14 110:9 118:18 139:21 140:20 141:7,14 letters 141:1 let's 23:22 94:6 98:7 133:8 level 12:23 18:22 19:24 20:8,8 22:16 35:12	49:9 70:20 71:8 71:13 75:6 levels 17:15 33:22 license 17:5,8 20:1 39:25 licensed 38:21,25 licensure 13:19 13:22,25 14:4,6 16:8,8,10,23 17:17 18:9 20:20 32:6 34:2 35:8 39:20,23 46:5 86:1,7 112:23 113:3,8 114:12 life 11:18 12:24 13:1,4,6,9,10 33:14 121:12 122:12,15,21 like 9:10,14 16:19 20:12 24:5 30:5 32:20 33:21 34:5 38:20,25 41:22 46:14 52:5 55:21 58:9 61:17 66:6 73:22 75:18 91:23 92:6 94:12 152:12 156:12 limit 31:7,16,19 32:1 Limited 27:19 Linda 29:14 line 111:16 118:24 149:2 164:18,19 lines 44:11,20 153:15 Lisa 43:15 78:11 78:11 79:4 89:24 162:7 172:3 list 19:10,11 20:3 59:6,24 67:14 72:24 listed 107:8 listen 127:24 listening 80:9 little 14:24 93:3 133:16 157:20 161:24 181:7 lived 26:9 70:25 lives 117:2 living 3:4 4:10 9:2 9:3,6,12 40:13 71:25 72:1	located 140:2 location 25:15 locked 34:4,5,15 Lodge 9:11 log 73:2 99:6 100:6,7 long 5:14 6:20 19:10,11 34:6 43:24 68:11 97:24 119:15,23 120:2,5,10,13 123:18 158:3 165:23 longer 35:20 69:2 long-time 134:19 look 11:14 27:1 32:23 33:8,18 34:18 35:2 43:16 73:24 74:2,8,8 94:23 94:23 100:11 125:14 132:15 153:24 159:7 169:12 looked 44:24 61:18 149:6 164:20 168:10 looking 12:20 20:3 24:22,24 27:3 33:11 55:6 59:1 96:5 97:22 103:11 105:21 106:1 109:18 113:12 119:10 119:11 122:9 132:21 133:4,19 159:7 164:15 165:22 167:20 167:21 Lorna 1:6 4:11 10:24 11:16 25:7,8,12,20,25 26:6,11,19 27:17 28:4,9,18 28:22 29:4,22 32:1 35:15,19 35:25 38:6 42:13,20,23 43:1 44:14 46:25 48:9,17 48:23 49:15 52:11 53:22 54:14,18 55:13 55:19 56:19 57:22 59:13 60:15 63:12,24	64:3,12 69:13 70:3 72:8,9 86:12,18 89:1 91:22 92:13 102:16 107:11 107:21 108:15 123:23 126:18 128:23 132:4 134:24 135:1 137:20 147:12 148:2 149:11,16 150:20 154:14 154:20 158:7,10 158:12 160:4 165:25 166:3,21 166:24 167:10 167:12,15,24 176:15 178:3,21 180:8 182:15,23 Lorna's 28:24 31:3,7,15 50:15 52:9 53:3 55:18 63:21 70:23 71:19 72:1,18 81:19 85:16 92:4,10,19 101:6 110:16 121:12 122:12 122:15,21 124:4 126:13 127:20 137:13 166:1,23 170:22 lose 77:15 163:7 lost 104:20 lot 15:23 41:4,5 58:3 61:11 71:24 72:4 low 34:11 36:11 LuAnne 29:11 30:11 33:1 43:2 43:14 46:21 52:13,22 58:7 65:9 77:5,7,9,16 78:5 79:5 96:15 97:12 108:12 110:10 112:7,13 138:15,18 139:22 140:21 141:20 143:12 143:20,23 144:11 145:15 146:2,11,16,19 150:11,22 160:25 161:6 162:18,22 168:6 172:2 178:10,14	178:15 LuAnne's 112:13 114:12,15,18 lumped 143:8,9 lunch 165:18 <hr/> M <hr/> M 2:5 made 9:19 10:3 11:18 20:20 22:14 46:22 49:3 66:17 71:15 87:24 88:1,15 103:6 105:4 107:10,12 107:12 109:8 115:10 116:5 122:10 134:13 137:14 139:17 139:17 169:21 177:17 main 12:5 maintain 7:4 10:19 11:15,19 37:8 73:8,9 maintained 41:17 108:21 maintaining 73:17 123:23 major 23:7,10,12 23:19,20 24:5 24:20,25 25:19 27:12,14,22,24 28:3 40:18,19 45:9,15 46:2,8 46:15 53:16 57:25 59:21,25 60:3 62:11 68:3 75:9 116:1 126:13,23 130:10,17,21 134:20 155:8 161:15 163:13 majority 18:18,25 make 4:20 13:21 14:1,17,24 15:2 15:3,5,6,7 17:22 18:6 20:14 24:7,9,15 39:20 46:15,25 50:1 60:19 69:10 87:17 88:8 112:21 114:21 126:7 136:12 144:23 169:25
--	--	---	--	---

Patricia Fishley

maker 55:20 makes 10:1 46:7 179:1 making 16:22 51:23 53:5 male 51:12 man 47:17,18 80:22 management 6:18 6:21 7:15,16,18 12:6 16:5,7 21:5 21:17,25 22:3,8 27:9 39:19 60:15 75:25 98:2 114:23 manager 11:5,25 16:20 21:14 23:4 26:3,8,14 29:18 32:5 39:10 43:1,19 45:25 60:22,23 109:1,2 113:21 113:22 manner 24:11 163:12 164:8 manning 36:5 manpower 37:8 many 7:6,8 70:23 70:25 84:3 116:16 179:12 Margarita 65:6 165:18 mark 42:2 78:13 94:22 128:14 129:22 marked 42:5 78:17 95:2 96:1 102:24 108:7 128:17 129:25 138:21 168:4 188:1,2,3,4,5,6,7 Marquita 54:22,24 56:3 65:4,8 89:5 89:6 143:14,16 160:24 162:25 163:3,14 165:9 165:18 172:22 179:4,6 material 97:1 matter 86:13,19 87:2 92:18 94:3 189:7 mattered 122:22 may 4:17 11:13 34:13,13 42:10 47:15 50:10	54:13 55:3,5 59:5,9 61:25 63:5 72:24 78:25 79:17 80:3 83:24 85:1 89:19,21,24 98:4 108:13 118:25 119:3,4 119:6 120:7 125:21,21 126:14 135:7 145:18,22 162:14 174:6 179:17,19 180:16 maybe 35:11 36:25 63:21 68:13 98:4 123:9 156:16,19 Ma'am 135:13 meals 34:9 mean 4:11 24:13 28:19,21 33:23 53:23 54:1 55:4 60:12 61:17 67:21 96:7 98:22 99:1 100:4 118:19 147:10 163:15 means 105:9 106:10,11 118:16 meant 24:9 104:21 105:22 110:24 Medicaid 9:9,16 12:14,14 18:13 18:19 36:25 medical 41:22 60:6 76:18 102:8 104:6,13 104:23 105:6,23 114:5 130:25 154:19 158:15 160:7,15 168:13 168:16,23 169:8 170:7 181:18,21 182:1,2,7,9 183:16,18 medication 44:15 meet 10:17 49:21 55:20 59:4 67:9 68:11 77:7 78:5 79:10,19,24 83:22 96:15,17 116:18 117:1	119:17 153:19 162:6 meeting 29:11,21 29:21 30:4,8 43:24 44:9 45:3 45:5,7,10 46:18 49:22 55:22 58:7,20 59:3,16 67:24 80:2,3 83:8,16 86:21 89:7,12,18 97:14 116:23 117:9 118:2 119:21 120:22 121:9 122:1 123:1 128:6 143:16 150:16 176:25 meetings 10:15 10:20 149:21 173:15 175:5 member 125:19 members 10:10 21:7 56:6 161:19 memo 102:18,20 148:6 153:23 179:17 memorandum 95:17 mental 40:5 70:20 160:8 164:2 182:5 mentally 8:25 9:8 15:22 19:5,14 19:21 22:25 40:8,10 mentioned 149:16 158:9 mentioning 156:1 Mentor 1:20 3:24 Meridian 25:14 met 25:21,25 43:21 49:18 55:2,3 78:24 79:7 80:17 116:24 119:16 120:24 135:13 138:15 145:21 145:24 175:8 Michelle 1:16 185:6 186:14 Mick 102:22 middle 72:8 86:11 Midland 2:15 3:16 might 36:25 65:15	69:22 107:3 114:11 139:24 156:18 163:7 mild 70:21 Miller 21:20,21 75:25 97:16,17 mind 37:18 137:21 mine 166:6 minute 148:25 159:2 minutes 15:13 68:13 Mishkind 2:4 missed 61:19,21 mistake 118:11 misunderstandi... 140:23 141:6 mix-up 48:7,8 moderate 70:21 modify 20:5 116:6 Moeller 1:6 4:10 25:7 38:6 42:23 49:16 51:6 54:14 55:2 81:1 91:3 98:20 102:16 107:21 126:18 131:13 137:17,20,25 141:22 142:7 151:12 154:15 158:7,10 160:4 173:7 176:15 178:21 180:8 Moeller's 4:12 10:25 11:16 42:13,20 47:7 59:13,22 107:11 108:15 128:23 145:5 146:23 148:2 152:4 172:1 178:3 Monetary 107:17 money 30:17 36:23 monies 32:19 monitor 13:17 14:10,22 16:12 16:15 17:25 25:5 26:9 34:17 38:8,9 39:11 monitoring 7:20 12:7,8 16:2 26:14 27:10 77:18 98:20 113:18,20	115:15 130:20 134:21 155:17 monitors 39:19 month 6:19 123:9 123:11,14 monthly 26:17 124:8 127:25 more 9:11,16,24 26:10,12 39:7 39:23 40:13 74:5 84:6 89:23 114:11 116:20 133:16 144:24 157:20 161:10 161:24 179:10 179:25 180:3,22 morning 43:1,8 44:18 65:7 85:17 86:5 92:21,25 100:16 141:25 150:5 mortality 102:9,17 160:15 Moscarino 3:5 most 55:14 78:8 mouth 92:10,19 move 35:16,21 98:7 MR/DD 1:19 3:21 111:18 much 15:24 23:18 44:13,17 51:20 53:23 61:8 69:2 83:20 MUI 48:12 49:2,8 49:10,11,12 50:5 75:3,11 96:14 103:13 108:25 109:5 110:12 113:6 115:17,20 119:18 120:14 128:8 129:11,13 137:22 138:2,20 139:8,23 141:18 142:14,21,25 143:3,24 145:17 146:13 154:18 155:8,9,24 157:6 163:25 164:11 168:3 169:21 177:1,18 177:25 178:1,3 181:11,18,24 MUIs 75:7 137:19 142:19
---	--	--	--	--

must 84:24,25 myself 58:6 M.D 102:20 <hr/> N <hr/> N 187:1 name 4:8 21:19 47:14 48:20 50:25 54:23 60:25,25 61:1 61:14 62:25 85:8 87:15 143:11,15 146:21 154:9 165:9 named 185:9 name's 135:14 natural 47:11 50:14 near 159:11 necessarily 14:21 18:12 26:17,18 45:22 necessary 48:15 need 8:11 9:22,23 9:23,24 22:23 51:15 60:25 90:9 103:16 106:3,3,4 107:1 139:16,17 156:13 needed 8:1 46:23 49:25 58:19 75:21 99:7,9 105:25 107:2 176:7 needing 37:24 needs 7:22 37:8 negatively 67:11 83:13 neglect 23:22 negotiate 15:12 Neither 35:25 89:6 155:25 never 17:19 37:6 57:13,15 110:6 110:8 173:23 176:4,6,11 178:16 new 7:4 22:4 next 6:4,5 7:10 21:15 54:11,16 54:17 62:16 89:20 111:4 132:15 133:24 152:9 172:9,11	night 44:12 54:16 54:17 55:14 61:20 69:14,14 69:15 71:24 72:3,7,8 79:16 85:17 86:5 90:21 91:15 165:10 170:25 171:3 179:6 nine 87:20 92:14 92:21 nobody 60:17 61:10 81:18 105:15 156:3 Nodding 38:17 162:9 none 135:6 160:25 163:1 normal 64:20 normally 163:12 164:8 nose 92:10,19 Notary 1:17 185:6 186:14 notation 167:21 note 84:18 86:22 86:25 87:3 90:4 93:16 97:6 131:11,16 166:11,16 167:2 noted 166:20 notes 41:6,6,9,13 55:22,23 72:14 73:7,8,9,12,15 73:18 74:9 80:3 80:5,8 81:2 91:2 96:24 159:25 162:16 nothing 39:14 69:22 102:1 103:3 105:18,19 115:19 185:11 notice 1:18 112:2 112:5 138:22 148:20 notified 66:4 114:23 notify 52:9 noting 166:19 number 8:24 18:17 24:4,18 24:21 33:19,21 36:5,15 37:19 37:22,24 67:6,7 84:25 85:15 86:10 88:21	93:15 94:8 98:9 98:17 100:19 101:25 102:7,25 103:2,2 108:4 108:10 111:16 112:1,12,21 113:1 114:3 148:15 149:3 158:25 159:5,8 159:8,23 164:16 164:17 165:21 165:24 166:7,8 168:4,5,11 170:5,17 174:15 181:13 182:13 182:18,19 numbered 148:14 numbers 36:11 37:4 nurse 38:21 39:3 39:3 55:17 80:20 81:3,5,7 81:12,19,23 82:1,6,8,13 85:7 85:13 86:13 87:10,10 88:4 88:20 89:19 97:2 98:13 99:10,11 101:14 101:14,15 103:23,25 104:11 105:19 105:20 106:2,7 106:16 114:4 132:1,2 148:18 150:6 151:11 170:5,18 173:15 183:14 nurses 39:1 nurse's 98:10 99:6 nursing 9:17,18 9:24 15:20 100:7 <hr/> O <hr/> object 69:22 142:16 objected 69:20 Objection 63:25 69:17 81:16 82:11 83:4 98:16 104:25 144:2,19 145:7 147:7 152:5 161:4 173:1,3	178:23 179:24 obligation 19:15 19:18 114:20 126:2 observation 142:8 observations 143:2 observed 92:23 observing 183:4 obstruct 161:2 obstruction 50:13 110:17,25 obtain 5:10 41:22 161:23 obtained 44:9 obvious 92:18 obviously 142:22 occasion 14:13 78:25 161:18 Occasionally 28:18 occasions 55:17 179:12 occurred 48:8 150:10 occurring 105:18 odor 92:6 94:12 94:13 OEDI 40:14 off 22:4,12 28:12 33:9 37:9 52:23 59:20 69:8 71:25 72:1 94:16 95:5,20 102:14 130:3 135:10,21 165:20 177:20 181:8 184:4 office 2:6 7:24 44:6 50:17 84:2 86:14 138:16 140:3,4 171:17 180:20,20,23 186:6 often 13:8 16:15 25:25 123:7 Oh 2:8,17 3:9,13 3:18,24 6:13 8:5 11:12 25:8 33:2 53:4 54:15 57:17 76:12 103:17 144:22 154:11 158:11 167:23 180:11 Ohio 1:2,17,20 4:2 40:14 74:25	111:17 160:8 182:4 185:2,7 186:7,15 okay 27:4 34:24 61:23 69:24 74:17 76:12 84:20,24 90:18 91:8 93:20 94:10 101:3 103:15 133:1 142:18,23 145:20 146:3 148:8 149:17 159:1,8,17 179:6 180:15 184:2 ombudsman 15:19 ombudsmen 15:24 once 13:11 26:13 57:17 72:19,20 72:21 80:15 84:7 116:21,22 123:9,11,14 145:14 176:20 179:16 180:1,22 one 9:11 12:5 15:11 28:18 36:12 37:5,22 37:23 39:2,5 43:15,25 44:24 47:8 49:22 54:22 57:7 59:25 60:14,14 65:8 68:20,25 69:1 78:24 82:9 82:14,21 84:18 85:6 98:17 100:15 103:20 110:7 111:16 118:8 121:20 123:18 124:3,13 130:8 132:23 137:7,15 138:22 140:25 142:21 148:16 151:6 157:3 158:19 159:6,9 167:24 168:11 169:5 170:12,14 175:16 179:5 181:6 ongoing 34:1,2,6 106:20 179:3,10 only 14:15 28:11
--	---	---	--	--

Patricia Fishley

28:25 39:2 52:17 71:15 76:15 145:2 146:18 166:3,24 167:10,15 179:15,16,23 operation 100:9 Opportunities 9:12 opportunity 143:21 162:10 175:17 opposed 122:7,23 161:11 162:19 174:16 option 16:25 20:24 35:19 options 13:16 14:22 20:19 21:3 oral 101:3,19 order 31:21 132:8 orientation 7:4 112:9,19 168:19 169:11 original 62:16,17 71:16 originally 48:8 155:11 OT 9:17 10:7 other 7:5 8:19 16:1 21:3,5,6 28:12,13,16 33:3,5 34:14 39:2,5 41:21,23 43:16 54:22 55:8 56:3,6,8 59:20,23,25 60:21,23 67:10 71:4,9 72:14,17 72:19,20,22,22 73:19 75:17 76:6 89:11,17 94:12 97:11 98:8,11 100:14 100:17 107:7,9 108:17 115:3,8 115:22 117:19 123:1,22 136:16 136:16,22 138:5 138:25 142:1,2 142:18 143:16 144:14 157:3 161:14,15 164:4 166:19 169:5 171:17 174:19	179:7 180:17,25 183:1,21 others 24:5 otherwise 186:3 ourselves 35:3 out 11:21 14:9 20:21 23:9 26:16 27:11,20 32:9,18 33:6,9 33:12,15 34:14 34:22 35:15 36:15 39:14 40:22,25 41:1 43:2,3,6,21 44:21,23 48:23 49:12 50:10 52:7 54:15 55:4 55:19 59:17 60:16 61:9 62:13 63:12 64:4,12 65:3,10 65:17,19 69:13 70:3 72:17,23 73:1,5 77:6 78:7 79:16 81:25 82:4 91:7,15 92:1,9,18 110:23 117:8 118:17 132:24 153:21 154:18 154:23 155:2,7 159:22 162:4,15 163:7 165:17 172:22 178:9,22 189:8 outlining 104:4 output 105:13 106:5 outside 16:4,6 45:22 67:9,16 104:6,13,23 105:6 109:18 143:22 146:1,15 146:19 173:12 over 6:4 11:1 21:15 29:19 33:1 34:15 50:3 98:10 122:18 143:18 170:21 own 45:24 111:24 156:18 P page 65:7 84:18 131:5,12,17 132:15 133:24	148:5,9,16,17 150:6 151:5 152:9 159:8,11 162:17 165:22 166:8 167:22 182:16 189:8 paged 44:12,25 66:25 77:15 100:15 141:24 149:7,11,15 150:20 164:22 164:25 170:24 pager 44:24 149:7 164:21 Pages 19:12 paging 99:21 pain 61:11 70:7 72:9 91:4 142:7 155:2 paper 41:5 80:16 paragraph 75:8 148:9,13,14,15 159:13 166:9 paramedics 54:4 pardon 159:4 park 97:23 part 14:1 17:20 40:17 41:10,18 42:12 52:21 54:11 59:15 64:20,22 68:3 71:2,3 76:21 86:21 88:18 96:6 134:16 135:23 136:17 139:2 161:6 169:10 particular 45:4 52:19 114:13 153:13 parties 40:23 41:4 189:13 party 186:3 passed 43:1 53:22,25 55:5 57:22 60:7 passing 26:6 28:7 63:24 past 28:7 Pat 109:23 patience 184:3 patient 137:8 PATRICIA 1:14 4:1,6 135:11 154:7 157:23 171:13 177:14	181:9 183:11 185:9 187:3,6,9 187:12,15,18,21 187:24 189:6 payroll 93:6,10 peculiar 94:13 penalty 107:17 people 7:8 8:7 9:3 9:22 19:7 22:25 27:9,11 37:24 58:3 64:17,21 66:2 67:19 70:25 71:9,11 71:12 78:24,25 79:3,7 80:9 85:5 89:20 90:25 91:11 98:23 121:12 125:1 126:24 134:8,9 142:11 167:1 172:6 182:10 183:20 people's 74:1 per 84:10 percent 11:12 performing 12:2 124:25 period 23:12 58:2 59:8 123:14,16 146:10 158:16 172:24 periodically 10:13 permanent 164:12 person 21:6 23:4 33:13 43:16 48:3 49:10 50:23 51:14 77:14 90:11 116:18 122:20 126:24 150:4 152:18 173:20 178:8 182:25 183:2,4 personal 32:20 personally 58:25 76:20 128:11 persons 105:24 person's 43:18 perspective 162:4 pharmacy 44:16 phone 15:4,6,8,10 15:11 48:3,4 51:3 123:2 141:8,15 165:17 172:21 175:7 phones 50:22	phrase 9:5 physical 25:15 physically 90:9,10 physician 50:21 51:11,12,13 94:3 97:3 171:7 physicians 103:22 154:13 picked 99:4 153:25 piece 8:9,12 place 8:22 9:19 19:16 114:20 185:20 189:8 placement 7:19 7:21,23,23 8:1 8:12 10:12,16 11:17 27:12 places 9:10 12:21 67:10 placing 19:7 plaintiff 1:7 2:3 158:1 plaintiff's 158:25 plan 17:25 18:1,4 169:12 176:10 176:13 planned 147:17 plans 114:24 players 74:13 PLEAS 1:1 please 4:20 69:23 95:7 108:11 130:5 pleased 28:14 plus 157:21 point 27:19 34:20 44:24 46:13 48:14 52:1 53:1 115:16 122:1 136:10 141:17 143:23 police 40:24 policies 40:6,7 163:22 164:1 168:12,22,25 169:7 policy 11:20 portion 168:17 POS 36:21 posed 160:7 position 5:22 21:22 23:17 29:3 74:21 97:18 98:1 160:18
--	--	---	--	--

<p>possibly 110:16 110:24 160:17 post-fact 134:11 potential 109:9 141:11 potentially 114:5 170:7,19 Potti 46:22 practical 38:21 39:1 practice 20:16 37:7,17,17 41:16 64:23 73:19,21 prefer 29:23 prepare 13:10 59:23 163:25 prepared 87:4 95:18 141:18 164:8 preparing 84:8 95:14 131:6 presence 143:22 146:1,15,19 173:13 185:15 present 29:12,21 55:24 57:2 58:12 67:19 68:20 110:18 111:1 117:3 136:12 162:12 162:22 presented 48:19 Pressern 61:13 63:5 pressure 98:11 106:4 170:21 pretty 23:18 44:13 44:17 53:22 55:14 61:8 83:20 117:16,16 135:19 171:1 prevent 77:21 preventable 110:17,25 160:17 previously 168:10 primary 126:17 Primehealth 3:12 prior 6:23 25:18 25:20 26:2 28:24 29:1 45:1 51:23 54:7 55:1 59:5,23 63:5 67:14 72:23 84:4 94:3</p>	<p>119:17 153:18 171:15 privately 161:19 probably 23:14 25:10 26:17 37:24 43:9 55:23 62:15 66:4 78:9 156:21 problem 18:6 21:8 45:23 107:5 131:2 157:5 problems 36:5 38:12 39:24 112:25 115:12 138:3 procedure 4:3 8:7 47:2 procedures 163:17,22 164:2 168:13,22 169:7 process 41:10,19 produced 173:20 production 169:18 professional 136:2 professionals 10:3 program 7:24 8:8 8:16,23 9:9 10:9 progressive 17:3 17:15 pronoun 104:20 pronounce 80:21 85:9 Prospect 2:16 3:17 provide 17:23 19:20 45:2 108:17 136:9,24 140:7,12 156:6 169:20 provided 4:2 73:16 81:15 89:11 108:20 117:24 124:14 125:20 127:10 153:1,7 providing 105:23 123:22 124:15 157:6 Proving 74:18 public 1:17 34:25 185:7 186:14 punched 93:6</p>	<p>purchase 36:19 36:22 purchased 33:5 purported 77:10 173:25 purpose 23:25 25:3 73:17,23 purposes 42:5 78:17 95:2 96:1 108:7 128:17 129:25 pursuant 1:18 put 138:8 P-R-E-S-S-E-R-N 61:15 p.m 1:21 86:14 93:19 165:25 166:22 167:13 182:15</p> <hr/> <p>Q</p> <p>qualifications 57:9,14 58:4,10 58:11,14,19,23 qualified 35:20 116:1 185:8 qualifies 8:7 qualify 8:22 40:8 40:9 quality 12:24,24 13:1,4,9,10,23 13:24,24 26:20 26:22 27:7 33:14 quarterly 10:17,20 question 4:23 32:6 34:22 64:10 69:25 79:14 87:14,20 87:21 88:8,14 89:15 90:24 91:6 93:15 94:8 96:24 103:16,18 112:10 131:15 132:17 134:2 141:11 142:4 143:8,18 144:5 144:9 151:19,23 176:2 questioned 58:10 questioning 69:11 questionnaire 35:14,16 questions 4:16,19 13:3,5 25:20 34:13 54:7</p>	<p>58:15,21 59:6 59:24 61:18 67:15 72:25 75:22 76:25 77:6 78:8,8,22 78:23 79:19 80:7 83:21 85:4 87:5 89:10,17 100:20 117:14 117:18 126:22 135:9,16 136:22 145:22,25 146:5 154:6 160:7 171:10 183:10 quotations 110:21</p> <hr/> <p>R</p> <p>raise 113:3 rather 162:5 165:23 ratio 37:5 rationale 50:12 ratios 37:6 RDR/CRR 1:16 reach 126:7 reached 127:17 133:14 134:4,10 134:12,15 read 92:3,17 102:13 132:16 148:21,22 reading 92:15 189:13 real 15:25 28:14 realize 120:18 really 26:25 32:13 33:8,19 34:19 68:1 71:20 72:5 85:3 96:6 105:15 119:23 129:12 138:7 153:24 162:20 180:21 reason 24:14 72:4 74:7 82:6,23 165:13 174:16 reasons 9:22 reassurance 77:20,25 recall 30:19,23 35:18 36:3 43:17 57:1 58:16,23 68:7 70:4 72:5,12,16 73:1 100:24 101:4 112:7</p>	<p>116:12 118:5 138:20 146:17 147:24 153:13 153:25 158:21 159:21 168:6,24 173:9 177:10 179:11 180:21 receive 8:8 96:9 112:2,5 114:4 170:6,18 181:17 183:25 received 64:16 65:7 88:3 96:13 100:25 101:7 109:13,14 110:9 112:8,14,18 120:9,13 127:11 127:13 141:8 154:20 158:14 168:18 169:15 169:17 176:1 181:21 receiving 10:8 100:24 101:5 113:2 114:18 147:12 168:15 recent 97:23 recently 113:19 recess 69:9 recollection 30:7 30:9,21 42:18 71:17 82:1 86:24 93:21 119:20 140:19 175:2,13 recollections 74:1 recommendation 20:19,23 104:11 104:22 105:4,9 106:14 170:9 recommendatio... 14:17,25 15:1,3 15:6 20:14 103:5,7,12,20 103:21 107:8,10 107:13 111:13 111:15,21,23 114:9 115:10 116:5 126:8 132:12 168:5,7 168:11 169:3,21 176:5 recommended 111:17 record 11:20 35:1 35:3 48:17 69:8</p>
---	--	--	---	---

Patricia Fishley

73:2,24 95:5 130:3 135:10,21 156:15,21 164:12 165:20 181:8 184:4 records 11:16,19 35:10 41:22 74:3 83:10 87:6 93:6,18,23 151:25 recounted 44:17 red 113:3,7 reduced 185:14 189:10 refer 75:8 81:2 85:16 87:9,10 88:21 158:24 167:19 reference 100:15 167:16 references 87:9 referral 7:19 referred 8:3 12:7 87:15,18 134:6 referring 29:6 82:3 88:24 93:22 97:5 102:9,11,19 117:22 153:1 167:25 183:3 refers 86:13 88:15 112:1 reflected 130:23 refuse 136:8 regard 28:2 42:23 47:20 53:7 72:6 72:13 85:19,25 87:20 100:12 101:21 107:10 109:8 113:10 116:6 126:12 156:1 158:9 168:20 176:4 regarding 11:16 33:21 37:3 49:15 52:11,20 54:14 57:8,13 58:22 60:2,4 78:22 100:18 105:12 126:18 127:20 129:4 131:12 137:19 139:22 141:11 141:21 143:3 154:14,19 168:13,22 169:3	169:7 183:19 regardless 33:24 99:12 regards 138:2 registry 75:3 regulate 14:23 regulated 19:24 regulating 58:22 115:7 regulation 36:18 101:21 134:23 135:3 regulations 12:4 12:13,15,17,19 18:11 36:14,15 36:24 37:3 57:8 85:19,22,23 regulator 13:17 78:2 regulators 20:5 Reigert 43:20 56:9 79:4 83:17 145:23 162:8 172:3 reiterating 111:14 relate 70:16 142:22 related 133:22 142:15 relates 142:23 relation 30:20 71:19 88:3 162:14 relationship 8:13 55:6 relative 186:2 relatively 97:23 relayed 61:3 68:2 151:10 release 156:20 relevant 12:17 rely 73:25 74:9 100:8 182:7 relying 100:6 111:5 126:6 remainder 53:10 remember 28:3,9 28:25 29:24,25 32:17,24 33:6 33:12,16 35:1 36:2,4,9,20 37:13 39:13,17 43:6,18 44:8,11 45:6 47:14 48:19 50:25 53:20 54:20,23	55:10,18 57:4 57:23 58:8 62:19 64:19 65:1 68:1 70:11 71:20 72:5 80:25 81:12,17 83:6,9,18 84:9 85:1 89:23 93:24 94:14 114:7,12 117:15 117:18 118:2 119:14,16,22 120:2,20 121:23 123:18 129:9,12 138:7,21 141:5 143:11 146:24 147:2 148:5 153:9 154:25 162:20 170:22 173:10 174:10 174:22,24 179:15 remembered 159:19 Reminger 2:13,13 3:14,14 rendition 134:3 repeat 42:21 69:25 110:15 repeating 110:19 rephrase 144:4 report 13:21 23:11 24:8 25:2 31:4 41:8,17,23 45:15,16,17,17 46:12,16 53:12 53:15,16,21,23 54:7 55:12,18 59:21 60:1,4 62:11,16,17 68:3 75:14 92:2 92:15 94:16,19 96:16 97:9,12 103:13 108:12 115:25 116:2,25 117:11,19 119:23,24 120:9 120:13 124:8 129:8,10 130:14 130:17,23,24 131:6 132:11,20 133:13,25 134:14 138:18 138:23 149:11 149:19,22 151:6 154:18,22,24	155:6,24 160:2 160:14 163:19 181:14 reported 23:24,25 24:6 55:13 60:14,21 61:9 70:4 71:10 92:22 94:1,2 112:7 115:23 131:22 132:9 133:2,3 149:7 149:10,16,20 155:18 164:21 165:9,24 166:21 167:15,23 178:21 179:5,9 182:14 Reportedly 86:11 reporter 4:17 189:10 reporting 77:24 92:12 105:14 138:4 155:10 179:2 reports 41:6,14 45:10,12,21,24 46:3,11 59:10 59:11,12 75:15 80:15 85:7,13 87:6 88:4 92:8,9 93:17 116:8 126:23 131:7 149:15 151:3 152:13,25 153:10 156:23 166:2,23 167:10 170:23 182:8 represent 4:9 135:14 represented 109:17 representing 109:16 158:1 request 35:22,23 48:12 49:4 75:20 122:10,16 122:17 165:14 165:16 169:16 169:19,25 178:9 requested 36:1 112:6 121:11 136:9 169:14,24 189:9 requesting 105:10 require 40:24 115:24 130:13	130:16 required 38:21 40:20 73:4 160:6 169:2 requirement 24:8 90:13 requirements 14:7 requires 19:25 46:12 reserve 135:8 reside 7:8 resided 26:21 residence 5:25 6:1,15 62:23,24 resident 6:13,24 7:9,11 9:20 13:8 15:16 38:15 40:4 47:1 56:1 68:21 70:16 91:14 103:9,22 104:10 106:21 116:9 124:21 150:6,7 160:6 183:24 residential 3:4 4:9 5:24 7:23 8:2,19 39:6 88:21 89:1 90:2 residents 7:6 16:21 21:6 26:23 28:17 33:4,14 34:18 36:16 62:14 67:20 68:12 70:23 71:5 72:22 90:20 91:3,10 115:13 125:6 142:2,2 143:1 155:3 156:2 178:20 resident's 160:16 residing 13:13 25:12 resignation 84:12 resigned 84:15,19 137:3 179:20 resolution 23:6 resources 24:4 respirator 52:12 52:17 respond 66:3 69:23 72:25 169:3 175:18 responded 112:13 142:9
---	---	---	--	--

167:14 171:3 responding 54:7 90:4 response 20:1 64:24 66:11 68:6,7,9 78:21 85:6,15 90:18 94:9,18 95:8,10 95:15 114:13,16 114:18,19 168:7 168:9,17 169:12 169:15,20 176:2 176:5 responses 96:24 100:20 118:25 responsibilities 6:8,11 109:4 responsibility 19:20 38:11 77:1,18 79:18 114:8,10 responsible 24:19 26:19 restricting 31:3 result 85:24 86:6 107:20 147:25 retain 41:12,13,24 retardation 40:5 70:20,22 160:8 164:3 182:5 retarded 8:25 9:8 15:22 19:5,14 19:21 22:25 40:8,10 retention 11:20 retired 11:3,11 retrospect 74:2 return 87:25 88:10 101:6 returned 64:14 89:2 158:13 179:3 review 12:1 13:9 13:19,24 46:4,5 59:9 77:6 93:5 96:15 97:4 102:9,17 105:19 115:25 134:1 160:16 168:21 reviewed 10:13,14 24:9 30:9 59:14 104:17 118:25 126:22 131:8 169:6 170:1 reviewing 12:21 16:20 24:19	75:10 168:24 reviews 26:20,22 27:7 review/update 168:12 revised 24:18 revocation 17:17 20:1 revoked 17:8 revoking 17:5 revolving 178:3 right 6:3,3 8:18 12:13,14 15:7 16:24 24:10 25:17 27:8,24 30:10,12,15 31:5,12 33:9 46:4 49:14 51:7 55:5 57:19 59:1 71:25 72:1 74:4 74:5 85:3 90:3 92:6,7 93:3,4,12 94:24 96:8 103:1 104:14 105:1 106:13,17 115:19 119:9 122:18 131:3 132:3 138:6,8 138:10 140:18 146:6,9,21 147:2 148:22 157:4 158:19 159:19 163:24 175:11,19 176:23 177:19 179:11 180:9,13 rights 22:25 23:3 23:21 30:10,20 31:11,15,16 128:21,24 129:1 129:5,14 Rita 56:12,15,17 67:15 83:24 84:4,9,18 89:4,6 91:21 92:4 122:2 137:2 145:5 146:20,25 147:8 158:5,8 158:11,17 159:12,15 167:18,19,25 179:13,13,18 180:16,17 182:20 183:1 Rita's 84:11 road 6:3 140:5,7	role 11:25 14:10 14:14 15:18,19 16:10 42:22 43:18 125:14,16 125:18,23,25 roles 124:25 Romain 42:11 Roman 74:13,14 75:23 room 71:25 72:2 131:2 178:21 rooms 62:5,9 71:18 rough 27:3 97:23 123:9 Roxanne 49:6,9 127:3,4 rule 37:10,11 135:4 rules 4:2 12:20,22 13:16 24:23 run 26:3 Ruth 62:3 67:22 67:23 70:4,13 70:15 72:5,15 Ruth's 70:20 71:18	86:11 87:23 104:5 118:14 150:19 153:16 170:5 175:13 scenario 44:14 scenarios 73:22 Schalt 140:8 SCHALTENBRA... 3:22 16:4 20:7 22:22 29:5 68:23 69:2,6 88:25 98:1 100:21 102:2 109:23 140:9,15 148:10,12 153:4 156:7 157:8,15 157:19,22 177:25 184:6 schedule 171:17 171:20 scheduled 14:8 96:14 school 8:6 Schubert 43:15 56:10 79:4 83:17 162:7 172:3 screaming 61:9 155:2 se 84:10 seal 186:6 season 119:21 second 2:7 4:19 36:12 37:12 38:1 56:12 62:2 62:10 129:8,10 129:11,17 150:16 154:24 159:16 165:10 182:25 section 24:23 152:17 Security 30:17 see 12:2 18:1,8 20:11 23:22 42:12 43:16 65:17 72:23 90:9,11 93:14 95:12,17 115:25 117:6 118:14 121:14 125:15 125:16,18,23,25 130:9 138:6 152:22 156:7 seeing 167:12 168:6	seem 50:13 150:3 seemed 170:25 seems 24:14 150:8 seen 15:23 107:25 108:1,2 120:16 sees 29:23 send 81:20 94:16 105:20 140:13 sending 13:23 59:20 123:18 sense 4:20 24:15 sent 75:24 95:10 95:19 118:16,18 128:1 131:19 137:8 139:7 158:12 sentence 28:20 86:10 89:14 106:10 111:4 148:20 165:23 167:9 168:21 separate 16:21 142:14 179:9 separately 44:5 68:17,19 September 108:13 113:6,18 113:24 115:11 116:4 120:8,8 120:10,14,15,17 120:21 series 13:3 serious 38:14 125:9,10 service 5:9,11 22:5,7 36:19,22 73:16 services 8:8 9:17 10:8 18:20 21:17 35:20 37:24 41:2,3 set 43:3 52:14 54:8 58:13 77:5 78:6 162:21 173:15 186:6 189:8 seven 23:22 92:14 92:20 93:3,17 114:3 170:5,17 several 55:17 Shaking 67:11 83:13 shared 45:25 46:3 46:4 175:21 Sharon 121:24,25
---	--	---	---	---

Patricia Fishley

sheet 93:11	smoke 29:22,23	somewhere 56:4	specifically 10:3	16:9,22,25
she'd 44:12	30:11,13,15	59:19 63:17	65:1 125:4	17:23 18:20
100:16 123:8	31:5,24	66:8 92:13	146:25 147:16	20:7,9,25 23:11
164:21	smoking 25:20,21	117:2 120:7	182:20	23:20,24 24:1,3
She'll 184:7	28:3,11 29:1,1,6	sorry 5:13 6:10	specified 185:21	24:19 25:2 32:8
shift 36:13 38:1	29:7 30:18 31:3	10:22 20:2	specifies 24:18	32:17 35:9 37:1
41:6 54:16,21	31:8,12,17 32:1	31:25 50:20	specify 70:2	37:23 39:20
56:12 152:12,23	129:14 137:21	61:16,23 69:19	122:25 157:15	40:14 41:8,15
158:18 159:16	142:22	80:13,14 86:2	speech 9:17 10:7	42:24 45:16
182:25	snack 33:23	95:11 100:23	spell 36:15 61:14	46:4,9,16 48:13
shortly 59:22	snacks 33:22 34:3	103:17 109:3,16	62:25	49:1,5,9 50:5
172:13	34:4,15	112:3 115:5	spent 32:19	51:18 52:7
should've 89:2	social 5:2,6,8,11	120:11 131:15	121:12 122:11	53:13 57:8
show 40:16 42:1	10:8 30:17	142:5 147:15	122:21	58:22 59:21
78:13 93:6,10	solely 126:8	148:17,25	spoke 47:10	68:4 74:18 75:5
93:11,18 95:23	some 9:22 18:22	150:14 159:4	48:14 54:15	75:10 77:25
108:4 128:13	19:25 36:7	163:16 166:10	61:6 63:9 65:3	85:18 90:13,25
shred 11:21	39:16 48:7,8,13	166:14 176:9	65:18 67:19	94:18 101:21
sign 93:11,18,22	55:21,23 60:7	177:13 180:6	78:7 84:15	107:10,12,14
signature 184:5,7	67:10 72:3 85:5	sort 19:25 110:23	132:1 137:5	108:18 115:23
189:1	86:22 92:2,24	sounded 61:17	139:2 143:15	124:11 126:18
signing 189:13	113:2 133:9	source 126:17	145:3 146:24	127:2 130:14
signs 87:24	141:10,11 143:2	sources 8:5 18:18	147:3 159:12	131:7 134:22
similar 9:18 133:5	147:11 153:12	speak 47:12 50:16	163:14 164:20	135:3 138:11,12
simply 78:1	158:6 182:10	51:11 63:2,4	167:1,17 168:15	138:13 155:9
simultaneously	somebody 15:4	65:17 66:12	172:2,6,9,14,18	156:24 160:15
124:21 125:7	35:10 50:21	68:17 77:11	172:25 173:8,16	176:7,11 181:17
since 5:21 6:9,12	72:11 122:9,11	84:3 96:11	176:24 179:23	181:21 182:7,10
25:24 108:2	127:23 174:19	116:13 141:21	180:7,10 182:25	185:2,7 186:15
134:19 158:3	somehow 52:14	143:13,21	spoken 52:4	stated 147:13
169:23 176:18	someone 16:19	144:13 145:16	65:10 77:16	154:17
sister 35:25	19:13 22:9	146:13,14,19	87:12 139:4	statement 62:17
125:20	24:15,24 29:15	150:12,23 161:1	162:3	66:6 112:16,17
sit 21:2 39:14	45:25 46:14	161:18 162:11	SS 185:3	statements 33:14
71:18,24 80:25	50:16 51:2 78:1	165:6,6 167:6	Stacey 43:20,21	71:16,22 134:13
125:14,17 129:3	82:10,18 83:2	172:20 173:11	78:12 79:4	states 165:24
sitting 14:16	91:15 113:17	173:20,25 177:7	89:23,23,24	state's 25:4 38:16
33:15 161:25	122:6,13 125:9	179:12,13	145:23 162:8	107:21
situation 20:11	134:18 182:22	180:16	172:3	status 39:25
75:11 160:20	something 32:7	speaking 124:7	staffing 9:25	statute 1:15
174:12	32:15 33:11	172:17 173:9	22:16 33:22	steer 31:16
situations 114:6	44:20 46:8	174:8	37:3 38:5,10	stenotypy 185:14
170:8,20	58:25 74:2	specialist 5:24	stand 33:6,9	stepping 97:24
six 23:14 86:14	102:14 106:15	6:17,25 7:2,10	34:14	steps 32:1
93:16 112:1,12	106:16 118:24	7:11 11:6 23:8	standard 30:4	Steve 4:8 68:23
112:21 113:1	156:5 162:18	23:13 25:1	stands 33:15	100:22 132:20
164:22 165:25	177:17	27:15 57:25	39:14	STEVEN 3:6
166:22 167:13	sometime 63:23	115:17 134:20	start 40:18 63:3	Stewart 9:11
168:11 182:15	66:22 69:13	specific 27:9,10	143:18	Stifler 121:24
skills 40:13	87:1 93:2	27:11 44:25	started 57:20	still 11:15 52:1
Skylight 2:6	120:17 172:24	69:15 70:12	starting 150:15	56:22 62:20
sleeping 72:4	173:6,6	81:6 105:24	starts 148:17	64:7 66:22
90:18 91:8	sometimes 8:6	106:21 107:1	state 1:17 5:17,19	70:13 73:12
165:11 178:13	28:13 87:14,15	117:18 153:6	12:3,16 13:15	74:19 75:1 79:1
178:19	87:16 161:22	157:20 158:8	13:18,22,25	115:17 122:5
Smith 49:6,15	somewhat 30:12	175:11	14:11,17 16:3,8	152:21 172:15

180:24 stipulations 1:18 stop 29:4 76:16 stopped 27:6 story 149:25 straight 175:12 straightforward 83:20 Street 2:7 strike 121:16 141:18 structure 21:14 stuck 157:11 stuff 75:17 133:20 subject 16:19 submitted 59:6 110:11 176:10 submitting 54:6 subpoena 156:13 157:13,14 subsequent 175:6 subsequently 56:5 sued 121:6 suggested 49:2 superintendent 21:11 74:22 supervision 21:13 supervisor 6:14 6:24 58:6,9,14 66:4 97:14,15 124:12 126:2,4 162:19 173:24 174:5,8,11 supplied 32:21 89:18 supplies 34:11 supply 34:10 support 22:5,7 105:17 140:24 supported 9:2 supposed 101:22 161:1 163:1 sure 11:12,23 14:7 15:8,25 16:17 18:7 19:1 19:3 24:2,7,10 31:22 32:3,13 37:1,14 39:4,9 39:20 45:11 48:1 51:4,13 54:18 63:10,22 65:12 69:10 87:17 90:1 98:6 107:18 112:21 114:17 117:21	118:22 119:14 144:22 151:21 153:10 175:15 surprise 152:11 surrounding 124:4 128:24 147:21 surveys 14:3,11 suspect 48:21 suspension 20:1 sworn 4:4 185:10 sympathy 128:1 symptoms 87:24 synopsis 96:14 103:13 108:25 109:5 110:12 113:6 119:18 120:14 128:9 138:21 139:8,23 141:18 142:14 142:21 143:3,24 145:17 146:14 163:25 164:11 168:3 169:22 175:25 177:1 181:11,19,24 system 2:12 15:25 35:22 systems 8:6 136:17 <hr/> T take 4:17 19:14 20:23 31:14 33:13 41:9 52:23 55:22 68:24 69:7 71:21 72:14 80:3 94:22,23 98:21 106:3 147:10 171:4 taken 1:15 56:20 69:9 185:20 189:6,10 taking 8:20 119:14 127:21 134:8 talk 15:10,13 21:10,11 23:4,5 34:18 37:16 38:11 44:4 48:2 56:5 59:17 62:13 64:17,23 65:8,14,16,24 67:15 68:14 70:15 71:4,13	72:6,10,19,21 72:21 77:9 78:4 80:10 84:11 97:8,11 121:11 123:2,11 125:2 128:3 129:13 136:21 138:25 145:13 162:23 163:1 171:16 174:2,4 178:2 talked 37:14,15 50:23,24 51:22 91:13 127:25 137:12 163:6 171:21 180:1,4 talking 16:20 46:19 48:6 53:6 65:2 67:18 78:1 87:18 97:6 99:23 106:14,16 111:20 119:24 122:14 125:4 145:10 148:6 151:2 155:18 157:16,25 163:18 180:21 182:12 tape 30:4 taped 30:1 tasks 124:13 team 10:2,2,6,9,11 10:15,20,25 11:7 teams 10:17 tell 7:16 8:10,11 16:11 19:8 33:25 40:21 42:8 53:10 56:17,24 58:4 61:7 64:3 65:19 77:19 80:24 97:1 99:13,19 100:1 109:19 116:20,23 117:9 117:20,23 121:5 126:2,3,4 133:20 136:8 telling 44:11 66:11 69:12 109:21 166:12 166:13,17,18 167:3,4 171:4 tells 49:23 51:14 101:14,15 119:2 temperature 170:22	ten 15:13 17:22 71:2 134:21 tenure 7:9 39:10 115:2,6 term 55:21 terminology 45:13 53:15 109:3 terms 52:16 testify 185:10 testimony 185:13 185:17 Texas 52:7 thank 43:21 70:10 73:10 154:3,4 177:11,12 180:12 184:2 thanks 16:7 181:4 181:5 184:2 their 13:6 14:1 16:10 17:8 21:6 28:14 32:6 34:10,10 45:24 62:9 67:10 68:6 71:22 87:6,15 90:18 91:7 112:8 125:10 142:8 143:2 152:13,20,21,23 162:4 168:18,25 169:7 themselves 19:15 115:23 they'd 17:21 74:2 80:6 91:9 thing 28:12,25 29:2 34:2,6 125:3 131:3 179:3,10 181:16 things 16:13 24:10 25:2 33:21 41:7 49:12,22 54:5 85:19 86:4 88:9 91:7 92:2 123:10 124:2 131:8 135:18 156:21 165:16 167:3 179:9 183:22 think 19:1 21:4 25:14 28:12 33:9 34:1,19 36:12 39:16 51:15 60:2,5 62:8 69:11 72:19 78:12	83:24 102:8,24 103:11 120:19 122:3 133:17 143:8,8,25 154:2 156:14,16 156:17 162:6 171:2 172:5 177:2 178:25 179:1,15 182:24 thinking 43:12 47:15 78:11 88:2 158:22 175:9 179:8 180:19 third 54:16,21 131:5 137:22 138:2 142:25 149:2 151:5 152:12 thorough 135:20 though 11:14 17:10 38:3 84:15 105:13 108:21 114:16 125:13 134:7 thought 20:23 48:15,20 126:22 three 13:11 38:2 40:12 55:16 72:19 90:5,17 93:19 98:9,11 103:6,20 104:3 104:4 107:13 111:23 130:6 131:12,17 137:19 142:19 146:4 151:5 158:18 three-way 52:5,15 52:21 through 7:24 8:6 8:8 11:8 13:18 14:4,4,5 18:19 39:19 44:12 48:13 75:6 85:4 86:4 91:15 111:17,17 123:13,25 124:9 126:8,10 132:16 135:18 142:19 170:14 176:13 throughout 11:18 85:17 87:9 throw 11:21 thrown 44:14 times 31:22,23
---	---	--	---	--

Patricia Fishley

41:5 44:25 53:25 54:1 55:16 84:3 116:16 134:10 149:16 153:15 164:5 170:25 tired 149:17 150:7 150:20 title 102:14 189:8 titles 87:16 today 21:2 39:15 71:18 80:25 125:14,17 129:3 171:15 together 40:25 68:18 83:11 96:7,8 118:15 118:17 143:9 162:8 172:3 told 44:13 50:15 51:5,17 55:11 56:18 61:8 65:23 66:12 81:1,6,23 82:2 82:13 83:7 84:9 90:16,20 93:2 99:14 100:1,12 100:12 101:9,10 121:13 133:5 141:9 143:20 145:14 146:11 147:8 150:10 162:25 163:3 167:17 Toledo 117:8 tools 20:4,12 top 28:12 33:10 95:20 152:16 Tosti 2:5 42:8 102:7,13,19,22 102:24 103:10 103:15 118:23 119:4 132:20 133:1 149:2 155:23 156:1,4 156:9 157:2,5 157:24 158:1 166:7 169:14 171:9,16,19 181:6,10 183:9 187:13,22 toward 109:5 towards 17:16 Tower 2:6 Tracey 133:25 track 73:3 137:21	trained 39:12,22 105:23 106:23 training 5:5 7:3 39:24 105:11 106:2,20,22 112:2,6,8,14,19 113:1,10 114:4 130:20 168:16 170:6,18 183:13 183:16,18,19,23 183:25 transcribed 185:16 transcript 189:14 transcription 185:17 transfer 136:5 137:13,14 transit 137:17 transported 48:10 travel 117:5 treated 110:18 111:1 treatment 132:13 147:12 trenches 24:25 Treu 3:5 trip 88:10 trips 72:22 trouble 52:8,10 true 13:12 185:16 truth 185:11,11,12 try 15:11 20:10 31:18 70:1 74:12 82:7 103:16 105:3 126:11 133:8 135:17 158:2 trying 39:16 88:13 91:7 92:1 100:11 101:2 106:9 110:23 118:17 Tuesday 1:21 turn 120:3 TV 72:2 twice 84:7 180:22 two 4:15 15:10,12 36:12 43:25 55:16 56:1 61:6 61:7,12,18 62:14 68:11 71:15 72:22 83:7 85:12 90:19 103:20 118:15 124:2,7	124:13,14,24,25 126:12 138:5 142:2 148:9,17 149:21 155:3 156:2 157:21 167:3 179:8 type 7:22 17:3 40:3 177:18 typewritten 189:11 typical 152:11 155:20 182:6 typically 45:24 73:14 75:10 <hr/> U Uh-huh 10:21 17:2,2 21:1 29:8 50:18 67:1 104:8 142:20,24 unable 19:14 165:6 unassisted 178:22 uncomfortable 55:15 56:19 60:16 under 1:15 41:1 110:14 138:8 157:14 182:19 understand 16:9 19:23 20:6 27:2 46:10 64:9,10 75:11 91:24 110:22 111:19 120:12 133:21 understanding 17:14 18:24 22:13 24:24 27:3,5 32:16 57:22 70:19 87:19,22 90:7 93:10 97:5 101:17,18 105:8 105:21 106:6,10 106:19,25 122:4 127:5,6 131:10 131:18 132:18 133:9 134:11 137:11,18 152:10,14,24 161:8 171:24 understood 4:23 82:20 84:14 104:18 Unfortunately	171:11 unhappy 35:21 uninterrupted 15:13 unit 75:4 unprofessional 110:5 unqualified 57:15 until 6:18 26:24 27:17 28:2,8 33:7 70:6 107:4 113:19,24 141:17 143:23 179:4 180:8 unusual 23:7,10 23:13,19,20 24:6,20,25 25:19 27:12,14 27:22,25 28:3 40:18,19 45:9 45:15 46:8,15 53:16 57:25 59:21 60:1,3 62:11 68:3 75:9 116:1 124:17,25 125:1,3 126:13 126:23 127:23 130:10,17,21 134:20 144:1,13 144:20 150:3,8 155:8 160:11,20 161:15 163:13 update 168:21 updated 169:6 updating 168:25 upset 30:22,24 65:9 121:10 Urgent 56:14,20 use 15:24 65:11 65:13 95:14 used 9:5 73:20 122:13 164:4 using 30:16 33:3 42:9 usual 163:22 164:1 169:25 181:16 usually 46:2 66:7 <hr/> V various 8:5 9:22 53:6 103:8 134:9 ventilator 52:23 verb 122:13 verbal 89:23	verbally 101:1,8 133:17 versus 101:3 167:4 very 14:24 19:10 27:3 30:11 56:19 65:9 83:10 97:22 158:3 174:14 177:16 183:20 via 99:3 137:14 Victor 58:7,12 97:13 138:15 view 161:2 violate 101:20 violated 13:15 128:23 134:23 135:2 violating 37:2,10 37:11 violation 22:24 23:3 129:2,5 violations 14:19 14:20 23:21 107:15 visit 33:13 67:8 87:25 visited 176:18 visits 72:19 vocational 7:23 8:2 11:16 vomit 91:23 92:6 92:18 94:12 166:24 167:12 167:15,24 vomited 86:12,18 vomiting 53:24 55:14 89:3 91:21,22 92:4 105:14 149:12 165:25 166:3,21 182:15,23 vs 1:8 <hr/> W wait 19:10,11 82:10,24 148:25 159:2 waiting 82:18 103:17 waive 184:7,7 waived 189:15 waiver 18:19,20 want 15:9 28:21 46:10 63:16,17 65:6 68:25
--	---	---	---	---

69:10 74:12 81:20 85:5 87:17 118:7 136:21 140:6 141:9 156:9,18 156:25 157:10 157:16 177:16 wanted 29:3 31:7 31:12 52:16 73:24 165:5,11 wanting 161:10 Warner 43:15 56:9 79:4 82:2 83:16 85:13 86:20 88:18,18 93:16 98:24,25 101:14 101:15 131:12 131:16 148:18 148:24 149:21 150:10 151:7,9 162:6,11 166:13 166:17 171:2 172:2 Warner's 175:1 warrant 88:10 warranted 88:1 wasn't 15:4 27:20 28:14,18 30:13 50:1 51:20,21 69:11 72:4 81:22 109:2 115:14 122:9 139:25 165:2 170:12 175:9 watching 72:2 way 19:24 24:10 26:13 28:8 33:17 46:11 60:20 69:16 84:23 92:3,16 107:20 117:7 126:11 133:8 140:14 145:12 147:9,13 148:22 157:3 161:5 169:5 175:16 177:7 179:22 week 63:21,23 64:5 173:7 weird 65:15 weirded 165:17 well 11:17 16:21 21:9 25:13 29:11 34:21 39:20 52:10 55:12 66:15,16	72:7 74:7 80:6 87:6 98:14 126:3 138:13 140:5 153:11 178:2 179:25 180:7 183:20 went 43:21 44:15 46:24 50:3 54:15 56:4 65:3 73:5 78:6 79:16 83:20 172:18 weren't 16:13 37:9 65:14 82:24 91:11 165:13 177:21,23 178:5 West 2:7,16 3:17 we'll 42:2 78:13 94:22 128:13 178:2 we're 8:20 18:3,5 46:11 52:1 66:6 79:17 103:11 111:19 120:6 145:13 156:14 157:16 167:21 we've 37:14 102:24 142:18 145:10 158:3 whatsoever 85:25 117:25 126:1 136:23 WHEREOF 186:5 while 27:2 56:22 69:5 124:21 164:16 whole 175:22 185:11 William 42:11 willing 84:22 156:24 179:22 wise 37:19 witness 69:24 102:18 110:2 154:4 165:25 166:21 167:24 177:12 181:5 182:15 185:9,14 185:15,18 186:5 189:1 witnessed 182:23 woman 80:22,23 woman's 165:8 word 65:11,13 135:19 167:18 words 142:18 180:25	work 5:3 26:5,18 62:22 140:25 158:22 worked 93:18 158:18,21 159:15,18 worker 5:2,6 10:8 72:20 84:22 91:14 148:23,24 149:6 183:24 workers 56:2 70:16 103:23 104:10 working 6:15 12:20 17:13 28:8 55:4 56:22 79:1 122:5 172:15 workload 27:11 works 17:18 62:23 106:12 workshop 11:2,2 11:4 26:4 wouldn't 57:23 64:13 71:9 77:25 83:5 84:6 84:24 91:12 93:9 124:25 147:4 177:19 178:4 179:8 180:7 write 23:10 41:7 41:14 writing 151:9 162:16 169:24 169:25 written 41:18 44:20,23 45:3 45:18 59:23 80:15 81:11,15 81:25 82:4 105:16 110:6,10 130:7 131:16 133:18 140:21 152:16 153:11 153:12 168:6,8 wrong 24:13 92:16 122:13 130:22 133:22 171:25 wrote 96:13 131:12 134:8	Y Y 18:5,7,8 yeah 6:7,13 12:18 15:17 24:12 43:12 50:9 57:17 63:7 64:2 66:23 96:4,8 98:4 100:25 108:22 109:21 110:21 114:1 119:6 120:1,15 120:19 124:10 127:15 146:24 147:2 152:21 165:8 178:25 183:6 year 10:15 21:23 58:18 98:5,5 113:25 123:19 123:19 years 6:22 11:3 13:11 19:12 23:15 25:9 32:8 32:10 34:17 57:21 134:22 yelling 63:19 64:4 64:12	180:5,10 1:35 1:21 10:30 38:4 100 11:12 101 2:16 3:17 108:6 188:5 11 38:2 71:3 158:18 186:17 12 6:22 12th 118:13 128:16 188:6 129:24 188:7 13 88:21 135:11 187:7 14 90:4 165:21,24 166:7 174:15 182:13,19 14th 108:14 120:10,14 1400 2:15 3:16 1422 3:8 154:7 187:10 157:23 187:13 16 37:23 1660 2:7 17 91:19 166:5 171:13 187:16 177:14 187:19 18 91:19 166:5 181:9 187:22 183:11 187:25 1970 5:14 1976 5:21,22 6:9 6:12 1978 5:14 134:19 1990 26:11,24 1995 27:6 1997 25:18 28:2
			Z Z 18:5,7,8 Zoelbel 1:5 4:11 25:22 28:23 30:22,23 47:24 52:4,14 116:13 117:10,13,15 121:10 122:7,10 122:14,22 123:2 123:5,24 124:8 124:15 127:19 158:2 176:25 Zoelbels 118:3 119:17,21 120:16,23,24 121:3,6,9 122:2 171:22	2 2 78:14,17,20 84:8 100:23 148:10 148:11 158:25 159:5,7,8,23 164:16 165:22 166:8 174:14 175:23 182:18 188:2 2nd 22:1 91:21 92:5 158:22,23 180:2,2,5,10 2-1 159:18,19 2-2 159:17 2-3 86:15 89:2 132:23 159:17 2-4 92:9,12,12
			0 001107 1:9 01 1:9	
			1 1 42:2,5 74:12 188:1 1st 91:20 92:5 130:8 134:24 158:20,20 180:2	
		X X 18:5,7,8 37:24 187:1		

Patricia Fishley

132:16 148:24 167:10,15 2-4-00 149:6,10 2:30 38:4 2:45 164:22 2:54 149:8 150:5 20 68:13 146:22 2000 33:7 38:6 54:13 63:6 72:24 94:4 108:14 113:7,19 113:24 115:11 116:4,14 119:1 119:5 120:10,14 120:17,21 134:24,25 159:18 166:4,25 179:17,19 2003 1:21 22:1 186:8 2006 186:17 21 36:13 216 2:9,18 3:10,19 22 41:1 22nd 89:20 23rd 78:25 80:3 89:12,21 145:22 175:8,9 24 9:17,23 24/7 100:9 241-2600 2:9 25 75:22 87:5 145:4 146:22 25th 108:13 118:25 119:3,5 119:7 162:14 179:17,19 180:16	<hr/> 4 4 95:23 96:1,6 102:4,7 107:24 110:15 118:8,12 118:12 188:4 4th 43:10,11 46:18 49:17 52:2 53:8 54:13 59:8 85:18 86:6 94:7 116:14 122:23 123:15,17 126:14 132:24 134:1,14,25 152:9,20 153:8 166:3,24 180:8 180:14,15 4:6 187:4 42:4 188:1 440 3:25 44060 3:24 44113 2:8 44115 3:9 44115-1093 2:17 3:18 <hr/> 5 5 108:4,7,10 168:4 188:5 5-22 149:24 5-22-00 149:14 150:9 <hr/> 6 6 128:14,17,20 188:6 6:00 87:1 149:8 60 98:10 170:21 621-1000 3:10 630 3:7 660 2:6 687-1311 2:18 3:19 <hr/> 7 7 1:21 129:22,25 130:5 131:8,17 153:4,5 188:7 7:11 149:8 164:23 164:25 70 40:12 70s 25:10,11,24 78:16 188:2 <hr/> 8 80 7:8 80s 25:10,11,24	8121 1:20 3:23 <hr/> 9 9th 42:11 54:13 59:5,9 63:5 67:14 72:24 126:14 90 33:7 98:10 170:21 90s 11:13 91 26:11 911 171:5 92 32:13 93 32:13 94 26:25 27:6,13 95 26:25,25 27:13 27:17 28:2 95:1 188:3 95:25 188:4 97 170:23 99 170:23		
--	---	--	--	--



Ohio Department of Mental Retardation and Developmental Disabilities

Bob Taft, Governor

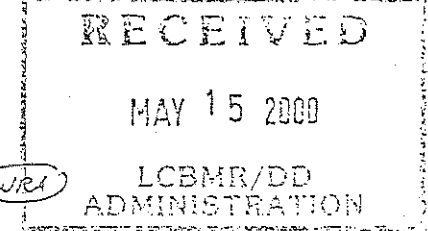
Kenneth W. Ritchey, Director

TO: Mr. Alfriede Roman, Superintendent,
Lake County MR/DD Board

FROM: William R. Angel, Jr., Assistant Deputy Director
ODMR/DD, Community MUI Registry Unit

RE: Death of Ms. Lorna Moeller

DATE: May 9, 2000



SCANNED

After review of the major unusual incident case of Ms. Lorna Moeller by the Community MUI Registry Unit and Dr. Andrew Eddy, M.D., ODMR/DD, Medical Director, the ODMR/DD has developed a list of questions to gather further information regarding the care, treatment and services Ms. Moeller was or was not receiving prior to her death.

Please gather all pertinent information regarding Ms. Moeller and answer all provided questions. Responses to the prepared questions are due back to the ODMR/DD, MUI Registry Unit by May 26, 2000.

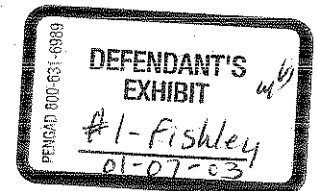
Questions:

- 1. What was the communication between residence staff and emergency department and hospital on 2/01/00?
- 2. Was all-pertinent history conveyed to the emergency physician?
- 3. Was the opportunity to convey pertinent history to the emergency physician provided by the emergency room staff?
4. What was the specific communication between residence staff and the nurse between 2/02/00 and 2/04/00?
5. Did the nurse know of continued vomiting?
6. Were the signs and symptoms of cardiovascular compromise relayed to the nurse? If so, did the nurse recognize the constellation of signs and symptoms as possibly signifying a serious medical condition?
7. What was the specific communication between the nurse and the physician the morning of 2/04/00?
8. What was the communication between the hospital and the residence staff and nurse on discharge from the hospital on 2/02/00?
9. Were the staff made aware of signs and symptoms, which would indicate a return visit to the hospital was warranted?

Organizational Services, 1810 Sullivant Avenue, Columbus, OH 43223-1239

Voice: 614.752.0487 Fax: 614.752.0486 TDD: 614.752.4687 Web Site: <http://www.state.oh.us/dmr>

The State of Ohio is an Equal Opportunity Employer and Provider of Services



10. If resident was seen in U.C.C. prior to Emergency Center evaluation, was this by choice, or was she triaged there and later sent to the Emergency Center?
11. What was the communication between these two service areas?
12. Based on these communications, what was each parties impression as to what was wrong with the resident?
13. Could further intervention been provided to the resident?
14. What happened on 2/02/00 and 2/03/00, i.e., what was the chronology of events after discharge from the hospital?
15. What were the resident's normal eating and bowel habits?
16. When was the resident's last normal bowel movement?
17. What was the specific nature of the vomits?
18. Was there an odor to the vomit? If yes, what?
19. How are orders for laxatives, anti-diarrheals, and other over-the-counter gastrointestinal medications received?
20. Was the nurse called?
21. Was the physician called?
22. Please provide copies of any standing orders.
23. Do staff make the determination as to what medication seems best suited for the resident at the time?
24. Are there guidelines or policies concerning the nurse being contacted by staff?
25. Are there guidelines or policies concerning the physician being contacted by the nurse?

Thank you.

CC: Kenneth W. Ritchey, ODMR/DD, Director
Mel Borkan, ODHS, Office of Medicaid
Dr. Andrew Eddy, ODMR/DD, Medical Director
Mick Ihlenfeld, ODMR/DD, Assistant Deputy Director, S.O.S.S.
Christine Oliver, ODMR/DD, Deputy Director, Legal Services
Nancy McAvoy, ODMR/DD, Deputy Director, Community Services
Ernie Fisher, ODMR/DD, Assistant Deputy Director, Licensure

MEMORANDUM

TO: Mr. Bill Angel, Assistant Deputy Director
ODMR/DD Community MUI Registry Unit

FROM: Pat Fishley, Lake County MR/DD, Case Management

DATE: May 25, 2000

RE: Lorna Moeller

Per your request please note the following information:

On 5/22/00, I met with Ms. Barbara Irwin of the Risk Management office of Lake East Hospital. She provided copies of the services/treatments provided to Lorna on her 2/1 - 2/2/2000 hospitalization. I also spoke with the nurse on duty, Aulikki Dieglio, who reported that the after care instructions were called into the Eastwood nurse due to not having residential staff available at the time of discharge. Lorna returned home via Tri-County ambulance service. Aulikki Dieglio reported that she did not want to send Lorna home with the instructions due to Lorna's inability to understand and relay the information.

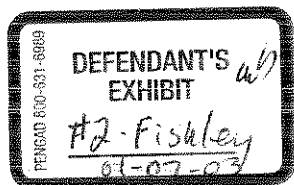
On 5/23/00, I again interviewed Eastwood nurse, Julie Warner. Also, in attendance was LuAnn Busch, Administrator; Lisa Shubert, Program Coordinator; and Staci Reigert, Home Manager.

On 5/24/00, I traveled to Madison Urgent Care Center to obtain a copy of their records of 2/1/00. (See Attached)

On 5/25/00, I spoke with Rita Freeborn, 2nd shift staff who escorted Lorna to the Urgent Care Center, Lake East Hospital on 2/1/00. Rita also worked on 2nd shift on 2/2/00 and 2/3/00. (Note: Rita resigned from Eastwood at the end of February 2000. She was contacted at home by this worker. She is willing to help any way she can.)

Response to questions from each above entity are as follows:

1. Hospital nurse reports that Eastwood direct care staff was present in the ER and provided information and "offered emotional support."



Moeller, Lorna

Eastwood nurse, Julie, reports having called the Emergency Room and speaking with a nurse. Julie could not recall the nurse's name and reports that the ER nurse only said that Lorna was going to be admitted for observation. The ER nurse then put Julie in contact with the direct care staff.

2. Eastwood nurse reports that transfer sheet was sent from Madison Urgent Care Center (Attached). Additionally, Julie reports that the hospital could've gotten the information from the computer. Emergency Room Physician report is attached.
3. In interview with hospital nurse Aulikki Dieglio and Risk Management Supervisor, Barbara Irwin, it was reported that Lorna's history and symptoms were conveyed to the Physician via Urgent Care transfer sheet, X-ray, and lab work. ER Physician report also states that he had contacted Lorna's physician, Dr. Kessler, prior to admission.
4. The Eastwood nurse, Julie Warner, reports that staff had paged her 4x during the night of 2/3/00 - 2/4/00. On 5/22/00, Julie reports being paged at 12 midnight, 3:30 a.m., and 5:00 a.m. on 2/4/00. During the initial interview with this worker on 2/4/00, Julie looked at her pager and reported that she had been paged at 2:54 a.m., 3:15 a.m., 6:00 a.m., and 7:11 a.m.. On 2/4/00, Julie reported that staff had paged to report that Lorna was vomiting. During 5/22/00 interview Julie reports that she was paged at above mentioned times and staff reported that "Lorna was tired." There is little documented information available between nurse and residential staff. The staff log contains no documentation of Lorna's status or medical information. It is unclear how staff received after care plan from the hospital discharge. There was some verbal information between nurse and direct care staff regarding the use of suppository prescribed by Physician. The nursing notes contain no information from Julie to staff. However, staff utilized the nursing notes to document the use of standing orders and Lorna's continued vomiting.
5. Yes. As mentioned above, the nurse was paged at least 4 times. The nurse worked from 10 a.m. - 4 p.m. on 2/2/00, 2:30 p.m. - 6:30 p.m. on 2/3/00, and 8:00 a.m. - 3:00 p.m. on 2/4/00. The nurse contacted the Doctor's office at 6:00 p.m. on 2/3/00. Reportedly, this was after Lorna had vomited "a large amount of brownish matter." Staff report that Julie assisted Lorna in changing her clothing and sheets after this episode. Documentation from the Urgent Care Center records

Moeller, Lorna

reports that they had been contacted by Julie to get in touch with the doctor. Documentation states that UCC advised to call 911 if they couldn't reach the Doctor or if condition worsened. (Report attached)

6. Documentation unavailable. Staff on 2nd and 3rd shift report paging the nurse. They report having taken blood pressure and temperature, on occasion. Staff report having given the information verbally to the nurse each time she was paged. Nursing notes show documentation from staff to Julie. There are no entries from Julie to staff regarding after care plans or status. Of concern to this worker: the nurse requested the blood pressure and temperature be taken at 3:30 a.m. on 2/4/00. Staff documented that blood pressure was 90/60 and temperature was 99.8. Julie "was notified, will look at her when she gets here. Client very cool and clammy." Julie reported that it was this information that she provided to the doctor and 8:30 a.m. on 2/4/00. Julie reports that she did not take vital signs herself when she arrived at Eastwood. There is discrepancy as to when Julie arrived at work on 2/4/00. She reports that it was at 7:00 a.m.. Sign-in/ Payroll records show that she worked 8:00 a.m. - 3:00 p.m.. The Doctor's office documentation shows that Julie contacted them at 8:30 a.m..
7. No documentation available. Julie reports that she contacted Dr. Heng. She reports that she informed the Doctor that Lorna still did not have a bowel movement and was continuing to vomit bile. She gave the doctor her vital signs from 3:30 a.m.. Dr. Heng prescribed Magnesium Citrate. Julie reports leaving the facility to purchase medication at Rite-Aide.
8. Lake Hospital nurse reports having called Julie at Eastwood to provide after care information. She reports making the call due to Lorna's mental capacity and that she was being transported via ambulance service rather than being picked up by Eastwood Personnel. Staff, when interviewed, did not recall receiving any after care forms from the ambulance driver upon Lorna's return. Staff believe that they received information from Julie verbally.
9. No documentation available. Eastwood notes do not indicate any information regarding Lorna. Staff notes for this time period do not mention Lorna at all. Nursing notes contain 5 entries regarding Lorna from staff to the nurse. There is no documentation available from the nurse to staff regarding after care or signs/ symptoms.

Moeller, Lorna

10. Eastwood transported Lorna to Madison Medical Center Urgent Care Center due to Lorna's vomiting and being in "agony." After evaluation and X-rays at UCC, she was transferred to Lake East Hospital, via ambulance. Lorna was then evaluated in the ER and admitted for observation.
11. Documentation from UCC and ER show that labs, X-rays, and symptoms were discussed via phone between Dr. Andur (UCC) and Dr. Jeronin (ER). Both doctors reviewed status with Lorna's physician, Dr. Kessler (in practice with Dr. Heng).
12. Dr. Andur's (UCC) report states that reason for transfer was "UTI - severe abdominal pain - R/O small bowel obstruction."
Dr. Jeromin (Hospital ER) reports "at this time, her clinical exam appears much more consistent with a gastritis complaint than a bowel obstruction."
At discharge, Dr. Heng's report states "no obstruction; + stool/gas/C/W constipation."
13. Residential staff felt that Lorna's should've returned to the hospital on 2/3/00 when vomiting continued. Eastwood nurse, Julie, states that Lorna was discharged from the hospital too soon. Julie believes that Lorna should've had a bowel movement before being discharged. There is no record that an ultra sound had been done, which may have picked up a high impaction not seen on X-ray.
14. On 2/2/00, at approximately 4:00 p.m., Lorna returned home via Tri-County Ambulance Service. Staff report that Lorna walked in to the facility and went to bed. Staff report that Lorna remained in her room most of evening. Staff report giving Lorna Milk of Magnesia at 5:55 p.m.. At 11:30 p.m., Lorna was vomiting and given Pepto-Bismal. Julie was notified via pager. Staff did not monitor or document intake or output. Neither staff or Eastwood nurse is aware of amounts of fluids Lorna took between 2/2/00 - 2/4/00.

Eastwood completes a census check every 3 hours. On 2/2/00 census form shows that Lorna was asleep at 10:00 p.m.. At 11:30 p.m., she vomited. On 2/3/00, at 1:00 a.m. she was "awake in bed." At 4:00 a.m. - "OK", 7:00 a.m. - sleeping, 10:00 a.m. - "OK", 1:00 p.m. - she was sleeping, 4:00 p.m. - sleeping, 7:00 p.m. - "OK". (Note: per census definition "OK" means "present and accounted for.") There is no documentation regarding Lorna prior to 4:00 p.m. on 2/3/00. House Manager states Lorna was "fine." The nurse, Julie, worked 2:30 p.m. - 6:30 p.m.

Moeller, Lorna

on 2/3/00. She reports that Lorna did not vomit until 4:00 p.m. She reports that this is when she contacted the doctor's office and a suppository was ordered. Julie reports giving Lorna a suppository at 4:00 p.m. UCC documentation shows that Julie had contacted them at 6:00 p.m. to reach Dr. Heng. UCC documentation states that Julie was "advised if unable to reach doctor or patient gets worse, call 9-1-1." Staff reported that Julie did witness Lorna vomiting at 6:00 p.m. and that Julie assisted with changing Lorna's bedding and clothing. Julie reports that she only saw Lorna vomit on 2/4/00.

Through 3rd shift hours, staff report that Lorna was up all night. She was unable to get comfortable and complained of being tired. Lorna continued to vomit and staff assisted in changing clothing and bedding through the night. The nurse was paged 4 times through the night (3:00 a.m., 3:30 a.m., 5:00 a.m., and 7:00 a.m.) Lab personnel arrived at 4:45 a.m. to do a routine draw. They were unable to complete draw due to not being able to get a vein. The nurse arrived at 8:00 a.m.; Julie contacted Dr. Heng who prescribed Magnesium Citrate. Julie left to purchase medication. Upon return, she took medication to Lorna. Lorna's eyes began to roll she was vomiting out of her nose and mouth. Julie instructed staff to call 9-1-1, at approximately 9:00 a.m.. Paramedics arrived, attempted to resuscitate. Paramedics radioed in that Lorna was D.O.A.. Paramedics gave Lorna Epinephrin in the ambulance and got a heartbeat. She was taken to Geneva hospital and put on a respirator. Dr. Greeny informed family that Lorna was brain dead. Family decided to discontinue respirator at 10:40 a.m.. Lorna was declared dead at 11:00 a.m. on 2/4/00.

15. Staff report that Lorna's normal eating habits were good, that "she was always ready for a meal or snack." Staff and Home Manager were less clear on bowel habits, stating that Lorna was "independent" and it was not charted since she did not required assistance. Staff report that she would've reported a problem if there was one.
16. Lorna reported having had a bowel movement on 2/2/00 prior to leaving Lake East Hospital. Staff were unsure when her last normal bowel movement occurred.
- 17: -18. Second shift staff, Rita Freeborn, reported that from 2/1/00 to 2/3/00 Lorna was vomiting large amounts of brownish bile. She reports no differences from what she observed on 2/1/00, 2/2/00, or 2/3/00. She reports that Lorna had not eaten and therefore there was no food matter. She reports that the odor was "like any vomit." Eastwood nurse, Julie Warner, reports "a brownish bile" on 2/4/00. She reports it

Moeller, Lorna

was a large amount coming out of Lorna's nose and mouth. She reports it was "obviously fecal matter." Julie reports that Lorna had also urinated and defecated "due to the body shutting down." Julie also reports that the odor "was no worse than any vomit."

19. Julie reports that the doctor will fax them to the pharmacy to be filled and delivered. If it is needed immediately, the doctor will fax to the facility. The nurse or direct care staff will take it to Rite-Aide to be filled.
20. - 21. This worker is unclear as to what these questions are referring to. If in regard to dispensing over-the-counter medications, the physician ordered the medications based on information received from Julie. The direct care staff received direction verbally or via phone to dispense medication. Direct care staff document in nursing notes when medication is given. If these questions are in relation to how often the nurse and physician were called, please refer to chronology of events listed above.
22. Attached. It is signed and dated by Dr. Heng on 1/18/00.
23. No, the nurse is paged. If not on grounds, the nurse will make the decision or contact physician based on presenting symptoms.
24. There is no policy regarding the nurse being contacted by staff. Eastwood Administrator, LuAnn Busch, reports that staff are informed at orientation to contact nurse for medical concerns. For medical emergencies, staff are instructed to call 9-1-1 and then the Administrator. This information is included on the Employee Information Sheet (Attached). Additionally, it is reported that direct care staff receive a 10 Hour Medication course training offered by the nurse and the R.N. consultant.
25. No.

PF/jlf

copy: David Miller, Case Management Director
Elfie Roman, Superintendent
Joe Jerse, Legal Counsel



Ohio Department of Mental Retardation
And Developmental Disabilities
Kenneth W. Ritchey, Director

State Operated Services and Supports
Andrew D. Eddy, MD, MS
Medical Director

66737 Old Twenty-One Road (740) 432-0344
Cambridge, Ohio 43725-9298 (740) 439-4382 FAX

To: Mick Ihlenfeld, State Operated Services and Supports
William R. Angel, Jr., MUI Investigation and Registry Unit

From: Andy Eddy, MD

Re: Lorna Moeller mortality review
Lake County Board of MRDD response to questions

I have reviewed the responses to questions forwarded by Pat Fishley, Lake County MR/DD, dated May 25, 2000.

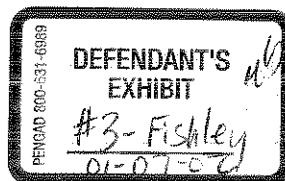
First paragraph: "Aftercare instructions were called to the Eastwood nurse due to not having residential staff available at time of discharge." This indicates to me that Ms. Moeller was discharged from the hospital without hospital staff having the opportunity to interview direct care staff as to Ms. Moeller's condition at discharge compared to her usual condition.

Questions one, two, and three: Staff were available to answer questions about medical history. Seemingly pertinent medical history was available to the emergency department staff evaluating Ms. Moeller.

Question four: This answer underscores my impression that there is insufficient communication and documentation of communication between direct care staff and nursing staff. This is also seen in the Lake Hospital System Patient Care Progress Notes, dated 2-4-00, 0830. This person documents that "Eastwood care giver call[ed]" (the caller was the nurse according to the answer to question four) and [Ms. Moeller] "still had not had BM and was vomiting bile." It is clear to me on review of the record that Ms. Moeller was vomiting fecal material, and somehow this fact was lost in the communication from direct care staff, to the nurse, to the hospital, and possibly to the physician.

Question five: The physician's office was called by the nurse at 6:00 pm, but I do not believe there is any documentation of the conversation or instructions given. The staff had documented what I believe to be emesis of fecal material, and I cannot tell if this was communicated to the nurse or to the physician.

Question six: This answer implies that signs of vascular compromise may have been missed by the nurse and physician. Again documentation is lacking.



Question seven: This answer implies that signs of vascular compromise may have been missed by the nurse and physician. Again documentation is lacking. Somehow the nurse believed the brown material was bile, underscoring communication problem.

Questions eight and nine: There is no documentation that hospital discharge instructions were provided to direct care staff, other than "staff believe they received information from Julie verbally." There is insufficient staff and nursing documentation of discussions and information shared. I question whether the staff or nurse understood signs and symptoms that would indicate that a return visit to the emergency department would be warranted.

Question ten: Records from the Madison Medical Center Urgent Care Center indicate that Dr. Amdur did do a rectal exam. There is no other rectal exam documented in records previously available to me. The physician record is difficult to read. However, I believe the rectal exam showed "no stool (illegible word), positive hemorrhoids." This exam is consistent with a fecal impaction that remained untreated in the hospital.

Questions eleven and twelve: Communication appears to have occurred between the urgent care physician, the emergency department physician, and the attending physician.

Question thirteen: This answer leads to another question. Do the nurses providing care in community settings feel that they can question care provided, or offer suggestions as to appropriate care? What would keep this nurse from sending Ms. Moeller back to the hospital if she felt care had not been adequate?

Question fourteen: Intake and output are very important parameters to monitor for anyone with emesis and abdominal pain. There is no reason this cannot be done in a residential setting. Output may not be accurate, but certainly a record of fluid intake could be maintained. The answer to this question simply outlines the unfortunate demise of someone dying of a bowel obstruction.

Question fifteen: The urgent care center and emergency department records indicate that Ms. Moeller's last bowel movement was in the am on 2/1/00. If Ms. Moeller was independent in toileting, how did staff know she had a bowel movement that morning? More importantly, what was the nature of the stool? Was it formed, or was it diarrheal in nature, possibly indicating overflow diarrhea from a fecal impaction? What information concerning the bowel history was conveyed to medical personnel, and how much of such information did the medical personnel request?

Question sixteen: I can find nothing in the records I have to indicate that Ms. Moeller had a bowel movement on 2/2/00 prior to leaving Lake East Hospital. If "staff were unsure when her last normal bowel movement occurred", then how did the urgent care center and the emergency department obtain the history of last bowel movement the am of 2/1/00?

Question seventeen and eighteen: Staff knew she was vomiting fecal material. The records and question answers seemingly indicate that this observation was lost in the communication between staff and the nurse, and between the nurse and the physician.

Question nineteen: noted

Questions twenty and twenty-one: The records and answers to questions indicate that the nurse was called by direct care staff, and the physician was called by the nurse.

Question twenty-two: Standing orders for both nausea/vomiting and constipation could lead to conflicting orders in the scenario of a resident vomiting due to bowel obstruction. The standing orders allow for Pepto-Bimol to be given, which apparently occurred in this case. Unfortunately, Pepto-Bismol can exacerbate constipation or fecal impaction.

Question twenty-three: Th nurse decides what medication is best suited for current condition.

Question twenty-four and twenty-five: Staff apparently do not receive training in recognition and treatment of medical emergencies, or in signs or symptoms that would indicate the nurse, physician, or EMS should be called.

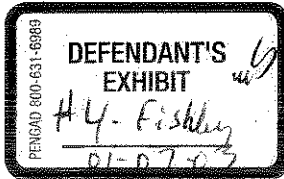
Conclusions

- 1) Discharge from the hospital was not coordinated with the direct care staff who would be monitoring Ms. Moeller.
- 2) Communication, and documentation of communication, about Ms. Moeller's condition after discharge from the hospital was inadequate between direct care staff, the nurse, and the physician. This led to inadequate interventions. The direct care staff may have felt they were communicating that Ms. Moeller was vomiting fecal material. However, the nurse apparently did not understand this message.
- 3) The nurse did not recognize that a blood pressure of 90/60 and an appearance of cool and clammy could signify vascular compromise.
- 4) Communication between staff and urgent care and emergency department personnel appears to have occurred. I am still concerned about the history of a bowel movement the am of 2/1/00, given Ms. Moeller's independence in toileting (see questions fifteen and sixteen).
- 5) Rectal exam done at the urgent care center showed absence of stool. This coupled with the discharge exam by Dr. Heng (left lower quadrant mass) is consistent with fecal impaction and bowel obstruction.

Recommendations

1. Discharge of a resident from the hospital should be coordinated with direct care and nursing staff, including assessment of current condition, and provision of specific discharge instructions to the nurse and to the direct care staff.
2. Improve communication and information exchange between direct care staff, nursing staff, both in content and in documentation of communications.
3. Ensure that either direct care staff have access to pertinent medical information in order to provide such to health care providers (e.g., the emergency department); or that resident health care providers (nurse, physician) speak directly with consulting health care providers. This will improve communication between the home and outside medical consultants.
4. Direct care staff should be trained in providing basic medical care for persons with specific conditions, on an as needed basis. For example, intake and output monitoring for someone with nausea and vomiting; or the importance of accurate bowel movement documentation for someone with abdominal or gastrointestinal complaints. Direct care staff should have training in recognizing signs and symptoms that would indicate the nurse, physician, or EMS should be called (i.e., training in the recognition of a medical emergency).
5. Clarify standing orders to avoid conflicting therapies for conditions that may present with similar symptoms (nausea/vomiting and constipation).

OHIO DEPARTMENT OF MR/DD
MEDICAL DIRECTOR'S MORTALITY REVIEW

Date: 4-12-00		Facility: Eastwood Residential Services	
Name: Lorna Moeller		Age: 65	Date of Death: 2-4-00
Time of Death: 1100		CPR Performed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
DNR In Place: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Documentation of DNR: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	
Cause of Death: Per Death Certificate: 1. Cardiac Arrest 2. Bowel Obstruction			
Autopsy Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Significant Autopsy Findings: N/A			
Medications: Premarin, Priaivil, Tenormin, Bamex, Calcium, Ibuprofen, Axid, Potassium, Multivitamin, 1500 Calorie low fat/low cholesterol diet.			
Cormorbidities: Hypertension, Hypothyroidism, Diverticulitis, History of Depression			
Death was: Possibly Preventable <input checked="" type="checkbox"/> Not Preventable <input type="checkbox"/>			
Discussion: Death determined to be to be possibly preventable if bowel obstruction had been diagnosed and treated when present.			
			
Physician: Andrew D. Eddy, MD, Medical Director, ODMR/DD			

MUI SYNOPSIS

TO: LuAnn Busch

FROM: Pat Fishley *Pat*

DATE: September 14, 2000

RE: Incident Involving: Lorna Moeller
Report of: Death
Date of Incident: 2/4/00

VERBAL NOTIFICATION: Date: 2/4/00 and 5/23/00
Person Spoken to: LuAnn Busch/Julie Warner

Please know, this incident has been reported to the Ohio Department of Mental Retardation and Developmental Disabilities, Major Unusual Incident State Registry.

As outlined in the Ohio Revised Code 5123.61 and Ohio Administrative Code 5123:2-17-02, the County Board of Mental Retardation and Developmental Disabilities is to review all major unusual incidents reported.

Summary of Incident:

Lorna passed away on 2/4/00 of cardiac arrest due to bowel obstruction.

Findings:

Based on reports, interviews, and medical review, it was determined that Lorna's death was possibly preventable, if "bowel obstruction had been diagnosed and treated when present."

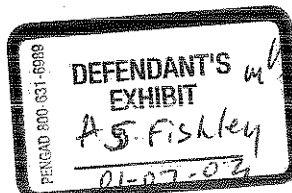
It was determined that a lack of coordination, communication, and documentation contributed to Lorna receiving inadequate care and interventions.

Case Disposition: ODMRDD Current MUI Review Status: Open
County Board Case Management Status: Open

Recommendations:

1-5, as recommended through the Ohio Department of MR/DD

1. Discharge of a resident from the hospital should be coordinated with direct care and nursing staff, including assessment of current condition, and provision of specific discharge instructions to the nurse and to the direct care staff.
2. Improve communication and information exchange between direct care staff, nursing staff, both in content and in documentation of communications.
3. Ensure that either direct care staff have access to pertinent medical information in order to provide such to health care providers (e.g., the emergency department); or that resident health care providers (nurse, physician) speak directly with consulting health care providers. This will improve communication between the home and outside medical consultants.



4. Direct care staff should be trained in providing basic medical care for persons with specific conditions, on an as needed basis. For example, intake and output monitoring for someone with nausea and vomiting; or the importance of accurate bowel movement documentation for someone with abdominal or gastrointestinal complaints. Direct care staff should have training in recognizing signs and symptoms that would indicate the nurse, physician, or EMS should be called (i.e., training in the recognition of a medical emergency).
5. Clarify standing orders to avoid conflicting therapies for conditions that may present with similar symptoms (nausea/vomiting and constipation).
6. Eastwood review/up-date policy/procedures regarding the handling of medical issues/emergencies. All staff receive in-service training on handling of medical emergencies. Case Management receive notification of in-service training as scheduled.
7. The nurse receive additional training in the handling of medical emergencies and potentially compromising situations.
8. Case Management be notified of any hospitalizations and discharge plans.

Case Management will continue to monitor all aspects of health/safety.

Please respond with Plan of Correction no later than September 25, 2000.

cc: Elfie Roman, Superintendent
David Miller, Case Management Director

BALDWIN'S OHIO REVISED CODE ANNOTATED
TITLE LI. PUBLIC WELFARE
CHAPTER 5123. DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL
DISABILITIES
LEGAL RIGHTS SERVICE; OMBUDSMAN SECTION; ABUSE OF MENTALLY RETARDED ADULT

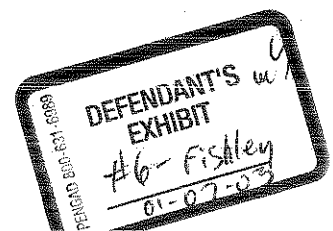
Copr. © West Group 2002. All rights reserved.

Current through 12/2/02, including File 185 of the 124th GA (2001-2002),
apv. 8/8/02

5123.62 RIGHTS OF PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITY

The rights of persons with mental retardation or a developmental disability include, but are not limited to, the following:

- (A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
- (B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
- (C) The right to food adequate to meet accepted standards of nutrition;
- (D) The right to practice the religion of their choice or to abstain from the practice of religion;
- (E) The right of timely access to appropriate medical or dental treatment;
- (F) The right of access to necessary ancillary services, including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavior modification and other psychological services;
- (G) The right to receive appropriate care and treatment in the least intrusive manner;
- (H) The right to privacy, including both periods of privacy and places of privacy;
- (I) The right to communicate freely with persons of their choice in any reasonable manner they choose;
- (J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
- (K) The right to social interaction with members of either sex;
- (L) The right of access to opportunities that enable individuals to develop their full human potential;
- (M) The right to pursue vocational opportunities that will promote and enhance economic independence;
- (N) The right to be treated equally as citizens under the law;
- (O) The right to be free from emotional, psychological, and physical abuse;
- (P) The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
- (Q) The right to participate in decisions that affect their lives;



- (R) The right to select a parent or advocate to act on their behalf;
- (S) The right to manage their personal financial affairs, based on individual ability to do so;
- (T) The right to confidential treatment of all information in their personal and medical records, except to the extent that disclosure or release of records is permitted under sections 5123.89 and 5126.044 of the Revised Code;
- (U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
- (V) The right to be free from unnecessary chemical or physical restraints;
- (W) The right to participate in the political process;
- (X) The right to refuse to participate in medical, psychological, or other research or experiments.

CREDIT(S)

(2000 H 538, eff. 9-22-00; 1996 H 629, eff. 3-13-97; 1993 S 21, eff. 10-29-93; 1986 S 322)

<General Materials (GM) - References, Annotations, or Tables>

HISTORICAL AND STATUTORY NOTES

Ed. Note: Former **5123.62** amended and recodified as 5123.90 by 1980 H 900, eff. 7-1-80; 1977 H 725; 1972 H 494; 1970 H 970; 1953 H 1; GC 1890-106.

Pre-1953 H 1 Amendments: 117 v 550, § 106

OHIO ADMINISTRATIVE CODE REFERENCES

Major unusual incidents, OAC 5123:2-17-02

Residential facilities; admission, discharge, and transfer, OAC 5123:2-3-05

LIBRARY REFERENCES

Mental Health  1, 31, 51.1, 331.

WESTLAW Topic No. 257A.

C.J.S. Insane Persons § 2 to 3, 21, 45, 47, 53, 86 to 92, 209.

Lake County Board of Mental Retardation - Developmental Disabilities
SUPPORTED LIVING/RFW PROVIDER
CONSUMER INCIDENT REPORTING FORM

ORIGINAL

CONFIDENTIAL

Consumer Name: Lorna Moeller Consumer SS# 270, 64, 1069 Department Code # EW F

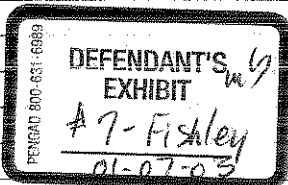
Complete one report for each incident or injured consumer. Report should be completed immediately if possible, or by the end of the shift.
 Document staff injury on Employee Accident Report Form.

Part 1: To be completed by employee who discovered the incident.

A. Date of Incident: <u>2/1/00</u>	B. Time: <u>10:30</u> Military	C. Day of Week	D. Observed? <u>Y/N</u>
E. Type of Incident (circle one)	F. Primary Location (circle one)	1. Mon. 2. Tues. 3. Wed. 4. Thurs. 5. Fri. 6. Sat. 7. Sun.	G. Incident Cause
1. Self-injury 2. Choking 3. Death 4. Fall/slip 5. Fire 6. Found on floor/ground 7. Ingestion of foreign object 8. Unexplained body mark 9. Missing/AWOL 10. Physical Assault 11. Verbal Threat/Assault 12. Sexual Assault 13. Sexually explicit behavior 14. Other: <u>Illness</u>	1. ARC 2. CDC 3. VGC 4. Willoughby 5. CLEO 6. Broadmoor 7. Community Program 8. Vehicle 9. Recreation 10. Supported Living / RFW Home 11. Specific Location: 12. Other:		1. Self 2. Other Consumer 3. Seizure 4. Defective Equipment 5. Staff Member 6. Weather Related 7. Visitor 8. Unknown 9. Injury/Mechanical Restrain 10. Injury/Manual Restraint 11. Injury/Transfer or Lift 12. Community Co-worker 13. Other: <u>Illness</u>
H. Others involved (Aggress. Victim, Other) Staff/Consumer			
SS# <u> </u> <u>AVOSIC</u>			
SS# <u> </u> <u>AVOSIC</u>			

I. Describe incident in detail including preceding or contributing events/actions, as well as resolution of the incident.

Client came to staff and stated that her rectal area hurt. Staff observed area, checked client's med chart, & then asked client to wash herself. When client refused, staff applied A+D ointment to the rectal area. At that time, client also stated that she had vomited & her stomach hurt. She asked for Pepto-Bismol & said that she did not feel like eating supper - was going to go lay down. Staff checked on client while fixing dinner & found her laying in bed, unable to get comfortable & having severe abdominal pain. Staff contacted Greenbrook staff who agreed to come to Eastwood & finish fixing dinner while EW staff took client to Madison Medical Campus. Tests were conducted at MMC & the decision was made to send client to Lake Hospital East Emergency Room for further testing. While at Lake East, blood work was done & medications to ease client's pain & nausea were given to client. (Client had been periodically vomiting small amounts of fluid.) The client done on & off. Client was admitted to Lake East & kept overnight for observation.



01 7 6 1/11

Consumer's Name: Lorna Moeller

Part I (continued) To be completed by employee who discovered the incident.

J. Nature of Injury 1. None/na 2. Abrasion/ bruise/contusion 3. Airway obstruction 4. Bite 5. Burn 6. Exposure cold/heat 7. Eye injury 8. Fracture 9. Head injury 10. Laceration/scratch 11. Puncture 12. Skin irritation 13. Sprain/strain/dislocation 14. Teeth injury 15. Unable to determine	K. Severity of Injury 1. No apparent injury 2. Minor (temporary injury; no further complications) 3. Moderate (injuries not serious; requiring medical attention) 4. Severe (serious injury requiring medical treatment and/or resulting in change in physical status) 5. Death	L. First aid/treatment given by: 1. None 2. Staff 3. RN/LPN 4. Physician 5. Other: _____
	M. Required Emergency Services? <u>Y</u> or N	

N. For Medication/Treatment Errors	
1. Incorrect time	6. Omission
2. Incorrect medication	7. Transcription error
3. Incorrect dosage	8. Medication
4. Incorrect route	9. Stray Pills
5. Incorrect individual	10. Other

Part II Completed by Supported Living Staff

O. Treatment Given/Recommendations:

Kept at Lake Hospital East overnight for observation.

NOTIFICATION:

DATE/TIME

Parent/Guardian:

/ / Military

Manager:

/ / Military

Other:

/ / Military

Part III Completed by Administrator

POTENTIAL Major Unusual Incident []

POTENTIAL Minor Unusual Incident []

P. Person(s) Notified: (All potential MUI's require notification of the Lake County Board MR/DD Office of Case Management)

List Persons Name	Date	Time	Copy Sent	Notified By:
Parent/Guardian:	<u>/ /</u>	<u>:</u>	Military	Y/N
Case Management:	<u>2/1/00</u>	<u>10:</u>	Military	Y/N
Program Director:	<u>/ /</u>	<u>:</u>	Military	Y/N
Other:	<u>/ /</u>	<u>:</u>	Military	Y/N

Q. Recommendations/Immediate Actions Taken:



Lake County Board of Mental Retardation - Developmental Disabilities
**SUPPORTED LIVING/RFW PROVIDER
CONSUMER INCIDENT REPORTING FORM**

CONFIDENTIAL

ORIGINAL

Consumer Name: Lorna Moeller Consumer SS# 2701641069 Department Code # Eastwood
Complete one report for each incident or injured consumer. Report should be completed immediately if possible, or by the end of the shift.
Document staff injury on Employee Accident Report Form.

Part 1: To be completed by employee who discovered the incident.

A. Date of Incident: <u>02/02/00</u>	B. Time: _____ Military _____	C. Day of Week	D. Observed? Y/N
E. Type of Incident (circle one) 1. Self-injury 2. Choking 3. Death 4. Fall/slip 5. Fire 6. Found on floor/ground 7. Ingestion of foreign object 8. Unexplained body mark 9. Missing/AWOL 10. Physical Assault 11. Verbal Threat/Assault 12. Sexual Assault 13. Sexually explicit behavior 14. Other: _____	F. Primary Location (circle one) 1. ARC 2. CDC 3. VGC 4. Willoughby 5. CLEO 6. Broadmoor 7. Community Program 8. Vehicle 9. Recreation 10. Supported Living / RFW Home 11. Specific Location: _____ 12. Other: _____	1. Mon. 2. Tues. ③ Wed. 4. Thurs. 5. Fri. 6. Sat. 7. Sun.	G. Incident Cause 1. Self 2. Other Consumer 3. Seizure 4. Defective Equipment 5. Staff Member 6. Weather Related 7. Visitor 8. Unknown 9. Injury/Mechanical Restrain 10. Injury/Manual Restraint 11. Injury/Transfer or Lift 12. Community Co-worker 13. Other: _____
H. Others involved (Aggressor, Victim, Other) Staff/Consumer			
SS# _____ A V O S / C			
SS# _____ A V O S / C			

I. Describe incident in detail including preceding or contributing events/actions, as well as resolution of the incident.

F/U on Lorna Moeller's hospital stay 2-1-00 to 2-2-00.
Received a call from the nurse on the unit @ Lake
East Hospital regarding Lorna. She had a bad case of
gastroenteritis. She was given milk of Magnesia to evacuate
the bowel & the doctor ordered Colace (stool softener) one every day.
She will be returning to Eastwood this afternoon via ambulance.



Lake County Board of Mental Retardation - Developmental Disabilities

SUPPORTED LIVING/RFW PROVIDER
CONSUMER INCIDENT REPORTING FORM

CONFIDENTIAL

ORIGINAL

Consumer Name: LORNA MOELLER Consumer SS# 2706411069 Department Code # Eastwood

Complete one report for each incident or injured consumer. Report should be completed immediately if possible, or by the end of the shift.

Document staff injury on Employee Accident Report Form.

Part 1: To be completed by employee who discovered the incident.

A. Date of Incident: <u>2/3/00</u>	B. Time: <u>22:00</u> Military	C. Day of Week	D. Observed? <u>YN</u>
E. Type of Incident (circle one) 1. Self-injury 2. Choking 3. Death 4. Fall/slip 5. Fire 6. Found on floor/ground 7. Ingestion of foreign object 8. Unexplained body mark 9. Missing/AWOL 10. Physical Assault 11. Verbal Threat/Assault 12. Sexual Assault 13. Sexually explicit behavior <u>14. Other: <u>ill - Vomiting</u></u>	F. Primary Location (circle one) 1. ARC 2. CDC 3. VGC 4. Willoughby 5. CLEO 6. Broadmoor 7. Community Program 8. Vehicle 9. Recreation 10. Supported Living / RFW Home <u>11. Specific Location: <u>Kitchen</u></u> 12. Other:	1. Mon. 2. Tues. 3. Wed. <u>4. Thurs.</u> 5. Fri. 6. Sat. 7. Sun.	G. Incident Cause 1. Self 2. Other Consumer 3. Seizure 4. Defective Equipment 5. Staff Member 6. Weather Related 7. Visitor <u>8. Unknown</u> 9. Injury/Mechanical Restrain 10. Injury/Manual Restraint 11. Injury/Transfer or Lift 12. Community Co-worker 13. Other:
H. Others involved (Aggress., Victim, Other) Staff/Consumer SS# <u>AVOSIC</u> SS# <u>AVOSIC</u>			

I. Describe incident in detail including preceding or contributing events/actions, as well as resolution of the incident.

Staff was informed upon arrival of shift, that resident had returned from hospital and that she had been vomiting. Resident was seated at kitchen table sipping ginger ale then 2 hrs later staff assisted client in changing her clothes due to spots of vomit on her clothing. Staff ask client if she was ok or if she felt any pain. Client responded no. Client stated she was going to lie down because she was tired. Approx. 40 minutes later client came out of bedroom with spots of vomit on her clothing. Staff assisted in changing her again. Staff stayed with client afterwards. Around 3:15am. Client stated she had vomited. Staff assisted again in changing client. Staff again ask client if she was ok or felt in pain. Client stated she only felt tired. Lab personnel arrived and was unable to draw blood from client. Lab personnel stated due to her hospital visit her veins were "blown out". Staff took clients Blood pressure. Blood pressure read 9/60. Staff called nurse (SW) and nurse instructed staff to take clients temperature. Her temperature was 99.8. Staff informed nurse that client had a brown coloring to her vomit. Nurse stated she would arrive first thing in morning to check on client. First shift arrived and was informed of the evenings events.

END OF INCIDENT

Date Completed: 2/4/00 Time: 10:00 Military Signature/Title: Therese Burton RCW

Lake County Board of Mental Retardation - Developmental Disabilities

**SUPPORTED LIVING/RFW PROVIDER
CONSUMER INCIDENT REPORTING FORM**

CONFIDENTIAL

ORIGINAL

FAXED

Consumer Name: Lana Moeller Consumer SS# 2701641100A Department Code # FW

Complete one report for each incident or injured consumer. Report should be completed immediately if possible, or by the end of the shift.
Document staff injury on Employee Accident Report Form.

Part 1: To be completed by employee who discovered the incident.

A. Date of Incident: <u>2/14/00</u>	B. Time: <u>9:00</u> Military	C. Day of Week	D. Observed? <u>Y/N</u>
E. Type of Incident (circle one) 1. Self-injury 2. Choking 3. <u>Death</u> 4. Fall/slip 5. Fire 6. Found on floor/ground 7. Ingestion of foreign object 8. Unexplained body mark 9. Missing/AWOL 10. Physical Assault 11. Verbal Threat/Assault 12. Sexual Assault 13. Sexually explicit behavior 14. Other: _____	F. Primary Location (circle one) 1. ARC 2. CDC 3. VGC 4. Willoughby 5. CLEO 6. Broadmoor 7. Community Program 8. Vehicle 9. Recreation 10. Supported Living / RFW Home 11. Specific Location: <u>Bedroom</u> 12. Other: _____	1. Mon. 2. Tues. 3. Wed. 4. Thurs. 5. <u>Fri.</u> 6. Sat. 7. Sun.	G. Incident Cause 1. Self 2. Other Consumer 3. Seizure 4. Defective Equipment 5. Staff Member 6. Weather Related 7. Visitor 8. <u>Unknown</u> 9. Injury/Mechanical Restrain 10. Injury/Manual Restraint 11. Injury/Transfer or Lift 12. Community Co-worker 13. Other: _____
H. Others involved (Aggressor, Victim, Other) Staff/Consumer SS# _____ AVOSIC SS# _____ AVOSIC			

I. Describe incident in detail including preceding or contributing events/actions, as well as resolution of the incident.

This morning I came into Living Room covered in brown vomit, asking for help - saying that she was very tired. I helped her back into her room and helped her clean up - I then called JW to notify - JW asked me to dress her so she could take her to Dr. I did this, then she wanted to lay back down in bed. About 1/2 hr later she walked into kitchen + sat at table asking for something to drink - I had a few sips of water - began vomiting again - JW talked to Dr. Henry to have her admitted to Hosp. Dr. Henry said to get Magnesium Sulfate to clean her out - JW left to purchase medicine - I (TC) walked her back to bed - When JW returned I (TC) got portable toilet for her + proceeded to help JW with her. She needed to be held up she was so weak - JW told me (TC) to call 911 - as she was vomiting out of nose + mouth at this time. JB was notified - AMO seemed to expire at this time - Ambulance came + tried to resuscitate - when paramedics left they said she was OOA - I transported by ambulance to Emerson Hosp.

Date Completed: 2/14/00 Time: 9:00 Military Signature/Title: Dracul Chrus