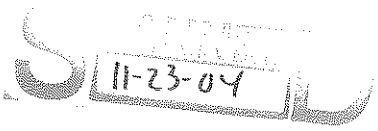
IN THE COURT OF COMMON PLEAS

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.

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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.

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

EXAMINATION OF PATRICIA FISHLEY

BY MR. FORBES:

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

Have you ever been deposed before?

A. No.

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

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

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

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

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

Q. Your current job is? 13:35:41

A. Social worker.

Q. For whom do you work?

A. Deepwood Center.

Q. Your education and training to 13:35:54
become a social worker at Deepwood Center, can you explain that to me?

A. I have a bachelor's in social service.

Q. When did you obtain the BS in 13:36:05
social service?

A. It's a BA.

Q. BA, I'm sorry.

A. 1970 -- 1978. It's a long time ago. 13:36:23

Q. Where did you get that diploma?

A. Cleveland State.

Q. After graduating from Cleveland State what did you do, employment-wise?

A. I've been here at Deepwood Center 13:36:32
since 1976.

Q. In 1976 what was your position at Deepwood?

A. Residential specialist at the adult residence center. 13:36:47

Q. Where is the adult residence center? 13:36:50

A. Right up the road, right -- the next building over.

Q. The next building on Deepwood Boulevard? 13:36:59

A. Yeah.

Q. Have your job responsibilities changed since 1976?

A. I'm sorry? 13:37:08

Q. Have your job responsibilities changed since 1976?

A. Oh, yeah. When I was a resident supervisor it was direct care at the adult residence center and working with the direct 13:37:18 care staff. After that I was a staff development specialist for Deepwood, and then I was in the case management department until last month.

Q. How long were you in the case management department? 13:37:36

A. 12 years.

Q. Your job immediately prior to that was, you say, resident supervisor?

A. Staff development specialist. 13:37:47

Q. What is a staff development specialist? 13:37:49

A. Conduct all the training and orientation for new employees and maintain certification for the other employees. 13:37:56

Q. How many residents are there at Deepwood?

A. How many people reside here? 80.

Q. After your tenure as the resident specialist what did you do next? 13:38:17

A. After resident specialist was staff development.

Q. After staff development what did you do?

A. Case management. 13:38:26

Q. Tell me about the case management job.

A. The case management job was we did information referral, placement, intake, monitoring. 13:38:41

Q. What is involved in placement?

A. Anybody that needs any type of residential placement or vocational placement in our program would come through our office and then we would assist them in finding 13:39:02

whatever placement it is they needed, whether it be vocational or residential. 13:39:06

Q. How are these individuals referred to Deepwood?

A. Oh, various sources. Either through the school systems, sometimes we have an intake procedure that qualifies people to receive services through the county program and we would do that piece first. After we do the initial intake then they would tell us what -- 13:39:15 13:39:31 the families would tell us what they need and then we would do the placement piece for them.

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

A. Deepwood is the county board program. 13:39:45

Q. Deepwood is a county-run agency?

A. Right.

Q. Other than the residential housing here at the facility where we're taking this deposition, within Lake County where else would you place individuals who would qualify for the program? 13:39:52

A. There is a number of intermediate care facilities for the mentally retarded. 13:40:05

There is group homes such as Eastwood and we have a supported living department that assists people in living in the community either in homes or apartments. 13:40:10

Q. I believe the phrase you used was intermediate living? 13:40:30

A. Intermediate care facility for the mentally retarded, ICFMR. That would be a Medicaid program facility and it would be places like Deepwood Center, Broadfield, Stewart Lodge, there's one more, Lakeland Living Opportunities. 13:40:44

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

A. The ICFMR is a larger facility, they're Medicaid funded, generally have more services, speech, OT, 24 hour nursing. It'd be similar to the nursing homes for the elderly. 13:41:02

Q. How is a decision made to place a resident in the ICFMR or the group home? 13:41:27

A. Generally it's based on the client need. There's some people for various reasons that need a larger facility, need 24 hour nursing, behavioral issues where they need more intense staffing. 13:41:46

Q. Who makes that decision? 13:41:48

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

Q. Are there general categories of 13:42:08 folks who are on an interdisciplinary team?

A. It would be speech, OT, if they're receiving those services, social worker, the team leader would be a habilitation or program coordinator, family members would be on the 13:42:19 team.

Q. Is the placement decision periodically reviewed by anyone?

A. It's reviewed at the annual, annual team meetings every year as to the 13:42:35 appropriateness of the placement.

Q. Do these teams meet quarterly?

A. They do.

Q. So the county would maintain documentation on the quarterly team meetings? 13:42:44

A. Uh-huh.

Q. I'm sorry, yes?

A. Yes.

Q. Did you know who was on Lorna Moeller's team? 13:42:54

A. When she was over here at the workshop it would have been the workshop staff. The later years when she retired from the workshop it would have been her home staff, a county case manager, and I believe that was it. 13:42:54 13:43:09

Q. Was there a habilitation specialist on the team?

A. That would have been through Eastwood at the time because she had left employment here. 13:43:27

Q. Do you know when she retired?

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

Q. But Deepwood still would maintain records regarding Lorna Moeller's vocational experience here as well as placement decisions that were made throughout her life? 13:43:51

A. We would maintain those records.

Q. Is there a record retention policy? Do you ever throw them out, shred them, do anything with them; do you know? 13:44:05

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

Q. In your role as case manager was it 13:44:24

ever within your function to review group homes or ICFMRs to see if they were performing appropriately and consistent with state regulations? 13:44:26

A. That was one of the main functions of the case management department, we would do what's referred to as monitoring. 13:44:39

Q. Were you involved in monitoring ICFMRs?

A. We were -- individuals in the ICFMRs. 13:44:55

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

A. Medicaid. Right, Medicaid regulations. 13:45:09

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

A. Yeah.

Q. Are there also county regulations, county rules? I'm looking for your working knowledge based upon reviewing these places and what you would do to enforce rules. 13:45:15

A. What we did at the county level was we had a quality of care or quality of life assessment. 13:45:31

Q. What is a quality of life assessment? 13:45:38

A. It's a series of questions for the quality of life, the consumer answered the questions as to whether or not they were happy with the different aspects of their life, job, community access. 13:45:48

Q. How often would you have a resident or consumer review a quality of life assessment or prepare a quality of life assessment? 13:46:07

A. At least once every three years.

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

A. Yes, it would.

Q. If a group home violated the state or federal rules what were the options for you as a monitor and a regulator? 13:46:23

A. That would go through the state licensure department and they would review those. 13:46:43

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

A. We were sending the quality -- the assessments, quality review or quality of care to the state licensure department and then they 13:46:54

would make that part of their -- 13:46:57

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

A. Through licensure or through --

Q. Through anybody. 13:47:11

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

Q. As a monitor, in your role were you 13:47:20 ever involved in county or state surveys of group homes?

A. On occasion.

Q. What would your role be?

A. Basically the only time that we 13:47:33 would be sitting in would be the exit interview when the state would make the recommendations.

Q. If a group home within Lake County was cited for any violations would you be apprised of those violations? 13:47:47

A. Not necessarily.

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

A. Very little. We could make recommendations. 13:48:04

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

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

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

A. Yeah, that's fair to say.

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

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

Q. Keeping it in housing for the mentally retarded.

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

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

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

MR. FORBES: Outside of case management, thanks.

A. The licensure, state licensure.

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

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

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

A. I'm not sure.

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

A. Right.

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

they can cite homes, correct? 13:50:27

A. Uh-huh. Uh-huh.

Q. Is it a progressive type of discipline, they begin with citations and then end with revoking of the license? 13:50:37

A. Yes.

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

A. No.

Q. You do know homes, though, that have been cited, correct? 13:50:50

A. Yes.

Q. From your working knowledge in your day-to-day job do you have any understanding of the levels of that progressive discipline beginning with citation and going towards licensure revocation, can you give my anymore detail as to how that works? 13:51:04

A. Having never experienced the latter part I would have no idea. I know that when there was a citation they'd have a certain amount of time, ten days, 30 days, to make a correction and to provide that to the state. 13:51:19

Q. When there's a citation followed by a plan of action from the home, as a monitor do 13:51:36

you follow-up to see if the plan of action is being implemented? 13:51:42

A. If we're aware of them.

Q. So if a plan of action came to you saying we're going to do X, Y and Z to address a problem, then it would be your job to make sure X, Y and Z was done or to follow-up and see if X, Y and Z were done? 13:51:51

A. If licensure would have asked to us to do that we would have done that. 13:52:06

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

A. Not that I'm aware of.

Q. How were the group homes funded; do you know? 13:52:17

A. There's a number of different sources. I believe the majority of it is Medicaid funding now through the waiver services, state waiver. 13:52:37

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

A. I don't know about exclusive.

Q. It's your understanding the majority of funding is governmental? 13:52:52

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

Q. Fair enough.

A. I don't know for sure.

Q. Can you describe for me how abundant the housing is for mentally retarded folks in Lake County? Is there difficulty placing people? Do you have an excess? Can you tell me about it? 13:53:07

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

Q. How long is the wait list?

A. Pages, years.

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

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

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

A. Yes.

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

response or a license suspension or revocation? 13:54:16

A. I'm sorry, say that again.

Q. I'm looking for a complete list of the tools that are available to the government regulators to modify behavior from the group 13:54:25 homes. Do you understand what I'm saying?

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

MR. FORBES: State and county.

Q. To the extent you know. Let me try 13:54:37 that again. If you see a situation you don't like, what are the tools that are available to you to change it?

A. We could make recommendations to the facilities and that was generally based on 13:54:54 what we generally believed to be best practice. We did not have any ability to do citations.

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

A. Licensure could be made aware, they 13:55:15 could go out, they could do citations.

Q. So if you confronted a home that didn't take a recommendation that you thought was important you then had the option of going to the state? 13:55:28

A. Uh-huh. Yes. 13:55:29

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

A. Not that I can think of.

Q. Other than case management was there any other person who residents or their family members could complain to if there was a problem? 13:55:41

A. I don't -- well, they can go up the ladder, they could, you know, talk to the superintendent here, they could talk to the administrators at the group homes. 13:56:04

Q. As far as your supervision here as a case manager, what's the structure, who's over you and then who's next? 13:56:26

A. There was a director of case management services.

Q. Who is that?

A. At the time his name was David Miller. 13:56:33

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

A. A year ago.

Q. Who is it now?

A. There's no case management 13:56:44

department as of January 2nd, 2003. 13:56:45

Q. What happened to the case management department?

A. We were laid off and there's a new department called service and support 13:56:54 administration.

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

A. I would defer that to someone else.

Q. How did that affect your individual 13:57:05 job?

A. I was laid off.

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

A. I would defer that. 13:57:12

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

A. I would defer that to the administration. 13:57:26

Q. Fair enough.

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

Q. If there was a violation of the Bill of Rights for mentally retarded people how 13:57:36

would that be handled if that came to your attention? 13:57:40

A. If there was a rights violation the case manager would talk to the person involved, the consumer involved, they would talk to the facility staff and if there was no resolution they would bring it to the major unusual incident specialist, which at the time was me, and then I would go out and interview the consumer, then I would write a major unusual incident report that would go to the state. 13:57:56 13:58:26

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

A. Probably the last five to six years. 13:58:52

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

A. It was pretty much what I just described, for any major unusual incident, and the state determined what the major unusual incidents were, there were rights violations, abuse, neglect, let's see, there was seven I believe, hospitalizations, those would all be reported to the state. 13:59:06

Q. The purpose of them being reported 13:59:31

to the state was what? 13:59:33

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

Q. Is it fair to say the state had a fairly -- had a fair number of resources and folks like yourself and others who when a major 13:59:54 unusual incident was reported they could investigate to make sure the home was handling it appropriately, and the requirement to report it meant that it got reviewed by folks to make sure things were being done the right way in an 14:00:07 acceptable manner; fair enough?

A. Yeah.

Q. I mean, if I'm wrong let me know, but that seems to me to be the reason you'd have it; does it make sense to you as someone 14:00:19 who does this or did it?

A. There is, and I don't know the revised code number, but that specifies that the state is responsible for reviewing all the major unusual incidents. I don't know that 14:00:32 number.

Q. I'm not looking for the code section or for what it says in those rules. I'm looking for your understanding as someone in the trenches and as a major unusual incident 14:00:45

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

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

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

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

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

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

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

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

A. Right, exactly.

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

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

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

contact with her? 14:02:09

A. It was infrequent prior to my becoming a case manager, you know, I'd run into her at the workshop or whatever. There was no direct contact, my job was not to work with 14:02:21 Lorna at that time, it was just passing in the hall.

When I became a case manager I was assigned to monitor the consumers that lived at Eastwood and then I had more direct contact 14:02:36 with Lorna. That would have been 1990, '91.

Q. You say "more direct contact", can you describe that contact in any way once you're a case manager and you're monitoring the home and her condition? 14:02:56

A. Again, I would be out there probably on a monthly basis, not necessarily always -- not necessarily to work directly with Lorna but I would be responsible for doing the quality reviews for all of the ladies that 14:03:13 resided in the home.

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

A. '95 -- '95, '94. I'd really have 14:03:27

to look at all those dates. 14:03:34

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

A. Okay.

Q. -- just to get an understanding. 14:03:40

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

A. Right. Our department, case management department then had specific people to do the monitoring and specific -- we divided 14:03:53 out the workload basically, specific people to do intake, major unusual incidents, placement.

Q. So '94, '95 is when you assumed, about the time you assumed the major unusual incidents specialist? 14:04:11

A. I believe so.

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

A. Limited at that point because I wasn't out at the house. 14:04:23

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

A. Right, or if there was major unusual incidents involving the home, certainly 14:04:31

I would say hello to her. 14:04:35

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

A. No. 14:04:50

Q. From the time that you knew her going past her in passing when she was here working all the way until she died, do you remember any complaints from Lorna about the home? 14:05:10

A. Smoking was an issue. The only other thing I can think of off the top of my head were sometimes there were other consumers that she wasn't real pleased with their behavior. 14:05:36

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

A. Occasionally. Lorna wasn't one to complain about anything, I mean, her first sentence to everybody and anybody was honey, I don't want to bother you, so, I mean, that's who Lorna was. 14:05:45

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

A. The only thing I remember with 14:06:03

Carol prior was the smoking, that smoking thing. 14:06:05

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

MR. SCHALTENBRAND: You're referring to the smoking? 14:06:15

MR. FORBES: Smoking.

A. Uh-huh.

Q. Yes?

A. As far as I know. 14:06:20

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

A. Yes.

Q. -- and was there a Linda Henry, is that someone -- 14:06:28

A. Yes.

Q. Who was she?

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

Q. So all of these folks would have been present at a meeting, and at that meeting didn't Carol say Lorna doesn't smoke when she sees me, I prefer she not smoke when she's at the home; do you remember that? 14:06:33

A. I do not remember that. I do know 14:06:45

that they taped it. 14:06:46

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

A. Yes.

Q. Is that standard, to tape a meeting like that? 14:06:54

A. That hadn't been before.

Q. What's your recollection of that meeting?

A. My recollection is that we reviewed the client rights, that she does have the right 14:07:09 to smoke. The family was very angry. LuAnne was somewhat angry that she had the right to smoke when it wasn't in her best interest.

Q. The family's anger was not about her being deprived of the right to smoke, the 14:07:29 family's anger was that she was using her Social Security money on cartons of cigarettes and then smoking?

A. My recall is that the anger was in relation to the client rights. 14:07:45

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

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

Q. Who in the family was angry? 14:07:54

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

Q. He was angry because the home was restricting Lorna's smoking?

A. No, because I filed a report that said she had the right to smoke. 14:08:05

Q. Is it fair to say that both the family and the home wanted to limit Lorna's smoking?

A. Yes.

Q. Based on your interpretation of the client rights this is an individual who had the right to do what she wanted, including smoking? 14:08:15

A. Correct.

Q. Did the home take any action consistent with the Bill of Rights and Lorna's rights to attempt to steer her and limit her smoking? 14:08:24

A. Yes, I do believe that they did try to limit it.

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

A. There was a doctor's order, and I believe that there were times -- I'm not sure on that. I believe there were times that she could smoke, but I don't --

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

took steps to help Lorna limit her smoking with her agreement? 14:09:00

A. I'm not sure.

Q. During the time when you were a case manager interacting with Eastwood was their licensure ever brought into question? 14:09:17

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

Q. When you say "years ago", when was that? 14:09:40

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

Q. When you say something financial, do you have any understanding of what that was? 14:10:01

A. I remember that there was a state auditor that came out, there was allegation of impropriety with client monies being spent on household items, personal like hygiene items that should have been supplied by the facility. 14:10:21

Q. Anything else?

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

Q. Do you remember who the administrator was at the time? Was it before 14:10:45

or after LuAnne Busch took over? 14:10:48

A. Oh, before.

Q. Other than using client funds to buy items for the residents but that should have been purchased by the home, any other 14:11:03 citations that you remember that stand out from '90 until 2000?

A. You know, I'd really have to look. To stand out for me to think of right now off the top of my head -- 14:11:25

Q. I'm looking for something that jumps out as you remember in your job as being the person who would visit the home and take statements on quality of life from residents, anything as you're sitting here that stands out 14:11:36 that they were cited for that you remember in any way?

A. You know, I'd have to look, I really don't. There was a number of -- I don't know if there were citations. There was a 14:12:01 number of concerns regarding things like food, snacks, staffing levels.

Q. What do you mean by food and snack concerns? Regardless of whether there's a citation, tell me about those. 14:12:19

A. There was an ongoing, and I think it was a licensure, there was an ongoing thing about the snacks, the client, the consumer snacks being locked up and that they shouldn't have been locked up. It was like a -- it was an ongoing thing for a long time. From time to time there would be complaints that there was no food at the home. 14:12:21 14:12:31

Q. No food in between meals?

A. No, that their supply -- their supplies were low. 14:12:53

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

A. I'd have to really think about it at this point. 14:13:27

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

A. Okay.

Q. We do know the citations are public 14:13:36

record. Aside from what you remember whatever else was there we could look up and judge the home's record for ourselves; is that fair? Yes? 14:13:38

A. Are you asking -- 14:13:50

Q. When I'm asking about these citations, if the home was cited for behavior that affected licensure, those citations or any sanctions that are available to the state would be -- somebody has those records, correct? 14:14:05

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

Q. During your time when you were doing the assessments and the questionnaire that Lorna would fill out, anything in that questionnaire that caused you concern to move her to another facility? 14:14:23

A. Not that I recall.

Q. There was an option if either Lorna no longer qualified for group home services or was unhappy she could move to another home within the system, or at least request it? 14:14:39

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

Q. Neither Lorna nor her sister Carol 14:14:47

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

A. No, not that I recall.

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

A. There were some concerns about that.

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

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

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

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

Q. What's a purchase of service home?

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

be state, I'm not sure. 14:16:14

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

A. There was no numbers. Here in the ICFMRs there's a one day ratio; the group homes never had those ratios. What we were saying that best practice, they didn't have the manpower to maintain everybody's needs. 14:16:23

Q. So, first off, they weren't violating any rule? 14:16:39

A. They were not violating any rule.

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

A. I'm sure that we've talked -- that we had talked about it. 14:16:50

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

A. Number wise?

Q. Yes. 14:16:59

A. You know what? I couldn't give it a number. I could not say one to eight, the state says that, but one to 16 with, you know, people needing X number of services, probably not enough. 14:17:19

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

A. Generally three to 11. All of those homes are different, though, it could be 2:30 to 10:30.

Q. Did you know what the staffing was in 2000 when Lorna Moeller died? 14:17:27

A. No.

Q. It would be whoever the monitor was, if the monitor had complaints, concerns about staffing it would be his or her responsibility to talk to the home to address those problems? 14:17:55

A. Yes.

Q. Certainly if they were serious enough to affect resident care that would be the county and state's job to fix? 14:18:03

A. (Nodding head affirmatively.)

Q. Yes?

A. Yes.

Q. Are group homes like Eastwood required to have a licensed practical nurse on staff? 14:18:14

A. I don't believe so.

Q. Are there group homes within Lake County like Eastwood that don't have licensed 14:18:30

practical nurses on staff? 14:18:32

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

Q. What is the one other? 14:18:46

A. Brittany Residential.

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

A. I'm not sure.

Q. In your tenure as case manager and monitor do you know if Eastwood was ever cited for having the staff inappropriately trained? 14:19:14

A. I don't remember.

Q. Nothing stands out as we sit here today? 14:19:36

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

Q. It would be the county's job through the case management and the monitors as well as the state licensure to make sure that the homes have folks who are adequately trained, correct? 14:19:45

A. That would be more licensure.

Q. So any problems with training would affect what, the license or status with the 14:20:00

home? Could? 14:20:02

A. It could.

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

A. Anybody with mental retardation, 14:20:26
there's individual policies or there were individual admission policies with the homes.

Q. To qualify as mentally retarded, to qualify for government-funded housing -- do you know what the definition of mentally retarded 14:20:53
is?

A. IQ below 70, deficits in three or more areas of daily living skills. There's a state assessment called an OEDI, Ohio Eligibility Determination Instrument, and that 14:21:14
would show deficits.

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

When there's a major unusual incident and you're required to investigate it 14:21:43
tell me about what you do.

A. We would go out and interview the consumer and the involved parties. If it's an abuse/neglect, it would require police interview also, we would go out together 14:22:00

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

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

A. Generally, yes.

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

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

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

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

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

A. No. 14:23:14

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

- - - - -

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

- - - - -

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

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

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

A. Yes. 14:24:17

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

A. Would you repeat that?

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

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

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

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

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

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

A. Yeah, I'm thinking so.

Q. When you got there what did you do?

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

Q. Do you remember the person's role?

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

Q. Stacey Reigert? 14:25:55

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

Q. How long was this meeting?

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

again. 14:26:23

Q. Was it at Eastwood?

A. Yes.

Q. Did you talk to the individuals separately? 14:26:26

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

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

A. I believe that they gave me the time lines. I remember Julie telling me that she'd been paged through the night, and that's when they told me that -- they pretty much described the scenario of when Lorna had thrown up and that Julie went to get the medication from the pharmacy -- from the drugstore and they pretty much recounted what happened that morning. 14:26:41 14:27:03

Q. When you said they gave you the time lines, was this something that was written out or they just described for you the time frames? 14:27:15

A. I don't believe it was written out. At one point Julie looked at her pager and gave the specific times that she had been paged the 14:27:31

prior evening. 14:27:35

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

A. I don't believe at that particular meeting they did. 14:27:49

Q. Do you remember anything else about that meeting?

A. No.

Q. Did you ask for major unusual incident reports at that meeting? 14:28:09

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

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

A. Major unusual incident report is a report that goes to the state. 14:28:20

The incident report is the report that was generated at the facility written by the direct care staff or whoever was involved in the incident. 14:28:29

Q. When there are incident reports are those necessarily given to anyone outside the facility if there's no problem? If they just generate their own reports are those typically shared with you as someone -- as a case manager 14:28:42

or not? 14:28:46

A. Usually for a major incident the incident reports are always shared -- generally shared. The state has a right to review those, the licensure will review those on a consistent 14:28:53 basis, I believe.

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

A. The state.

Q. So I just want to understand the 14:29:04 way we're labeling those reports. There would be an incident report for whatever requires those to be generated. At that point it would go to someone like you who would decide whether they're going to make a major unusual incident 14:29:17 report to the state?

A. Yes, correct.

Q. You leave this meeting on the 4th after talking to the folks at Eastwood, what do you do? 14:29:36

A. From there I -- LuAnne had informed me that she had made an appointment at Potti Funeral Home that I needed to attend because she couldn't, and I went to the funeral home to make arrangements for Lorna. 14:29:55

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

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

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

A. I do know one was not.

Q. Do you know why?

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

Q. Which coroner did you speak with?

A. The Ashtabula County.

Q. Do you remember his or her name?

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

Q. It was a man?

A. It was a man.

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

A. I have no idea.

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

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

Q. Did you talk to the coroner on the phone or were you in person with him?

A. On the phone.

Q. How did it come that you were talking with the coroner? 14:31:25

A. There was some mix-up and -- there was some mix-up that occurred. I originally had been informed that Lorna was being transported to Lake East Hospital and I 14:31:44 contacted Lake County coroner I believe at the request of the MUI, we have a consultant or had a consultant through the state and at some point in all of that I spoke with her, she thought an autopsy was necessary, and I called 14:32:10 Lake County coroner.

They had no record of Lorna, they have didn't know anything about it. When I presented, and I don't remember the lady's name, to her, she said that she thought it was 14:32:20 suspect enough that Lake County would do an autopsy.

I then found out that Lorna, in fact, was not in Lake County, that she had gone to Geneva Hospital and that it would be the 14:32:35

Ashtabula County coroner. The state consultant that we had at that time for the MUI suggested that we get the autopsy and that's when I made the request. 14:32:38

Q. Who was the state consultant? 14:32:53

A. Roxanne Smith.

Q. What's her job?

A. She was the MUI -- they divided into districts at the state level and Roxanne would be the MUI contact person, kind of our consultant for is this an MUI, is it not an MUI, those kinds of things. I'm blanking out here. 14:33:10

Q. That's all right. When did you first contact Ms. Smith regarding Lorna Moeller? 14:33:27

A. It would have been the 4th.

Q. After you met with the folks at Eastwood?

A. Yes. 14:33:34

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

A. She let me know that I needed to 14:33:47

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

Q. You agree to do that?

A. I went over.

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

A. Yes.

Q. That consultant says get an autopsy?

A. Yeah.

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

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

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

A. Uh-huh.

Q. Yes?

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

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

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

Q. Do you know if that lady was a doc or if that lady was someone who answered the phone? 14:34:44

A. I'm not sure.

Q. All she told did you was no Ms. Moeller here? 14:34:53

A. Right.

Q. Then you contact the Ashtabula County coroner?

A. Yes. 14:35:03

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

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

Q. That person tells you we don't think there's a need for an autopsy? 14:35:16

A. Correct.

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

A. There wasn't much I could do, he said he wasn't going to do an autopsy. 14:35:27

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

A. I don't know. 14:35:39

Q. At this point we're still on February 4th, correct? 14:35:42

A. Yes.

Q. Have you spoken with Carol Zoelbel?

A. There was like a three-way conversation. Carol and her husband were in Texas, they were out of state, and there was difficult -- they had trouble getting a hold of them to notify them of Lorna's death, and they -- well actually at the time they had trouble getting a hold of her regarding Lorna being at the hospital and on a respirator and they finally got a -- I believe LuAnne finally got a hold of Mr. Zoelbel and then she somehow set up a three-way conversation so we could discuss what they wanted to do in terms of the respirator. But that was the only conversation -- there was no conversation with Carol that particular day, it was with Hank and it was regarding -- 14:35:52 14:36:19 14:36:41 14:36:57

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

A. Yes.

Q. The autopsy was not discussed at 14:37:14

that point? 14:37:16

A. No.

Q. When was Lorna's funeral?

A. Oh, a couple days later.

Q. After making the funeral 14:37:38
arrangements, talking to the various coroners, did you do anything else with regard to your investigation on the 4th of February?

A. No.

Q. Tell me about the remainder of your 14:37:48
investigation.

A. I filed the initial report with the state.

Q. Let me just get a handle on terminology. The initial report, would that be 14:37:57
the initial major unusual incident report?

A. Yes. Yes.

Q. Would Eastwood be copied on that?

A. No.

Q. Do you remember what was in that 14:38:07
report?

A. That Lorna had passed away, pretty much that, I mean, the initial report that's -- that she had been vomiting and that she had passed away and then had the times. 14:38:25

Q. When you say "the times" you mean what? 14:38:26

A. The time of death, the time that the paramedics were called, those kinds of things. 14:38:34

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

A. I believe -- I believe this was the next part of the investigation. 14:38:50

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

A. Oh, I went out and spoke with the third shift staff, was that the next night? It was either -- I believe it was the next night, I'm not completely sure on that, after Lorna died. 14:39:11

Q. Do you remember who was on the third shift staff? 14:39:31

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

Q. Marquita Burton?

A. Yes. 14:39:45

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

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

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

A. No.

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

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

Q. Did you take notes of this meeting?

A. I probably took some notes.

Q. Was anyone else present?

A. No. 14:41:04

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

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

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

A. No.

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

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

Q. Rita Freeborn? 14:41:54

A. Yes.

Q. What did Rita tell you?

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

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

A. Yes.

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

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

Q. Was anyone else present at that interview?

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

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

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

Q. Yes.

A. I don't know.

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

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

Q. When?

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

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

A. I wouldn't remember that.

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

A. You know, that's difficult because there was a period of time where there was a lot of people. 14:43:34

Q. Tell me about the qualifications issue. 14:43:42

A. My supervisor and myself were meeting with Jim Victor and LuAnne, and from what I remember it was the first time -- she had like just come on, my supervisor had questioned the qualifications, her qualifications. 14:44:00

Q. And Mr. Victor was present with Ms. Busch and they set forth what her qualifications were and your supervisor asked questions about it; fair enough? 14:44:13

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

Q. Following that meeting were there ever any questions from the folks in charge of regulating, state, county, federal, regarding Ms. Busch's qualifications that you recall? 14:44:34

A. Not that I'm aware of. That's not something I personally would -- 14:44:49

Q. Right. I'm looking for your knowledge. 14:44:51

So after the meeting with Ms. Freeborn did you meet with any folks at Eastwood prior to May 9th when Mr. Angel submitted a list of questions? 14:45:06

A. I don't believe so.

Q. In that time period, February 4th to May 9th, did you review Eastwood's incident reports? 14:45:27

A. Which incident reports?

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

A. I would have reviewed those. That would have been part of the initial. 14:45:42

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

A. Somewhere in there.

Q. Other than your sending off the major unusual incident report to the state shortly after Ms. Moeller's death did you prepare any other written document prior to getting a list of questions from Mr. Angel? 14:45:58

A. I believe there was one other major 14:46:14

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

Q. That was filed by you?

A. Yes. 14:46:59

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

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

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

A. The consumers reported to the other case manager.

Q. And the other case manager?

A. Came back to me.

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

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

Q. Did you investigate the information that was relayed to you by Ms. Ketchum?

A. Yes.

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

A. I spoke with the two ladies.

Q. What did the two ladies tell you?

A. Pretty much what I just told you, that they reported that she was screaming out, that nobody would help her, that she was in a 14:48:00 lot of pain.

Q. Who are these two ladies?

A. Anna Pressern.

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

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

MR. KRAUSE: I'm sorry, I don't mean to interrupt. It sounded like there were two questions and I don't know if I looked down and I missed the answer to the first. You asked what night and then what ladies; was 14:48:25 there an answer that I missed?

MR. FORBES: No.

MR. KRAUSE: I'm sorry, okay.

MR. FORBES: That's fine, I just may have -- 14:48:35

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

Q. And the second lady?

A. Ruth Fineman.

Q. Do you know where these ladies' rooms were, are? 14:48:49

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

Q. Where were they at the time?

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

I don't know where their rooms are.

Q. Did you include that in the second major unusual incident report? 14:49:12

A. Yes.

Q. When did you go out to talk to these two residents?

A. It would have been probably the next day after I got the original report -- the original statement -- report from Judy. 14:49:25

Q. Do you know when that was?

A. I don't remember.

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

A. Yes.

Q. Where does Judy work?

A. She works at the residence, Deepwood Center Residence.

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

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

Q. Did you speak with anyone at Eastwood -- let me start again.

Did you speak to these folks, Ms. Pressern and Ms. Fineman, prior to May 9th of 2000? 14:50:05

A. Yeah, I believe it was before that.

Q. Do you have any idea of when you spoke to them?

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

Q. Do you know when they were claiming Lorna was calling out?

A. Before she died. Before she died is what they're saying, that they --

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

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

Q. I want to know somewhere within the time frame of when she died when these folks were saying they heard the yelling.

A. It would have been within a couple days after Lorna's death, maybe within a week, I'm not sure. 14:50:47

Q. So sometime within a week before Lorna passing away?

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

connecting -- 14:51:08

A. Yeah.

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

A. It would have been within a week 14:51:13
after she died.

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

MR. FORBES: I understand. I understand. I was connecting on that question. 14:51:21

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

A. They wouldn't say a time but they were saying from the time she returned from the hospital to the time she died. 14:51:40

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

A. I don't remember.

Q. As part of a normal investigation 14:51:59
if you were hearing information that people were ignoring cries for help it would be part of your practice to talk to folks and get a response?

A. Yes. 14:52:09

Q. But you don't specifically remember talking to them? 14:52:09

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

Q. Correct. 14:52:18

A. -- I always want to say Margarita -- I received a page the following morning from Marquita saying that no one was allowed to talk to me anymore, that LuAnne was very upset that I'd come out and spoken with her, so it kind of got -- I don't know what word to use -- I don't know what -- I'm not sure what to say, what word to use, but it kind of got -- the staff weren't going to talk to me and I was aware of that so there might not -- it got weird. 14:52:38 14:53:04

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

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

Q. Yes. 14:53:24

A. No.

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

A. Anyone -- 14:53:33

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

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

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

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

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

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

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

A. To me?

Q. To you. 14:54:31

A. The day after I interviewed her.

Q. So sometime still early February?

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

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

A. Uh-huh. 14:54:47

Q. Then you called her back?

A. Yes.

Q. Where was she when you called her back? 14:54:56

A. I believe it was a home number. It was not an Eastwood number.

Q. Did you ever visit any of the Eastwood folks outside the Eastwood home, meet them at their houses or some other places? 14:55:10

A. Staff? (Shaking head negatively.)

Q. No?

A. No.

Q. Prior to that February 9th list of questions did you ever talk to Rita Freeborn outside of Eastwood? 14:55:29

A. No.

Q. After talking -- were any Eastwood people present when you spoke with the residents? 14:55:58

A. You mean Anna and --

Q. Ruth.

A. -- Ruth? No.

Q. What time of day was that meeting?

A. I'm guessing afternoon, I don't 14:56:14

really remember. 14:56:15

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

A. Yes. 14:56:23

Q. What was their response?

A. I don't recall a response.

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

A. No. 14:56:35

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

A. Maybe 20, 30 minutes.

Q. Did you ever talk to them again about this incident? 14:56:56

A. No.

Q. Did you speak with them separately or together?

A. Separately.

Q. And no one else was present but you and the resident? 14:57:10

A. Correct.

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

MR. FORBES: If you want one you 14:57:21

can have one, yes. 14:57:22

MR. SCHALTENBRAND: How much longer do you have?

MR. FORBES: It's going to be a while. 14:57:25

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

(Discussion had off record.)

(A recess was taken.)

Q. I just want to make sure I clarify because I think my questioning wasn't crystal. 15:09:16

The folks were telling you they heard Lorna crying out sometime during the night: Was it the night before she died, was it the night before that? Were they specific in any way? 15:09:29

MR. KRAUSE: Objection.

You can answer.

A. I'm sorry?

Q. He objected. 15:09:38

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

THE WITNESS: Okay.

A. Would you repeat your question? 15:09:52

Q. I'll try to do better. Can you specify for me when these folks were saying Lorna was crying out? 15:09:54

A. As I recall, Ruth reported that from the time she came home from the hospital until the time she died she was saying that she was crying, that she was in pain. 15:10:09

Q. What about --

A. Anna.

Q. Anna, thank you. 15:10:27

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

Q. Is Ruth still at the home?

A. Yes.

Q. Did Ruth talk to any of the resident care workers about it, did she relate that to you? 15:10:38

A. I don't know.

Q. Do you have an understanding of Ruth's level of mental retardation? 15:10:46

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

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

A. How many people lived there? 15:11:02

Q. Yes. 15:11:03

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

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

A. No.

Q. Why not?

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

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

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

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

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

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

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

Lorna's bedroom is right off from the living room and Anna would be up watching TV or whatever during the night because for some reason she wasn't sleeping a lot from what I recall and Ruth -- I really don't remember. 15:12:10 15:12:21

Q. With regard to Anna, did you talk with her, well she's up late at night in the middle of the night hearing Lorna complain or hearing Lorna indicate she's in pain, did you ask Anna what she did, did she go talk to somebody? 15:12:34

A. I don't recall.

Q. I asked this with regard to the other folks: Did you take notes of these conversations with Anna and Ruth? 15:12:54

A. I don't recall.

Q. So other than the time you're out there on the day of Lorna's death and then I think we have three other visits, once to talk to Ms. Burton and the other care worker, once to talk to Ms. Freeborn and once to talk to the two other residents, other than those trips did you go out to see anyone of these four prior to May 9th of 2000 when you get the list of questions to respond to? 15:13:20 15:13:38

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

Q. Is there any kind of log or record that you keep that would keep track of what you did on your investigations? Are you required to fill anything out that says I went here, 15:13:57 here, here, did this, that?

A. That would be in our case notes.

Q. Do you maintain those case notes? Does Deepwood maintain the case notes?

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

Q. To your knowledge do those case notes still exist?

A. Yes.

Q. Typically what would be in case notes? 15:14:16

A. The time, the service provided.

Q. What's the purpose of maintaining the case notes?

A. Other than being good practice it's also -- they were also used for billing. 15:14:39

Q. Why is it good practice?

A. For scenarios like this.

Q. So the purpose is you would have a record so if anybody else wanted to look in and assess what was done they don't have to rely on 15:14:53

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

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

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

A. That's fair.

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

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

Q. That I knew.

A. Okay.

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

A. Yes. 15:15:41

Q. What's her current position?

A. Superintendent.

Q. And then who's Mr. Angel?

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

Q. Do you know if he's still around? 15:15:53

A. I believe so.

Q. What is the community MUI registry unit?

A. That's the department at the state level that does all the follow through with MUIs. 15:16:02

Q. They refer in the first paragraph to a major unusual incident case. What would the folks at the state be reviewing typically in an MUI situation? Do you understand what I'm asking for? 15:16:25

A. No.

Q. They would have your report or reports, correct? 15:16:40

A. Correct.

Q. What other stuff do they gather before getting back to you like they did?

A. They would -- actually they would request of us any additional information that they needed. 15:16:52

Q. Now were these 25 questions communicated to you by Ms. Roman?

A. This was sent to the director, the case management director, David Miller, who 15:17:09

gave them to me.

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

A. No.

Q. Did he give them to you with any other information? 15:17:18

A. No.

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

A. The bottom? 15:17:25

Q. The cc.

A. Oh, okay.

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

A. Only by -- 15:17:42

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

A. He's the medical director.

Q. Do you know him?

A. No, I don't know him personally. 15:17:50

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

A. No.

Q. You get these questions, you're 15:18:01

charged with the responsibility of getting answers? 15:18:05

A. Correct.

Q. What do you do?

A. I set up an appointment with LuAnne to go out there and review these questions. 15:18:09

Q. Did LuAnne agree to meet with you?

A. Yes, she did.

Q. Did you ever talk to LuAnne about her purported instruction not to have her folks speak with you? 15:18:19

A. No, I did not.

Q. Why not?

A. The staff person was concerned when she paged me that she would lose her job if LuAnne knew that she had spoken to me. 15:18:37

Q. As an employee of the county charged with the responsibility of monitoring group homes did you tell her -- did you give her any reassurance that you could act to prevent that from happening? 15:18:51

A. No, because I couldn't.

Q. Could you give anyone who was concerned about reporting information to you any reassurance that the state wouldn't let 15:19:03

someone fire them for simply talking to a regulator? 15:19:07

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

Q. What happens after you talk to LuAnne, she agrees to meet with you? 15:19:20

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

Q. Was anyone else there? 15:19:37

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

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

- - - - -

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

- - - - -

Q. Can you identify exhibit 2 for me? 15:20:21

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

Q. In answering these questions you met with the people at Eastwood on one occasion, the 23rd of May, correct, people 15:20:41

still working at Eastwood? 15:20:46

A. Yes.

Q. The people identified as Julie Warner, Lisa Schubert, Stacey Reigert and LuAnne Busch -- 15:20:56

A. Yes.

Q. -- are those all the people you met with at Eastwood?

A. Yes.

Q. Did you ask to meet with Ms. Burton? 15:21:00

A. No.

Q. Why not?

A. For this question --

Q. Yes. 15:21:10

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

Q. Now that we're in May and you're charged with the responsibility of answering the questions did you ask to meet with Ms. Burton? 15:21:19

A. No.

Q. Why not?

A. I don't know.

Q. Did you ask to meet with Ms. Freeborn? 15:21:31

A. No.

Q. And of this meeting I assume -- did you take notes, the May 23rd meeting?

A. Yes.

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

A. Well they'd be in here, they would be answers to these questions.

Q. The handwritten notes that you took actually when you were listening to the people talk, you didn't save those? 15:21:53

A. No.

Q. And a day before --

A. I'm sorry.

Q. I'm sorry, go ahead.

A. Once these reports were written then it's just extra paper. 15:22:00

Q. A day before you had met with Ms. Irwin and --

A. Yes.

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

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

Q. Man or woman?

A. Woman.

Q. What did they tell you? Do you remember independently as you sit here today 15:22:26

what those folks told you about Ms. Moeller? 15:22:28

A. I would refer to my notes.

Q. Did Nurse Dieglio --

MR. KRAUSE: Alaki Dieglio.

Q. Did Nurse Dieglio explain to you 15:22:48
what specific after-care instructions she told the nurse at Eastwood?

A. No.

Q. Did you ask?

A. I believe I asked for a copy of it, 15:23:07
of whatever they had written.

Q. Do you remember if Nurse Dieglio ever explained to you if there were ever any communications different or in addition to what was written or provided to you? 15:23:30

MR. KRAUSE: Objection to form.

A. I remember her being concerned that there was nobody there at the hospital and that she had called to the nurse because of Lorna's functioning, she didn't want to send it home 15:23:45
with her without communication.

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

A. Whatever the instructions were written out. 15:23:57

Q. So it's your recollection Nurse Dieglio told you that she informed Ms. Warner what the instructions were by referring to the document and what was already written out? 15:23:59

A. I believe so. 15:24:08

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

Did you ask Nurse Dieglio if she was concerned about no one from Eastwood being there why she didn't wait for someone? 15:24:22

MR. KRAUSE: Objection to form.

A. Say it again.

Q. Nurse Dieglio told you she was concerned that there was no one from Eastwood at the hospital, correct? 15:24:31

A. Correct.

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

A. I believe that they understood that no one was going to come from Eastwood. 15:24:44

Q. Did you ask her --

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

Q. Did you ask her if she ever called 15:24:58

back and asked if anyone would be there if they could have someone there, expressed her concern to anyone at Eastwood? 15:25:00

MR. KRAUSE: Objection.

A. Not that, I wouldn't know. 15:25:04

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

A. No. I remember Ms. Irwin being very helpful in getting all the records together. 15:25:24

Q. Anything else?

A. (Shaking head negatively.)

Q. No?

A. No. 15:25:33

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

A. We went pretty much straightforward down answering these questions. 15:25:46

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

A. Now I'm -- I think that Rita may have called me. 15:26:22

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

A. At my office.

Q. How many times did you speak with Rita after the interview at the home and prior to -- 15:26:43

A. It wouldn't have been more than once or twice.

Q. -- before preparing exhibit 2?

Do you remember what Rita told you?

A. Not per se. 15:27:06

Q. Did you talk about Rita's resignation from Eastwood?

A. No.

Q. You understood that she had resigned, though, when you spoke with her, 15:27:21 correct?

A. I don't know.

Q. Page one says: "Note: Rita resigned from Eastwood at the end of February"?

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

Q. You say: "She was contacted at home by this worker. She is willing to help in any way she can."

A. Okay. She must have -- I wouldn't have her number, she must have called me. 15:27:42

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

A. I really don't right now.

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

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

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

Q. Dieglio? 15:28:14

A. Dieglio.

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

A. That would be Julie.

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

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

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

to Eastwood's licensure? 15:29:38

A. I'm sorry?

Q. Did this documentation issue, whether or not things were documented through the night of the 3rd and into the morning of 15:29:47 the 4th, did that result in any inquiries into Eastwood's licensure and any citations?

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

Q. Number five there, the sentence in 15:30:10 the middle that says: "Reportedly, this was after Lorna had vomited 'a large amount of brownish matter.'" This refers to the nurse contacting the doctor's office at six p.m. on 2-3? 15:30:30

A. Correct.

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

A. From Julie Warner. 15:30:37

Q. Is that part of this meeting --

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

Q. So it's your recollection that there's a staff note which indicates that 15:30:56

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

A. I believe there was a staff note.

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

A. Yes.

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

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

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

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

A. What's my understanding?

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

warranted?" Made aware of by whom? 15:33:17

A. I'm thinking that that was in relation to Julie having received the after-care reports from the nurse and then there not being any documentation from Julie to the 15:33:37 direct care staff.

Q. So you answered it -- you were answering the question did Julie make the direct care staff aware of things that would warrant a return trip to the hospital? 15:33:56

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

Q. I know, I'm trying to get a handle on what question you were answering. "Were the staff made aware": "Staff" refers to whom? 15:34:12

A. The direct care staff.

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

A. No, Julie would be the nurse. 15:34:23

Q. Number 13 you refer to residential staff?

A. Yes.

Q. Who were you referring to there?

MR. SCHALTENBRAND: Which? 15:34:54

Q. "Residential staff felt that Lorna should've returned to the hospital on 2-3 when vomiting continued." 15:34:56

A. That would have been Rita or Marquita. 15:35:07

Q. Neither Rita nor Marquita are at the meeting?

A. Correct.

Q. So is it fair to say then you were answering these questions with information other than information that was provided at the February 23rd meeting with the Eastwood staff and your February -- 15:35:16

A. That sentence --

Q. I butchered my question. 15:35:28

Is it fair to say you're answering these questions with information other than information that was supplied to you in meeting with Barbara Irwin and Nurse Dieglio on May 22nd and with the Eastwood people the next day, on May 23rd? 15:35:45

A. It could have also been either Stacey -- I remember Stacey being more verbal than Lisa, it may have been Stacey also that issued that concern. 15:36:05

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

A. Right now, no.

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

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

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

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

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

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

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

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

addition, when they were asking what was going on, in addition to the notes from Eastwood about the condition of Ms. Moeller residents had indicated that she was in pain? 15:37:34

A. Did I -- 15:37:47

Q. In answering this question -- I guess I'm trying to figure out if their things are okay and sleeping, did you ever ask them at all about whether they'd heard these cries of help that the residents had heard? 15:38:01

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

Q. Did you ask them if they had talked to any resident care worker about this issue of someone crying out through the night? 15:38:17

A. No.

Q. Why not?

A. I don't know.

Q. Going down to 17 and 18. There's a description from Ms. Freeborn that on the 1st, 2nd and 3rd Rita was vomiting -- excuse me, Lorna was vomiting large amounts of brownish bile that was like any vomit. 15:38:52

Do I understand what you're saying correctly, is that what's going on? I'm just 15:39:12

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

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

A. Right.

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

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

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

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

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

A. I believe there was. 15:40:53

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

A. Right.

Q. And then I believe your review of 15:40:58 the payroll records show that she punched in at eight?

A. I believe there was a discrepancy.

Q. And this wouldn't be, my understanding of the payroll, I don't show up 15:41:08 and sign a sheet, I would show up and do a time card; is that right?

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

Q. Let me see if I can find it.

If we go back to question number 15:41:27 six. You note that she, being Julie Warner, reports that it was seven a.m. arrival time. Sign in/payroll records show that she worked eight a.m. to three p.m.?

A. Okay. 15:41:44

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

A. Geez, I don't -- I don't remember what it was now. 15:41:55

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

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

Q. Yes. Let's go back --

A. -- 4th?

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

A. Okay. 15:43:16

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

A. I don't remember.

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

A. Yes.

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

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

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

- - - - -

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

- - - - -

(Discussion had off record.)

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

A. It was the response from Dr. Eddy.

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

A. I'm sorry?

Q. Did you ever see this?

A. Yes.

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

A. Yes.

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

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

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

- - - - -

(Thereupon, Defendant's Deposition

Exhibit 4 was marked for purposes of identification.) 15:48:31

- - - - -

A. Yeah, it did come with that, that's what I was looking for. 15:48:41

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

A. Yeah, right, those came together.

Q. After you receive the information from Dr. Eddy do you do any further 15:49:29 investigation and speak to anyone at Eastwood or the hospital?

A. When I received this I wrote up the MUI synopsis letter for Eastwood and scheduled a time to meet with LuAnne to review this 15:49:48 report.

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

A. She did.

Q. Do you have any disagreement with 15:50:06 the information conveyed by Dr. Eddy?

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

Q. If we go down, his comments on the responses to question five, he notes: "The staff had documented what I believe to be 15:50:48

emesis of fecal material, and I cannot tell if this was communicated to the nurse or to the physician." 15:50:50

As you review this do you have an understanding as to what Dr. Eddy is referring to, what staff note he's talking about? 15:51:00

A. No, I do not.

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

A. No, I did not. 15:51:16

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

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

Q. Who's your supervisor? 15:51:27

A. It was David Miller.

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

A. When?

Q. Yes. 15:51:45

A. I don't know.

Q. I guess I'm just looking for very rough ball park. Was it relatively recent or did he have the job a long time before stepping in? 15:52:00

MR. SCHALTENBRAND: His position within case management? 15:52:01

MR. FORBES: Yes.

A. Yeah, I'm not -- maybe -- he may have been there a year, a year and a half, I don't know for sure. 15:52:09

Q. Now let's move to the conclusions. The first four conclusions, other than conclusion number three which has to do with the nurse's assessment of the 90 over 60 blood pressure, is it fair to say the other three have to do with improving communication between the nurse at Eastwood and the staff at Eastwood as well as the hospital and Eastwood? 15:52:36

A. Yes. 15:52:54

MR. KRAUSE: Objection to form.

Q. Number one would have to do: "Discharge from the hospital was not coordinated with the direct care staff who would be monitoring Ms. Moeller." 15:53:09

Did you take this conclusion to mean that the communication that was at issue here was from people at the hospital to the direct care staff, or Julie Warner and then Julie Warner to the direct care staff? 15:53:20

A. I took it to mean that it was fragmented before the direct care -- she came home via ambulance, there was no direct care staff that picked her up to get that information, there was no communication from Julie in the nurse's log to the staff as to what needed to be done. 15:53:23 15:53:38

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

A. From the nurse. From the hospital nurse. 15:53:50

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

A. I don't know that she -- I don't know that she answered that. 15:54:02

Q. Did you ask her?

A. I believe so.

Q. What did the direct care staff tell you? 15:54:17

A. Basically that they kept paging her.

Q. I'm talking about the communication after discharge about what the discharge instructions were: Did the direct care staff 15:54:27

tell you anything about what Julie told her? 15:54:30

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

Q. What do you mean?

A. That there was no communication in 15:54:36
the log, and that's what we were all relying on in the nursing log, there was no communication from Julie which is what they rely on because they're a 24/7 operation and Julie's not there all of those hours. 15:54:53

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

A. I don't believe that -- other than the one reference where Julie was paged and she 15:55:10
said she'd check with them in the morning I don't believe there was any other conversation regarding staff and Julie's communication.

Q. If we go to number eight on your responses to the questions. 15:55:35

MR. SCHALTENBRAND: Which exhibit, Steve?

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

A. The staff did not recall receiving anything from the driver. Yeah, they received 15:55:54

it verbally from Julie. 15:55:57

Q. What I'm trying to distinguish is the form versus oral communications, okay? So: "Staff when interviewed did not recall receiving any after-care forms from the 15:56:09 ambulance driver upon Lorna's return. Staff believed they received this information from Julie verbally."

So what the staff told you was Julie told them what the after-care 15:56:22 instructions were; is that correct?

A. Yes.

Q. So we have then a chain of events that is Nurse Dieglio calls Nurse Warner, tells the after-care instructions, Nurse Warner tells 15:56:35 the staff what the after-care instructions were; is that your understanding?

A. That's my understanding.

Q. And that chain of oral communication, that didn't violate any county, 15:56:51 state or federal regulation with regard to how group homes are supposed to handle discharges from hospitals?

A. Not to my knowledge.

Q. Conclusion number five, that had 15:57:26

nothing to do with Eastwood, correct? 15:57:28

MR. SCHALTENBRAND: That's exhibit 3?

MR. FORBES: I'm back to exhibit 4, I apologize. 15:57:35

A. Correct.

MS. TOSTI: Exhibit number 4 I think was identified as the medical director's mortality review, so are you referring to another exhibit? 15:57:49

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

MS. TOSTI: Why don't you read the title off of it or give a date or something so we -- 15:57:57

MR. FORBES: Lorna Moeller mortality review.

THE WITNESS: It's the memo.

MS. TOSTI: So you're referring to the memo from Dr. Andy Eddy, M.D. -- 15:58:03

MR. FORBES: Correct.

MS. TOSTI: -- to Mick Ihlenfeld?

MR. FORBES: Correct.

MS. TOSTI: I think we've marked that as exhibit number 3. 15:58:11

MR. FORBES: All right. 15:58:13

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

A. Correct.

Q. On the recommendations that were made is it fair to say that the first three recommendations involve improving communication between the various individuals involved in care when a resident has to be hospitalized? 15:58:39

MS. TOSTI: Can I ask what exhibit we're looking at? Because I think there's a difference in recommendations between Dr. Eddy's report and the MUI synopsis. 15:58:55

MR. FORBES: I'm on exhibit 3.

MS. TOSTI: Okay. 15:59:10

Q. Do I need to try my question again?

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

Q. Is it fair to say that recommendations one, two and three involve recommendations geared to improve communication between physicians, hospital, resident care workers, Eastwood nurse? 15:59:49

A. I believe the intent was to improve the communication with the Eastwood nurse, 16:00:13

direct care staff and coordination with the hospital. 16:00:20

Q. So as we go to the bottom of three, after outlining all that's in three, what Dr. Eddy says: "This will improve communication between the home and outside medical consultants"? 16:00:29

A. Uh-huh.

Q. So in addition to improving communication between resident care workers and the nurse, another key recommendation is to improve communication between the home and outside medical consultants; do I got that right? 16:00:36

A. That's what he has here. 16:00:49

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

A. Yes.

Q. I lost it in the pronoun so I'm just going to clarify. By "that" I meant a key recommendation was to improve communication between the home and outside medical consultants -- 16:00:58

MR. KRAUSE: Objection to form. 16:01:09

Q. -- right? 16:01:10

A. Yes.

Q. So I'm going to try again.

A key recommendation made by Dr. Eddy was to improve communications between the 16:01:14 home and outside medical consultants, correct?

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

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

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

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

A. He was looking for additional training or the nurse, as an example, to say this is what we need to do, we need to take her blood pressure every hour, we need to do an input -- an intake and output chart. 16:02:39 16:02:50

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

A. No.

Q. I'm just trying to get an understanding what this sentence means. 16:03:06

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

Q. Right, and we agree with that. So this first recommendation -- he's not talking about something that should be done for the nurse, he's talking about something that should be done for the direct care staff, right? 16:03:19

A. Yes.

Q. Do you have an understanding of when -- would this training be ongoing depending on a resident gets a specific condition, it's identified, the training comes in and the folks are trained on it as the conditions develop; was that your understanding? 16:03:29 16:03:42

A. That specific to client need on an as needed basis. 16:03:43

Q. So you might not be able to anticipate that until the clients had the problem? 16:03:53

A. Correct.

Q. Other than the conclusions and recommendations that are listed in exhibit 3, do you know of any other conclusions and recommendations that the state made with regard to Lorna Moeller's death? 16:04:16

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

Q. Correct. Can the state fine group homes for violations? 16:04:46

A. "Fine" as in?

Q. Monetary penalty.

A. I'm not sure.

Q. Do you know if Eastwood was sanctioned in any way as a result of your and the state's investigation into Lorna Moeller? 16:04:58

A. I don't know.

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

A. This is the first time I've seen 16:05:18

it. This case was the first time I'd seen it. 16:05:20

Q. Have you seen it since?

A. No.

Q. I'll show you number 5.

- - - - -

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

- - - - -

Q. Can you identify exhibit number 5 for me, please? 16:05:55

A. This was my report back to LuAnne.

Q. Between May 25th and September 14th, 2000 did you conduct any additional investigation into Lorna Moeller's death? 16:06:25

A. No.

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

A. I don't know.

Q. Any information you provided would be maintained in your file, though, correct? 16:06:46

A. Yeah. Yes.

Q. Do you know: To your knowledge did Eastwood -- after this incident and after your MUI synopsis did you continue to be the case 16:07:00

manager for Eastwood? 16:07:03

A. I wasn't the case manager.

Q. I'm sorry. Correct my terminology, whatever you were did your responsibilities toward Eastwood change after your MUI synopsis? 16:07:13

A. No.

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

A. Yes, I was. 16:07:28

Q. What was your involvement in those complaints?

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

Q. Any communications from an attorney representing you, I'm sorry, you're represented, I don't have to say that, I will say I'm not looking for that, so outside of communications with counsel tell me about this investigation into bias, alleged bias. 16:07:41 16:07:58

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

MR. SCHALTENBRAND: Pat, without saying what you discussed with Joe, are you aware of any investigation into whatever 16:08:09

allegations they were? 16:08:12

THE WITNESS: No.

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

A. I was unprofessional -- or I don't know, I never saw anything written on it. 16:08:27

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

A. No. I received a copy of a letter that LuAnne had written to Alfie. 16:08:47

Q. Was that after you submitted your MUI synopsis?

A. Yes.

Q. Under "Findings" you basically here repeat what is in exhibit 4, you say: "It was determined that Lorna's death was possibly preventable, if 'bowel obstruction had been diagnosed and treated when present.'" 16:09:20

Were you repeating Dr. Eddy's conclusion? 16:09:40

A. Yeah, it's in quotations.

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

So whatever was meant by "possibly preventable" and "bowel obstruction had been 16:10:01

diagnosed and treated when present" we'd have to ask Dr. Eddy about that, correct? 16:10:05

A. Correct.

Q. Again with the next sentence, "It was determined", you're again relying upon Dr. Eddy's investigation? 16:10:27

A. Correct.

Q. So it's fair to say then that that conclusion and finding beginning with "It was determined" is not your conclusion and finding, but it's Dr. Eddy's? 16:10:31

A. Correct.

Q. The first five recommendations, you're basically reiterating Dr. Eddy's recommendations? 16:11:02

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

Q. I understand. But what we're talking about there is Dr. Eddy's recommendations? 16:11:12

A. Correct.

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

A. Correct. 16:11:28

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

A. Yes, it does.

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

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

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

A. No, I didn't.

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

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

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

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

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

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

A. Yes.

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

A. I don't know.

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

A. I don't know.

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

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

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

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

Q. Who is that case manager?

A. At the time it would have been --

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

A. Yeah. I believe that was Judy Ketchum. 16:13:37

Q. What about number seven: "The nurse receive additional training in the handling of medical emergencies and potentially compromising situations"? 16:13:50

A. You know, I don't remember.

Q. Would you have any responsibility to follow-up on your recommendations or would Ms. Ketchum have that responsibility? 16:14:08

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

Q. You would have a copy of LuAnne's response in your file, though, correct? 16:14:20

A. We should have, sure.

Q. After receiving LuAnne's response did you contact her for any additional response and place any additional obligation on her to make any additional changes? 16:14:33

A. I don't believe so.

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

Does that now happen? 16:14:43

A. Yes, that happens. 16:14:58

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

A. I'm sorry? 16:15:05

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

A. No.

Q. Following your recommendations made 16:15:15 in September of 2000 are you aware of any additional problems that Eastwood had with residents that had to be hospitalized?

A. I'm not aware of any, but I wasn't doing the direct day-to-day monitoring at that 16:15:34 point.

Q. You were still the MUI specialist, correct?

A. Right. There was nothing that was MUI that I am aware of. 16:15:42

Q. You would be --

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

Q. Hospitalizations require an incident report which you would review to see 16:15:52

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

A. Correct.

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

A. I don't recall.

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

A. Yes. 16:16:36

Q. How many times?

A. I don't know.

Q. Did you meet with her in person?

A. Yes, I did.

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

A. I believe it was once.

Q. Tell me about that meeting.

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

Q. Where did you meet with her? 16:17:07

A. Somewhere up by where she lives.

Q. Was anyone else present?

A. Her husband.

Q. So you had to travel about an hour 16:17:18
to see her?

A. I was on my way to another group home out in Toledo.

Q. Tell me about this meeting with Ms. Zoelbel: What was discussed? 16:17:30

A. I gave them the report involving Dr. Eddy's conclusion.

Q. Did either Mrs. Zoelbel or her husband have questions?

A. From what I remember, Mrs. Zoelbel 16:17:47
just cried. It was pretty -- it was pretty emotional for her. If they had -- I don't remember if they had specific questions.

Q. Other than what was in the report did you tell them anything? 16:18:18

A. Anything? I'm not sure what you're referring to.

Q. Did you tell them anything about Eastwood, about the care provided, anything whatsoever? 16:18:28

A. No. 16:18:28

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

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

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

A. Yes. 16:19:14

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

A. I saw these two together. 16:19:29

Q. But that just means they sent them to you together. I'm trying to figure out when he sent -- when this letter from Dr. Eddy came to you, I mean exhibit 3.

A. This (indicating). 16:19:47

Q. Correct.

A. I'm not sure.

MS. TOSTI: Can I interject something here? The first line indicates that he reviewed her responses dated May 25th of 16:20:08

2000.

MR. FORBES: All that tells me it's after May 25th.

MS. TOSTI: It had to be after May 25th, 2000, if that's of any help. 16:20:18

A. Yeah, this is definitely after May 25th.

Q. I got that.

A. Right.

Q. I'm looking for -- 16:20:23

A. Yes, you're looking for June, July, August, I know.

Q. Correct.

A. I'm not sure. I remember it taking a long time. 16:20:31

Q. Do you remember when you met with -- did you meet with the Zoelbels prior to doing your MUI synopsis?

A. I don't believe so.

Q. Do you have any recollection of the season of the meeting with the Zoelbels? 16:20:53

A. You know, I don't know. I remember this report took a really long time.

Q. By "this report" you're talking about Dr. Eddy's? 16:21:12

A. Yeah, 3. 16:21:13

Q. Do you remember how long it took you to turn around yours after you got Dr. Eddy's?

A. Not long. 16:21:17

Q. So we can, we're now down to --

A. Somewhere between May and September -- June and September.

Q. You received Dr. Eddy's report not long before September 14th, 2000? 16:21:28

A. I'm sorry?

Q. So if I understand you correctly, you received your report not long before your MUI synopsis on September 14th, 2000?

A. Yeah, I'm guessing September. 16:21:39

Q. So you would have seen the Zoelbels then sometime in September of 2000, at best guess we realize?

A. Yeah, I think so.

Q. Do you remember calling Ms. Burton at her home in September of 2000? 16:22:02

A. Yes, that was after the meeting with the Zoelbels.

Q. When you met with the Zoelbels had they filed a lawsuit? 16:22:23

A. No, not that I was aware of. 16:22:25

Q. When you called Ms. Burton had the Zoelbels filed a lawsuit?

A. Not that I was aware of.

Q. So you didn't tell Ms. Burton that 16:22:37 the Zoelbels had sued Eastwood?

A. No.

Q. Why did you call Ms. Burton after meeting with the Zoelbels?

A. Mrs. Zoelbel was extremely upset 16:22:49 and had requested to be able to talk to the people who spent the last hours of Lorna's life with her and I told her that I would contact the staff to see if they would agree to do that. 16:23:07

Q. When you contacted staff -- strike that.

What did staff say -- who did you contact besides Ms. Burton?

A. No one. 16:23:29

Q. What did Ms. Burton say when you contacted her?

A. Geez, I don't remember.

Q. Did you contact Sharon Stifler?

A. Sharon -- I don't know who that is. 16:24:00

Q. At this point after meeting with the Zoelbels did you contact Rita Freeborn? 16:24:03

A. I don't think so.

Q. Do you have any understanding as to why you chose Ms. Burton who was still working at Eastwood as someone who could console Ms. Zoelbel as opposed to Ms. Freeborn who had left? 16:24:25

A. I wasn't looking at somebody to console Ms. Zoelbel. She had made a request that somebody who had spent the last hours of Lorna's life with her, and that's why. 16:24:36

Q. I used the wrong verb. Someone to help Ms. Zoelbel by talking with her about the last hours of Lorna's life; have I got what the request was? 16:24:53

A. That was the request.

Q. Right. Why Ms. Burton over Ms. Freeborn?

A. Because she was the person that had spent the last hours of Lorna's life with her. 16:25:05

Q. So it mattered to Ms. Zoelbel that it was time on the 4th as opposed to time on the 3rd?

A. She didn't specify that. 16:25:19

Q. Other than this meeting with Ms. Zoelbel did you talk to her on the phone at all? 16:25:26

A. With?

Q. Ms. Zoelbel. 16:25:30

A. Yes.

Q. About how often?

A. Gosh, I don't know. She'd call -- rough guess maybe once a month, I don't know.

Q. What kind of things did you guys talk about once a month? 16:25:44

A. It was basically assisting her through grief.

Q. What once a month time period? Is this from February 4th on or is it -- what time period? 16:26:01

A. February 4th, I don't know how long. I remember sending her a card at the one year anniversary, so within that year.

Q. Did you advise anyone that in addition to conducting the investigation into Eastwood and other folks providing care to Lorna you were also maintaining contact with Ms. Zoelbel and consoling her and helping her through her grief? 16:26:31 16:26:54

A. Say it again. 16:26:59

Q. We can agree two things were going on: One, you were investigating the circumstances surrounding Lorna's death, correct? 16:27:02

A. Correct.

Q. Two, you were speaking with Ms. Zoelbel monthly, hand delivering the report and helping her through her grief, correct?

A. Yeah. Yes. 16:27:20

Q. Did you inform anyone at the state or anyone who was your supervisor that you were involved in these two tasks: One, investigating the care provided; and, two, providing assistance to Ms. Zoelbel as she 16:27:34 dealt with her grief?

A. No, that would not be unusual.

Q. Had it ever happened to you before?

A. Had what?

Q. Investigating the death of a 16:27:50 resident while you are simultaneously consoling a grieving family?

A. I don't know.

Q. Why do you say those two -- performing those two roles wouldn't be unusual? 16:28:10

A. It's not unusual for people to call us and talk about whatever the issues are, that is not an unusual thing. 16:28:19

Q. I'm talking specifically now investigations into deaths or injuries of residents. Have you ever had another circumstance where you were simultaneously investigating the circumstances around a death or serious injury and helping someone affected by that death or serious injury cope with their grief? 16:28:33 16:28:52

A. No.

Q. Is it fair to say, though, as you sit here today and look back on the dual role that you see no conflicts of interest? 16:29:03

A. I don't see it as a dual role.

Q. So as you sit here today you don't see as a dual role consoling a grieving family member who's dealing with the death of her sister and investigating the care provided that may or may not have been involved in that death? 16:29:16

A. I don't see it as a dual role.

Q. We can agree then because you didn't see it as a dual role or any conflicts 16:29:32

of interest whatsoever that you felt no obligation to tell your supervisor? 16:29:34

A. Why would I tell my -- well, I didn't tell my supervisor.

Q. And then Dr. Eddy, we can agree that the information that Dr. Eddy is relying upon to reach his conclusions and to make recommendations is solely filtered through you, correct? 16:29:48

A. No. Filtered through me? 16:30:01

Q. Let me try it this way: Dr. Eddy got information from you with regard to two major unusual incidents, correct, after Lorna's death between February 4th and May 9th?

A. Yes. 16:30:19

Q. Is it fair to say you were the primary source of information as to Dr. Eddy and the state regarding Lorna Moeller?

A. I compiled the information for Dr. Eddy. 16:30:30

Q. And then when Dr. Eddy asked questions that he thought of after he reviewed the major unusual incident reports, you were the person who interviewed the people, collected the information and communicated with 16:30:45

Dr. Eddy, correct? 16:30:47

A. I communicated with the state, with Roxanne.

Q. And then Roxanne communicated with Dr. Eddy, to your understanding? 16:30:55

A. To my understanding.

Q. Then Dr. Eddy based his conclusions -- to the best of your knowledge Dr. Eddy based his conclusions on the information you had provided him, correct? 16:31:06

A. On the information he received, yes.

Q. And that information he received was from you?

A. And, yeah, from wherever I compiled it from. 16:31:12

Q. We can agree when Dr. Eddy reached his conclusions that you were both consoling Ms. Zoelbel and collecting information regarding Lorna's death? 16:31:29

A. No, he didn't -- I guess I'm taking exception with the consoling. It is not unusual when somebody calls that we would listen.

Q. You talked to her monthly and you 16:31:43

sent her a sympathy card, didn't you? 16:31:44

A. Yes, I did.

Q. Did you ever talk to her about the advisability of filing a lawsuit?

A. No, I did not. She asked me that 16:31:55
at that meeting and I said I could not answer or direct her.

Q. Have you ever delivered an MUI synopsis --

A. Yes.

Q. -- personally to family?

A. Yes.

Q. I'm going to show you what we'll mark as 6.

- - - - -

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

- - - - -

Q. Can you identify exhibit 6 for me? 16:33:28

A. Client Bill of Rights.

Q. Was Eastwood ever advised that it had violated any of Lorna Moeller's client rights in the events surrounding leading up to her death? 16:33:41

A. I don't believe it was a rights violation. 16:33:49

Q. So as you sit here today you don't believe there was an issue regarding a violation of client rights? 16:33:58

A. Involving her death?

Q. Yes.

A. Was that the second report? I don't remember.

Q. The second report? 16:34:25

A. The second MUI. You know what? I really don't remember.

Q. If we talk about the first MUI being smoking, that was a rights issue, correct? 16:34:44

A. Correct.

Q. And then the second --

A. Was the death.

Q. -- was the death.

A. It was filed as a death. 16:34:50

Q. Correct.

MR. FORBES: Mark these as 7.

- - - - -

(Thereupon, Defendant's Deposition Exhibit 7 was marked for purposes of 16:35:04

identification.)

- - - - -

(Discussion had off record.)

Q. Ms. Fishley, can you identify exhibit 7 for me, please? 16:36:37

A. It appears that it's the three or four incidents written by Eastwood staff.

Q. The first one is on February 1st. Do you see any -- if this by itself came to you would this constitute a major unusual incident? 16:36:55

A. Yes, because there was a hospitalization.

Q. So this by itself would require a report to the state?

A. Yes. 16:37:30

Q. So all hospitalizations require a major unusual incident report?

A. Yes.

Q. Based on your experience in training staff and in monitoring homes and in assessing major unusual incidents, is there anything that Ms. Freeborn did wrong as reflected in this report? 16:37:30

A. Based on this report she got medical attention. 16:37:58

Q. So Ms. Freeborn assessed the problem, got her to the emergency room, did the right thing? 16:38:01

A. Yes.

Q. You could go to the third page. 16:38:17

In preparing your report to the state, these incident reports that are exhibit 7 are things that you reviewed, correct?

A. Yes.

Q. Is your understanding of what happened consistent with the note that Ms. Warner wrote on page three here regarding her follow-up with Ms. Moeller when she got to the hospital? 16:38:38

A. I'm sorry, what was your question? 16:39:01

Q. Is the note written by Ms. Warner here on page three of exhibit 7 consistent with your understanding of what happened?

A. When she was sent home from the hospital? 16:39:18

Q. Correct.

A. Yes, Julie's reported this.

Q. But based on your investigation is that consistent with what happened?

A. That she came home with the ambu -- 16:39:35

that she spoke to the nurse, yes. 16:39:39

Q. The nurse called Julie --

A. Right.

Q. -- and indicated that Lorna had a bad case of gastroenteritis? 16:39:46

A. Yes.

Q. And that she was coming home and there was an order for Colace, that was --

A. That's what Julie reported, yes.

Q. So there is within the incident 16:40:10 report a documentation of what the diagnosis was and what the doctor's recommendations for treatment were?

A. Yes.

Q. If you look at the next page, which 16:40:31 is dated 2-4, if you could read through that and I have the same question: Is this consistent with your understanding of what happened based upon your investigation?

MS. TOSTI: Steve, which report are 16:41:06 we looking at, the date?

MR. FORBES: The date of the incident is 2-3 and this is the one with the crossed out 4th at the bottom and the time change. 16:41:17

MS. TOSTI: Okay. 16:41:17

A. Yes, this was reported.

Q. I know it was reported, I'm looking --

A. Is it similar to what I was told? 16:41:55

Q. Is it consistent with the factual conclusions that you drew after your investigation? Let's try it this way: You investigated and came to some understanding as to what happened; fair enough? 16:42:08

A. Fair enough.

Q. Is the information conveyed by Ms. Burton in this incident report consistent with the conclusions that you reached after your investigation? 16:42:21

A. Yes. There was a little bit more information I think verbally than there is written at any given time.

Q. Yes. I'm looking not for did they tell you additional stuff, but is there anything that you understand that's different or wrong as related by Ms. Burton here? 16:42:42

A. I believe this to be accurate.

Q. If we go to the next page, which is an incident report from Tracey Cherry dated 16:42:57

February 4th, I'd ask you to review it and I have the same question, which is: Is Ms. Cherry's rendition of what happened consistent with the conclusions you reached after your investigation? 16:43:01 16:43:14

A. This is what was referred to.

Q. I know that. In addition, though, to just taking what people wrote and gave you, you interviewed various people at different times and then reached a conclusion as to your best understanding what happened as a post-fact investigator. Are the conclusions reached -- are the statements made by Ms. Cherry in the incident report dated February 4th consistent with the factual conclusions you reached as part of your investigation? 16:44:24 16:44:36

A. Yes.

Q. Now as someone who's been employed by Deepwood since 1978 who has been a long-time major unusual incident specialist and who has been monitoring homes for at least the last ten years, do you know of any federal, state or county law or regulation that Eastwood violated from February 1st of 2000 when they took Lorna to the hospital to February 4th of 2000 when 16:45:09 16:45:33

Lorna died? 16:45:38

A. Any law that they violated?

Q. Any state law, federal regulation, federal law, county rule --

A. No. 16:45:49

Q. You know of none?

MR. FORBES: I may have a couple follow-ups, I doubt it, but I'll reserve that after these folks ask questions.

(Discussion had off record.)

EXAMINATION OF PATRICIA FISHLEY

BY MR. KRAUSE:

Q. Ma'am, we met a few hours ago. My name's David Krause. I represent Lake Hospital. 16:46:27

I just have a few questions, and hopefully I'll be brief. I'm going to try not to go through the things Mr. Forbes did, he did a pretty, I don't know what the word is, thorough job. 16:46:40

(Discussion had off record.)

Q. You interviewed Barbara Irwin and Alaki Dieglio at Lake Hospital as part of your investigation in this case?

A. Yes. 16:46:53

Q. When you interviewed Barbara was she cooperative and professional and courteous to you? 16:46:53

A. Extremely.

Q. Did she facilitate the transfer of information from the hospital to you? 16:47:01

A. Yes, she did.

Q. Did she ever tell you or refuse to provide any information that you requested at any point in time during your investigation? 16:47:13

A. No, not at all.

Q. Did she present and make available Alaki Dieglio for you to interview?

A. Yes, she did.

Q. Did you ask Barb to interview any other employees or any other staff at Lake Hospital Systems as part of your investigation in this case? 16:47:26

A. No, I did not.

Q. Did Barbara express to you that if you want to interview anybody else or talk to anybody else or had any other questions whatsoever that she would be happy to so provide those individuals or that information to you? 16:47:34 16:47:44

A. Yes, she did. 16:47:44

Q. Do you know why Rita Freeborn resigned?

A. I don't.

Q. You indicated when you spoke to Mrs. Dieglio she indicated that she was concerned because no one from Eastwood was coming and the patient was being sent home in an ambulance? 16:48:07

A. Yes. 16:48:19

Q. Was it your understanding having talked to Ms. Dieglio that at the time of Lorna's transfer she knew that the arrangements had been made to transfer her via ambulance because she already knew that no one was coming from Eastwood to facilitate or accompany Ms. Moeller in transit? 16:48:32

A. That's my understanding.

Q. Were there three MUIs regarding Eastwood and Lorna Moeller? And I'm going to track down in my mind what that was: Smoking, the death and then was there a third MUI? 16:48:51

A. Yes.

Q. And this was following the death of Ms. Moeller? 16:49:05

A. Correct. 16:49:05

Q. This third MUI was in regards to problems you were having in your investigation?

A. The additional reporting from the other two consumers -- 16:49:16

Q. I see, that's right.

A. -- and I really can't remember what we put that under right now, I should know that.

Q. That's right. 16:49:23

How are the findings of the state, whether it be -- by state I'm including the county and the state as well -- how are those findings communicated to Eastwood?

A. I met with LuAnne and Jim Victor in our office. 16:49:50

Q. And they're also communicated by your report which is addressed to LuAnne Busch?

A. Correct.

Q. Now I recall that your MUI synopsis -- I can't remember what we marked it as -- I notice no one from Lake Hospital was cc'ed on this report. 16:50:05

A. Correct.

Q. Did you talk to -- other than your 16:50:21

conversation with Barbara back around the same time that you spoke to Alaki Dieglio as part of your investigation, have you ever gone back and spoken to Barbara or Ms. Dieglio about this case? 16:50:23 16:50:34

A. No.

Q. Have you ever sent a copy of your MUI synopsis or informed Barbara Irwin or Alaki Dieglio or anyone from Lake Hospital of your findings in this case? 16:50:46

A. I don't believe so.

Q. And that's because your findings in this case are directed at the care of the Eastwood facility, correct?

A. Correct. 16:50:57

Q. The changes that would need to be made, if there are any, would need to be made by the Eastwood facility and the care-givers there, correct?

A. Correct. 16:51:08

Q. Do you have a copy of the letter from LuAnne Busch to Alfie regarding this issue after you issued your MUI synopsis that you might be biased or that the investigation wasn't fair? 16:51:32

A. I do have a copy of it. 16:51:33

Q. Where would that copy be located?

A. In my office.

Q. Is your office here?

A. No. Well, it's down the road. 16:51:38

Q. No, I don't want to go down the road. If you could provide that to Mr. Schalt --

MR. SCHALTENBRAND: Eric's fine.

Q. -- to Eric? 16:51:50

MR. KRAUSE: And I'd ask, Eric, if you could just provide that to all of us or send a copy to me and I'll disseminate it, that way we don't have to come back.

MR. SCHALTENBRAND: I'll have to get your card. 16:52:01

MR. KRAUSE: I'll get it for you right now.

Q. To the best of your recollection what was contained in that letter? 16:52:06

A. Gosh, LuAnne had written to Alfie that based on whatever investigation Joe did that it was a misunderstanding and that she would hope for continued support or continued being able to work with our agency, one of 16:52:34

those kinds of letters. 16:52:37

Q. Did it address your investigation at all or concerns Ms. Busch had about bias or the accuracy of your investigation?

A. I just remember it saying that it was a misunderstanding. 16:52:50

Q. Did the letter come after you received a phone call from the attorney who told you -- I don't want to get into that -- where you learned that there was some concern or some question regarding potential bias in your investigation? 16:53:05

A. Yes.

Q. So this letter was after you got that phone call? 16:53:14

A. Yes, correct.

Q. Up until the point in time when you prepared your MUI synopsis -- strike that.

When were you informed by Ms. Burton that LuAnne Busch had directed the employees not to speak with you regarding Ms. Moeller? 16:53:36

A. It was the day after I interviewed Ms. Burton. She had paged me the following morning. 16:53:50

Q. Was this before or after the other residents, the two other residents came forward and indicated to you that there were -- let me finish my question -- 16:53:51

A. I'm sorry. 16:54:01

Q. -- and indicated to you that Ms. Moeller was in pain and asking for help which, based on their observation, was not being responded to at Eastwood?

A. It was before. 16:54:12

Q. It was before those people came forward?

A. Yes.

Q. Is there a separate MUI synopsis related to that incident? 16:54:41

MR. FORBES: Object to the form.

A. To which incident?

Q. Okay. In other words, we've gone through the three MUIs, correct?

A. Uh-huh. 16:54:46

Q. I have an MUI synopsis and this one obviously doesn't relate to the smoking, it relates to the death, okay?

A. Uh-huh.

Q. Now the third MUI was the incident 16:54:53

where these residents came forward and informed you of some facts and what their observations were. Is there another MUI synopsis regarding that? 16:54:56

A. No. 16:55:06

Q. Why not?

A. You know, I don't know, it's a good question. I think we just lumped -- I think I just lumped it all together.

Q. After you were informed by Ms. -- I don't remember her name, who informed you that LuAnne Busch had issued this directive that employees were not to speak to you? 16:55:55

A. Marquita Burton.

Q. That's the name. After you spoke to Marquita Burton, other than the meeting that you had -- that was just going to be an awful question so I'm going to start over. 16:56:16

After Ms. Burton informed you of what LuAnne Busch had told the staff, did you ever have an opportunity to speak to any Eastwood employee outside the presence of LuAnne Busch up until the point in time when you issued your MUI synopsis? 16:56:35

A. I don't think so. 16:57:00

Q. Is that unusual? 16:57:01

MR. FORBES: Objection to the form.

Q. As you were --

MR. KRAUSE: I'll rephrase the question. 16:57:12

MR. FORBES: Give me the time frame.

MR. KRAUSE: I gave the time frame in the first question.

Q. In the course of your investigation 16:57:17 after you learned that LuAnne Busch had issued a directive to the employees of Eastwood not to speak with you, did you find it unusual, as compared to other investigations that you've conducted, that you would not be allowed to 16:57:33 have access to the employees of Eastwood to discuss with them what did or did not happen in this case?

MR. FORBES: Objection to the form.

A. I don't know if it was unusual. 16:57:59

Q. Did it bug you?

A. Oh, sure.

Q. Did it cause -- did it make your investigation more difficult?

A. I don't know that it did or didn't, 16:58:16

I don't know. 16:58:18

Q. And the only employee that you spoke to in this time frame was an employee that had left the Eastwood facility 25 days or so after Ms. Moeller's death, that being Rita Freeborn, correct? 16:58:30

MR. FORBES: Objection to the form. You said "this time frame."

MR. KRAUSE: It's the same time frame we've been talking about. 16:58:40

MR. FORBES: Can I just --

Q. Let me do it this way: Time frame, we're going to talk about the time frame between, once again, Ms. Burton told you that LuAnne Busch issued a directive of Eastwood employees not to speak to you and the time you issued your MUI synopsis. 16:58:51

MR. FORBES: May I just clarify my confusion?

MR. KRAUSE: Okay. 16:59:01

MR. FORBES: Which is they all met on May 23rd to discuss and answer the questions that Dr. Eddy issued, Stacey Reigert, all those folks all met.

MR. KRAUSE: The questions that I'm 16:59:12

asking, and I said this, outside the presence of LuAnne Busch. 16:59:13

MR. FORBES: Okay.

MR. KRAUSE: That was three questions ago. 16:59:20

MR. FORBES: Right. That's my confusion, that's why I --

MR. KRAUSE: That's fine. All right.

Q. In this time period between when Burton told you that LuAnne Busch had issued the directive to employees of Eastwood not to speak and the time that you issued your MUI synopsis, you did not speak to any active Eastwood employees outside the presence of LuAnne Busch, correct? 16:59:26 16:59:42

A. Not that I recall.

Q. The only employee that you did speak to outside the presence of LuAnne Busch during this time frame was Rita Freeborn, if I'm saying her name right, and that was the employee that had left Eastwood 20 days or 25 days or so after Ms. Moeller's death, correct? 16:59:54

A. Yeah, I don't remember when I spoke with Rita specifically. 17:00:11

Q. If the documents that you've -- 17:00:13
A. Right, yeah, I don't remember.
Q. -- indicate that you spoke to Ms. Freeborn in that time frame, you wouldn't disagree with that, correct? 17:00:22
A. Correct.
MR. FORBES: Objection to the form.
Q. When Rita Freeborn told you she would help in any way she could, what did you take that to mean? 17:00:44
A. She had some concerns about the care and treatment that Lorna was receiving and she had stated that she would help in any way that she could.
Q. Do you know if she -- I'm sorry. 17:01:04
A. I don't know what specifically she planned on doing.
Q. Do you know if she was fired?
A. I don't know.
Q. Has she ever communicated to you the circumstances surrounding her leaving Eastwood? 17:01:14
A. If she did I don't know, I don't recall.
Q. Did she leave as a result of 17:01:24

anything that happened in this case dealing with Lorna Moeller's death? If you know. If you know. 17:01:25

A. I don't know.

Q. On page, I don't remember which exhibit you were talking about, it's the memo that you did to Bill Angel -- 17:01:53

A. Okay.

Q. -- paragraph four on page two.

MR. SCHALTENBRAND: Exhibit 2. 17:02:04

MR. KRAUSE: Is it exhibit 2?

MR. SCHALTENBRAND: Yes.

A. Paragraph?

Q. It's the fourth numbered paragraph, paragraph number four. 17:02:11

A. On page one?

Q. Page two, sorry. It starts: "The Eastwood nurse, Julie Warner"?

A. Yes.

Q. In there I notice the sentence, and I'm going to read an excerpt from it and ask you if I read it the right way: "During the initial interview with this worker", this worker being Julie Warner, "on 2-4" -- 17:02:21

A. Wait a minute, I'm sorry. Where 17:02:38

are you at? 17:02:38

MS. TOSTI: Third line of item number four.

A. During the interview?

Q. "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."? 17:02:42

A. Yes.

Q. "On 2-4-00, Julie reported that staff had paged to report that Lorna was vomiting"? 17:02:53

A. Yes.

Q. "During the 5-22-00 interview Julie reports that she was paged at the above mentioned times and staff reported that 'Lorna was tired.'" Okay? 17:03:03

A. Yes.

Q. Is that in your report because it's a discrepancy between the facts as reported to you by Julie Warner in your two meetings? 17:03:13

A. It's in my report because that's what happened during the initial interview and that's what happened on 5-22.

Q. Did you ask her why her story was 17:03:32

different? 17:03:34

A. No.

Q. Does it seem unusual to you as a person who investigates homes such as Eastwood that at 2:54 a.m. and 3:15 a.m. in the morning 17:03:47 resident staff would page a nurse to inform her that a resident was tired?

A. That seems unusual.

Q. This 5-22-00 interview with Julie Warner occurred after you were told by Ms. 17:04:07 Burton that LuAnne Busch had issued a directive to Eastwood employees not to speak with you, correct?

A. I'm sorry, say that again. I'm starting to fade here. 17:04:23

Q. Yes. The second meeting with Julie --

A. Yes.

Q. -- when she says that the staff paged her because Lorna was tired, that was 17:04:29 after you had been informed by Ms. Burton that LuAnne Busch had said -- had issued a directive to the staff at Eastwood not to speak with you anymore?

A. Correct. 17:04:45

Q. On, I forget what the exhibit was, I'm talking about the bunch of incident reports. 17:05:04

A. Yes.

Q. Page three, the third incident report in that exhibit, it's the one by Julie Warner. 17:05:12

A. Yes.

Q. That writing by Julie Warner describes information that was relayed to her by the nurse or the staff at Lake Hospital when Ms. Moeller was discharged, correct? 17:05:30

A. Correct.

Q. So earlier when Mr. Forbes asked you if you knew if anything in addition to what's documented in the Lake Hospital discharge instructions was communicated and you indicated you had no information, would this assist you in answering that question? 17:05:56

A. Could you say that again? 17:06:16

Q. Sure.

Earlier Mr. Forbes asked you a question and said do you know if anything in addition to what's contained in the Lake Hospital records was communicated to Eastwood 17:06:27

on discharge, and I believe your answer was no, you didn't know. Does this assist you in determining what was communicated to Eastwood on Ms. Moeller's discharge? 17:06:29

MR. FORBES: Objection to the form. 17:06:40

A. Yes.

Q. Do you know anything about this change in the date in the bottom of the form on the next page, February 4th?

A. You know, yes. My understanding was that, and it's typical, it didn't surprise me, third shift staff are always like a day behind on their reports, that was my understanding. 17:07:05

Q. So the date of the incident was February 3rd as written in at the top in section A? 17:07:24

A. Correct. The staff person would have come in on the 3rd and would have, you know, left on the 4th but in their -- it's still the 3rd in their, yeah -- 17:07:36

Q. I see.

A. -- in their shift. That was my understanding.

Q. When were these incident reports 17:07:53

provided to you? And I'm referring -- 17:07:54

MR. KRAUSE: What exhibit is the incident?

MR. SCHALTENBRAND: 7.

MR. FORBES: 7. 17:08:02

A. Specific dates I don't know.

Q. Were any of these provided to you on February 4th?

A. Boy, I don't remember. We always ask for incident reports. I'm not sure that 17:08:28 they would have been written. Well I guess some of them would have been written that particular day. I don't recall if they were that day or if they were faxed to me.

Q. If the times on the lines at the 17:09:01 bottom where it says "Date Completed" are accurate, then all of these would have been completed prior to your arrival to the Eastwood facility to meet with the involved staff?

A. That's correct. 17:09:18

Q. Do you know if they were faxed out or would you have a copy in your file of the fax memo?

A. I'd have to look, I really don't know. I can't recall if I picked them up, I 17:09:32

don't know. 17:09:37

MR. KRAUSE: I think that's all I have. Thank you.

THE WITNESS: Thank you.

MS. ATKINSON: I just have a couple questions 17:09:47

EXAMINATION OF PATRICIA FISHLEY

BY MS. ATKINSON:

Q. Ms. Fishley, my name is Kathleen Atkinson. I'm here on behalf of Dr. Heng and Dr. Oh. 17:09:51

Did you at any time have any conversations with any of the physicians at Lake East Hospital regarding the death of Lorna Moeller? 17:10:00

A. I did not.

Q. Earlier you had stated to Mr. Forbes that an MUI report was filled out regarding the lapse of time between the medical care that Lorna received from when she got home 17:10:08 from the hospital and when she died, and now you're saying that you don't believe a report was filled out; is that correct?

A. No, that was that second report, I can't remember what -- the additional 17:10:21

information with the client, the client saying that she was in pain or screaming out. 17:10:22

Q. That was from the two residents, correct?

A. Correct. 17:10:37

Q. You're saying an incident report was filled out?

A. Major unusual incident, the MUI, not these forms, the MUI form, the state reporting form. 17:10:40

Q. Originally that information came from Judy Ketchum; is that correct?

A. Correct.

Q. Do you know how Judy got involved with the investigation? 17:10:47

A. She didn't get involved in the investigation, she was at least monitoring talking to the ladies and the ladies reported it to her and she brought it back to me. And, again, that's typical. 17:11:04

MS. ATKINSON: I don't have anything further.

MS. TOSTI: I don't have a copy of the MUI report that she's --

MR. KRAUSE: Neither do I. 17:11:17

MS. TOSTI: -- mentioning in regard to the two residents that were describing -- 17:11:19

MR. FORBES: Nobody does.

MS. TOSTI: -- events. So if, in fact, that is in the file, is that something you could provide us? 17:11:27

MR. SCHALTENBRAND: I'll see if it's in the file.

MS. TOSTI: If you want to give it to me I'll be happy to disseminate it to everyone. 17:11:33

MR. FORBES: I would just like everything. Do we need a subpoena to get it?

MR. KRAUSE: I think that, we're on the record, I know there are issues of confidentiality, I think maybe Jeanne can collect that and disburse it, although I think that each of us might want to get our own copy directly from the board, but maybe, Jeanne, if you would authorize them to release copies to us on the record probably expedite things. 17:11:43 17:11:58

MR. FORBES: I don't know if there are confidentiality issues with reports to the state. I'm willing to consider it.

MR. KRAUSE: You want the entire 17:12:10

file? 17:12:10

MS. TOSTI: I don't know what's in the file so I can't say one way or the other.

MR. KRAUSE: Right.

MS. TOSTI: I have no problem with 17:12:15
him providing everything, a copy of the MUI.

MR. KRAUSE: That's fine.

MR. SCHALTENBRAND: I don't know what's in the file.

MR. KRAUSE: I just don't want Eric 17:12:24
to be stuck later.

MR. FORBES: What I will do then is just subpoena and then whatever is appropriate under the subpoena then --

MR. SCHALTENBRAND: You can specify 17:12:33
to me what you want, what files we're talking about.

MR. KRAUSE: Everything.

MR. SCHALTENBRAND: You got to be a little more specific than that. 17:12:39

MR. FORBES: Everything plus two.

MR. SCHALTENBRAND: That's better.

EXAMINATION OF PATRICIA FISHLEY

BY MS. TOSTI:

Q. We were talking -- I am Jeanne 17:12:46

Tosti. I am representing the plaintiff, Carol Zoelbel, in this case. I'll try to be brief since we've been here a very long time already. 17:12:50

You had indicated that you had a conversation I believe with Rita Freeborn and that she had expressed some concerns to you about the care that Lorna Moeller had. Was there anything specific that Rita Freeborn mentioned to you in regard to the care that Lorna Moeller had? 17:13:02 17:13:15

A. Oh, gosh. I believe Rita felt that Lorna should have been sent back to the hospital, that she should have returned back to the hospital, that she should have received additional medical care. 17:13:37

Q. Was that during the period of time when Rita Freeborn was on duty? I believe she worked three to 11 or that evening shift?

A. Right, she was the one who took her to the hospital on the 1st, February 1st, and then I don't recall if she worked -- actually I'm thinking she did work the 2nd or the 3rd or 2nd and 3rd. 17:13:49

Q. I believe if you would refer to plaintiff's exhibit number 2 -- 17:14:08

A. Okay. 17:14:11

MR. FORBES: Hey, wait a minute, defendant's exhibit.

Q. I'm sorry, pardon me, defendant's exhibit number 2. 17:14:17

A. I don't know which one it is, I'm just look looking for a 2.

Q. Okay, number 2, and on page number one --

A. Yes. 17:14:24

Q. -- down near the bottom of the page it indicates "I spoke with Rita Freeborn", and in that paragraph --

A. Yes.

Q. -- I believe you say Rita worked 17:14:37 the second shift on?

A. On 2-2 and 2-3, okay.

Q. And she also worked on 2-1 of 2000?

A. Right, I remembered 2-1 that she was with her. 17:14:49

Q. And although you don't recall at this time, at the time that you had filled out defendant's exhibit number 2 this would have been based on your interviews and whatever notes you had at the time, correct, that 17:15:01

information that you've included in this report? 17:15:03

A. Correct. Correct.

Q. Now aside from the Lorna Moeller case have you ever investigated a death of a resident where you were required to answer questions posed by the medical director for the Ohio Department of Mental Retardation and Developmental Disabilities? 17:15:14

A. No, this was a first. 17:15:30

Q. So this was an unusual case, is that correct, based on your experience?

A. Yes.

Q. Have you ever come across a report from the state medical director, a mortality review, that indicates that a resident's death was possibly preventable in your experience with your position at Lake County's board? 17:15:42

A. No.

Q. So that's an unusual situation, too, at least from your experience? 17:16:00

A. It's the first time I saw that form.

Q. Now when Marquita Burton informed you that LuAnne Busch was angry and none of the 17:16:12

Eastwood staff was supposed to speak to you, did you view that as an attempt to obstruct your investigation in this case? 17:16:19

MR. FORBES: Objection to form.

A. Yes, and also a way for -- just for LuAnne or Eastwood to be a part of whatever interviews, just so that they would be there. 17:16:37

Q. I don't know that I'm understanding your answer.

A. I saw it more as them wanting to be involved as opposed to -- in addition to my not being alone with the staff. It's -- I don't know. 17:16:56

Q. You have done other investigations of other major unusual incidents, is that correct, in the course of your career here? 17:17:15

A. That's correct.

Q. Do you on occasion speak with individual staff members privately away from the administration of a group home? 17:17:28

A. Yes.

Q. Do you find sometimes that you obtain information from the staff that is a little more candid when they don't have an administrator sitting there? 17:17:38

A. Yes. 17:17:39

Q. In this instance would it be helpful to have spoken to the staff individually to find out their perspective on what happened rather than in the group? I 17:17:49 think you did meet in a group with Julie Warner and the administrator and Lisa Schubert and Stacey Reigert together?

A. (Nodding head affirmatively.)

Q. Did you ever have an opportunity to 17:18:04 speak with Julie Warner individually without the administrator present?

A. You know, there was -- it was in relation to this May 25th and I had asked -- I called out to Eastwood so that I would be clear 17:18:20 when I was writing up my notes and asked them to page Julie to give me a call so I could clarify something that was in here, and LuAnne called my supervisor as opposed to Julie calling me back. I can't really remember what 17:18:42 happened after that. I believe they set up a time and I don't know if LuAnne was present or not when Julie did talk to me, when she did clarify whatever I was asking.

Q. Now when Marquita Burton told you 17:19:01

that none of the staff was supposed to talk to you, did you keep that confidence as far as Marquita Burton, what she had told you? 17:19:04

A. Yes.

Q. And she expressed a concern to you that if she talked with you individually and they found out that she might lose her job; is that correct? 17:19:15

A. Yes.

Q. Now when you conducted this investigation did you conduct it in the same manner that you would normally conduct an investigation into a major unusual incident? 17:19:25

A. When I spoke with Marquita?

Q. No, I mean just in general -- 17:19:41

A. I'm sorry.

Q. -- the procedures you follow in talking with the staff and collecting the information and developing your report.

A. Yes. 17:19:50

Q. And it was in accordance with the department's usual procedures and policies; is that correct?

A. Right.

Q. Did you prepare your MUI synopsis 17:19:58

in accordance with the usual policies and procedures of the Lake County Board of Mental Retardation and Developmental Disabilities? Was this a format that you had used at other times? 17:20:05 17:20:17

A. Yes.

Q. This was an acceptable format and was prepared in the manner that you normally did; is that correct?

A. Correct. 17:20:23

Q. And this MUI synopsis, is this kept as a permanent record in the files here at Deepwood?

A. Yes.

Q. Now, I believe we were looking at defendant's exhibit number 2 a while ago and item number four indicates, I believe, about the fifth line down that during -- or the fourth line down, that during the course of the time that you spoke with Julie she looked at her pager and reported to you that she'd been paged at 2:45 a.m., 3:15 a.m., six a.m. and 7:11 a.m.; is that correct? 17:20:51 17:21:20

A. Yes.

Q. If she was paged at 7:11 a.m. by 17:21:36

When you spoke with those people did you note there was a discrepancy between the two things that Julie was telling you versus what the staff was telling you? 17:24:54

A. Yes. 17:25:02

Q. Did you speak with Julie about that, as to that discrepancy?

A. No, I'm assuming that that's why Julie -- that last sentence is in there that Julie reports she only saw Lorna on 2-4 because 17:25:16 I did ask Julie.

Q. And she denied seeing Lorna vomit at six p.m. on February 3rd?

A. Julie would have responded -- reported that she only saw Lorna vomit on 2-4. 17:25:32

Q. Now you have reference here to the staff and then you also told us that you spoke with Rita Freeborn. Does that "staff" word refer to Rita Freeborn?

A. Where are we looking? 17:26:10

Q. We're looking at that same notation on page five --

A. Oh, "Staff reported that Julie did witness Lorna vomit", that one?

Q. Yes. Are you referring to Rita 17:26:20

Freeborn there? 17:26:24

A. Yes.

Q. Now in the MUI synopsis, which has been marked as defendant's exhibit number 5, there are a number of recommendations. Do you 17:27:11 recall ever seeing a written copy of LuAnne Busch's response to these recommendations?

A. I believe there was a written response.

Q. Now we previously looked at item 17:27:28 number six and one of the recommendations was Eastwood was to review/update policies and procedures regarding the handling of medical issues and emergencies, and I believe Mr. Forbes spoke to you about all staff receiving 17:27:47 in-service training on handling of medical emergencies and the response to that portion was that they received that in their orientation.

But in regard to that first 17:27:58 sentence, Eastwood was to review and update policies and procedures regarding the handling of medical issues and emergencies, do you recall Eastwood ever doing that, reviewing their policies and updating them? 17:28:11

A. No, I don't. 17:28:13

Q. Would Eastwood be required to respond to you regarding these recommendations?

A. Yes.

Q. Do you know one way or the other 17:28:25 whether Eastwood ever reviewed and updated their policies and procedures regarding the handling of medical issues and emergencies?

A. I believe -- I believe that Eastwood -- that's the part they said was 17:28:41 covered in the orientation, I believe. I'd have to look at her response, her plan of correction.

MS. TOSTI: Now I have requested that response and haven't received it from 17:28:56 defense counsel as yet. I'm going to request it again because I have not received that in any of the production of documents that you've given me. So I am going to request again that you provide me with Eastwood's response to the 17:29:09 recommendations that were made on the MUI synopsis.

MR. FORBES: Since you've already requested that in writing I will forego my usual request that you make it in writing and I 17:29:18

will get that to you, I have reviewed it and will get it to you. 17:29:20

MR. KRAUSE: Can you cc me on that?

MR. FORBES: Yes, Mr. Krause.

Q. Now, number seven says: "The nurse receive additional training in handling of medical emergencies and potentially compromising situations." 17:29:29

Is that a recommendation that you formulated? 17:29:39

A. Yes.

Q. That wasn't one that came from Dr. Eddy; is that correct?

A. One through five were from Dr. Eddy. 17:29:47

Q. Why is it -- what was the basis for you formulating number seven? Why did you feel the nurse should receive additional training in the handling of emergencies and potentially compromising situations? 17:30:02

A. A blood pressure of 90 over 60, I don't remember what Lorna's temperature was, it was 97 or 99, the staff reports that she was cool and clammy, the staff had paged her four times in the course of the night, that seemed 17:30:21

pretty critical. 17:30:30

Q. Do you think that Julie Warner should have responded during the night by either telling the staff to take her to the hospital or call 911 -- 17:30:40

A. Yes.

Q. -- or contacting the physician?

A. Yes.

MS. TOSTI: I don't have any further questions. 17:30:49

MR. FORBES: Unfortunately, I have a few follow-ups.

EXAMINATION OF PATRICIA FISHLEY

BY MR. FORBES:

Q. First of all, prior to today did you ever talk to Ms. Tosti or anyone from her office other than to schedule the deposition? 17:30:55

A. That was it.

MS. TOSTI: I did call her to schedule the deposition. 17:31:04

Q. Have you talked to anybody on behalf of the Zoelbels?

A. No.

Q. My understanding, and correct me if I'm wrong, is that the day of the accident -- 17:31:14

the day of the death, Ms. Moeller's death, you spoke with LuAnne Busch and Julie Warner together, Stacey Reigert and Lisa Schubert all there? 17:31:18

A. You know, I don't -- I think so. 17:31:32

Q. You spoke to a group of people at the home?

A. Yes.

Q. The next day you spoke to Ms. Burton? 17:31:37

A. I believe it was the next day, I know it was close.

Q. And the following day or shortly thereafter you spoke to Ms. Freeborn who was still working at the home? 17:31:47

A. I believe so.

Q. So after speaking to Ms. Burton you went to the home and spoke to Ms. Freeborn?

A. No, I didn't -- no.

Q. When did you speak to Ms. Freeborn? 17:32:03

A. I don't know. After that phone call from Marquita I did not go out to the house.

Q. But sometime in that time period you spoke to Ms. Freeborn -- 17:32:10

MR. KRAUSE: Objection.

Q. -- in addition to Ms. Burton?

MR. KRAUSE: Objection to the time frame without defining it.

A. Yes. 17:32:17

Q. Sometime between -- sometime in the week following the death of Ms. Moeller you spoke to Ms. Freeborn?

A. I do recall speaking to Ms. Freeborn, I don't remember when in all of this. 17:32:26

Q. Did you ask to speak to any hospital employees outside of Ms. Irwin's presence?

A. No.

Q. To set up the meetings with Nurse Dieglio, you spoke to Ms. Irwin to do that, correct? 17:32:38

A. Correct.

Q. When you contacted Ms. Busch she always produced each person you asked to speak with, correct? 17:32:49

A. Yes.

Q. You never complained to Ms. Busch or internally to a supervisor about Ms. Busch's purported directive not to have folks speak to 17:33:08

you? 17:33:12

A. I did not talk to Ms. Busch about that.

Q. And you did not talk to your supervisor about that? 17:33:16

A. I may have.

Q. Is there any documentation of you speaking to your supervisor about it?

A. I don't --

Q. Do you remember any advice your supervisor gave you about how to deal with the situation? 17:33:25

A. No.

Q. Going back to exhibit 2, the very end of number 14, you don't -- is there a reason you say "staff" as opposed to Ms. Freeborn? 17:33:46

A. No.

Q. Could it have been somebody other than Ms. Freeborn? 17:34:12

A. Could have been.

Q. Do you remember --

A. I don't know.

Q. Do you remember when this information was conveyed to you by the staff 17:34:26

that is different than Ms. Warner's recollection? 17:34:31

A. I don't know.

Q. It could have been in your initial in-person meetings with Ms. Burton and Ms. Freeborn or it could have been in a subsequent phone call with Ms. Freeborn or it could have been on the 23rd when you met with the folks? 17:34:46

A. I'm thinking it wasn't the 23rd, but it could have been anywhere else. A specific date I don't have right now. 17:35:04

Q. And you asked Julie straight on, staff says this and your recollection is different?

A. I'm not sure. 17:35:34

Q. So you don't know one way or another whether you gave Julie an opportunity to respond to what the staff was saying?

A. You know, I don't know right now.

Q. To your knowledge was this information ever shared with Eastwood? The "information" being this whole entire exhibit 2. 17:35:49

A. I believe Eastwood got a copy after the synopsis. 17:36:14

Q. They received a copy of your response to the question? 17:36:16

A. Yes.

Q. And there was never -- with regard to Eastwood's response to the recommendations and conclusions, there was never any follow-up by the county or the state needed to implement those changes, correct? 17:36:27

A. I'm sorry, say it again.

Q. When Eastwood submitted its plan of action there was never any action by the state or the county saying you're not following through any plan of action, correct? 17:36:45

A. Correct.

Q. Do you know where Lorna Moeller is buried? 17:36:58

A. Arcola Cemetery.

Q. Since her death have you visited her grave?

A. I did once. 17:37:18

Q. When did you do that?

A. I don't know.

Q. That's all right. Do you know if it was before or after you spoke with Ms. Zoelbel in that meeting when you delivered your 17:37:28

MUI synopsis? 17:37:31

A. It was after, I think. I don't know.

Q. Fair enough.

A. Good. 17:37:46

Q. And after Ms. Freeborn said she would help any way she can, did you ever speak with her again?

A. No, not that I'm aware of. Not that I recall. 17:38:02

MR. FORBES: Thank you.

THE WITNESS: Thank you.

MR. KRAUSE: Sorry.

EXAMINATION OF PATRICIA FISHLEY

BY MR. KRAUSE: 17:38:12

Q. I want to be very clear. When you were made aware that something had happened that would generate an MUI, you know, type investigation, you wouldn't have known right off the bat which employees were involved and 17:38:27 which weren't -- which employees and staff at Eastwood were involved in the care and which weren't, correct?

A. No.

MR. SCHALTENBRAND: Which MUI? 17:38:37

Which MUI? 17:38:38

MR. KRAUSE: Well we'll talk about the MUI revolving around Lorna Moeller's death.

Q. You wouldn't have known which employees were involved and which weren't, 17:38:45 correct?

A. Correct.

Q. And the person whom you would have directed that request to to find out who was involved would be LuAnne Busch, correct? 17:38:53

A. Correct.

Q. Did she ever give you the identity of the employee who was sleeping on the couch?

A. Did LuAnne?

Q. LuAnne Busch. 17:39:02

A. No, but I never asked.

Q. And just so I'm clear about the time frame for when this employee would have been sleeping on the couch, would this have been around the same time that the residents 17:39:09 reported to you Lorna Moeller was in her room, unassisted and calling out for help?

MR. FORBES: Objection to the form.

Q. If you don't know, you don't know.

A. Yeah, I don't think so. 17:39:23

Q. What makes you not think so? 17:39:24

A. The clients were reporting that it was an ongoing thing from the time she returned from the hospital until her death, and Marquita was the one that reported to the staff, 17:39:44 Marquita was with her that night, okay? The other staff was there in the building, so they wouldn't have known. I'm thinking it's two separate things because they just reported it, it was a more ongoing thing, the clients. 17:40:03

Q. All right. Do you recall if -- on how many occasions did you speak or interview Rita Freeborn, speak with or interview Rita Freeborn?

A. I can only remember -- I think it was only once. 17:40:26

Q. If your memo of May 25th, 2000 indicates that your conversation with Rita Freeborn was on May 25th, 2000 and that she resigned from Eastwood at the end of February 17:40:31 and that you contacted her at home and she was willing to help any way she could, then that would be the only time you spoke to her?

MR. FORBES: Objection to the form.

A. Well it would have been more than 17:40:42

once then, because I would have talked to her around the 2nd, 1st or 2nd, so it would have been more. 17:40:43

Q. When you talked to her around the 1st or 2nd of what? 17:40:50

A. February, I'm sorry.

Q. You wouldn't have spoke -- well Lorna Moeller didn't die until the 4th.

A. Right.

Q. You spoke to her on the 1st or 2nd? 17:40:58

A. Oh, gosh, it had to be after that. Thank you.

Q. Right.

A. It had to be the 4th.

Q. After the 4th, okay, and before the 25th of May, did you speak to Rita Freeborn or conduct any other interviews with Rita Freeborn? 17:41:09

A. You know, I'm thinking that she called our office, that she called my office, but I really don't -- I don't recall talking to her more than once or twice. 17:41:26

Q. When she called your office was this before or -- was this still in February? In other words, was this before or after she 17:41:42

left Eastwood? 17:41:43

A. I don't know.

MR. KRAUSE: That's all I have, thanks.

THE WITNESS: Thanks. 17:41:58

MS. TOSTI: I've got just one little follow-up.

(Discussion had off record.)

EXAMINATION OF PATRICIA FISHLEY

BY MS. TOSTI: 17:42:11

Q. When you did your MUI synopsis --

A. Yes.

Q. -- you incorporated a number of the findings from Dr. Eddy's report.

A. Yes. 17:42:22

Q. Is that a usual thing for you to do when you receive information from the state medical director, to incorporate it in an MUI synopsis?

A. This is the first time I've 17:42:33 received anything from the state medical director.

Q. Why is it that you incorporated that information in this MUI synopsis, why did you do that this time? 17:42:42

A. Based on his medical background, his medical expertise and his evaluation of this entire case. 17:42:45

Q. As an Ohio Department -- or Lake County Department of Mental Retardation and Developmental Disabilities was it typical for you to rely upon the state medical director's reports or findings, directives? 17:43:00

A. Not just medical director, but anybody at the -- some people at the state we would get direction from. 17:43:15

Q. Now we were talking about this individual on item number 14 that is just described as the staff reported that Julie did witness Lorna vomiting at six p.m., it's on page five of -- 17:43:30

A. Yes.

Q. -- defendant's exhibit number 2 under item number 14. That information, even if you can't specifically say it came from Rita Freeborn, did that information come from someone that actually was there at the time and witnessed Lorna vomiting? 17:43:41

A. I can't -- I can't think of another second shift staff person that I spoke with 17:44:04

other than Rita. 17:44:07

Q. But the person that you're referring to here was giving you firsthand information of what that person was observing at the time? 17:44:16

A. Yeah.

Q. Yes? Is your answer yes?

A. Yes.

MS. TOSTI: I don't have any further questions. 17:44:25

EXAMINATION OF PATRICIA FISHLEY

BY MR. FORBES:

Q. Do you have any training as a nurse?

A. No, I do not. 17:44:30

Q. Do you have any medical training at all?

A. Medical training?

Q. Training regarding how to care for people who aren't feeling very well. 17:44:36

A. Other than basic first aid and those things that --

Q. Would you say your training is equivalent to a resident care worker, the training they should receive? 17:44:48

A. Yes. 17:44:51

MR. FORBES: Okay, thanks. Thank you for your patience.

(Discussion had off record.)

MR. FORBES: Eric, signature? 17:45:09

MR. SCHALTENBRAND: She's going to waive. She'll waive signature.

(Deposition concluded.)

- - - - -

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.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 15th day of January, 2003.

Michelle A. Bishilany

Michelle A. Bishilany, Notary Public
within and for the State of Ohio

My commission expires January 11, 2006.

I N D E X

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.

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 (WRA)
ODMR/DD, Community MUI Registry Unit

RE: Death of Ms. Lorna Moeller

DATE: May 9, 2000

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 20/2/00 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

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.

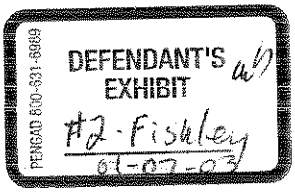
On 5/23/00, I again interviewed Eastwood nurse, Julie Warner. Also, in attendance was LuAnn Busch, Administrator; Lisa Shubert, Program Coordinator; and Staci Reigert, Home Manager.

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

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 then 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 regrading 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.

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.

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

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.

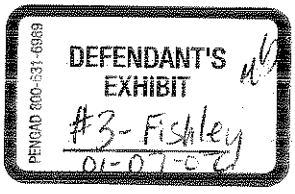
First paragraph: "Aftercare instructions were called to the Eastwood nurse due to not having residential staff available at time of discharge." This indicates to me that Ms. Moeller was discharged from the hospital without hospital staff having the opportunity to interview direct care staff as to Ms. 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 hemmorhoids." 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 ☒ No ☐	
DNR In Place: Yes ☐ No ☒	Documentation of DNR: Yes ☐ No ☐ N/A ☒	

Cause of Death:
Per Death Certificate:
1. Cardiac Arrest
2. Bowel Obstruction

Autopsy Yes ☐ No ☒

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 ☒ Not Preventable ☐

Discussion: Death determined to be to be possibly preventable if bowel obstruction had been diagnosed and treated when present.

PENGAD 800-631-6989
DEFENDANT'S EXHIBIT 44
#4 - Fishley
01-07-03

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.

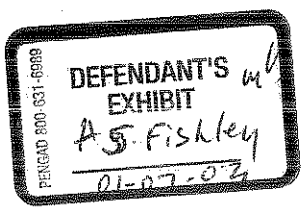
Case Disposition: **ODMRDD Current MUI Review Status:** Open
County Board Case Management Status: Open

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

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;

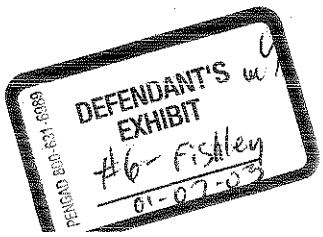
(M) The right to pursue vocational opportunities that will promote and enhance economic independence;

(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 # EWF

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: 2/11/00

B. Time: 16:30 Military

C. Day of Week
1. Mon.
(2.) Tues.
3. Wed.
4. Thurs.
5. Fri.
6. Sat.
7. Sun.

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 foriegn object
8. Unexplained body mark
9. Missing/AWOL
10. Physical Assault
11. Verbal Threat/Assault
12. Sexual Assault
13. Sexually explicit behavior
(14.) Other: Illness

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:

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: Illness

H. Others involved (Aggress., 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.

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 Glenbrook staff who agreed to come to Eastwood + finish fixing + serving supper 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 dozed on + off.

Client was admitted to Lake East + kept overnight for observation.

PEMCAD 800-631-6989

DEFENDANT'S EXHIBIT
#7 - Fishley
01-07-03

Consumer's Name: Lorna Moeller

1/21/00

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? (Y or N) — Y

N. For Medication/Treatment Errors
1. Incorrect time
2. Incorrect medication
3. Incorrect dosage
4. Incorrect route
5. Incorrect individual
6. Omission
7. Transcription error
8. Medication
9. Stray Pills
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/Gaurdian: / / 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:	/ /	:	Military	Y/N	
Case Management:	2/1/00	10 :	Military	Y/N	
Program Director:	/ /	:	Military	Y/N	
Other:	/ /	:	Military	Y/N	

Q. Recommendations/Immediate Actions Taken:

2/1/00

FAXED

Lake County Board of Mental Retardation - Developmental Disabilities

SUPPORTED LIVING/RFW PROVIDER CONSUMER INCIDENT REPORTING FORM

CONFIDENTIAL

ORIGI

Consumer Name: Lorna Moeller Consumer SS# 270 64 1069 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: 02/02/00

B. Time: ___ : ___ Military

C. Day of Week
1. Mon.
2. Tues.
(3) Wed.
4. Thurs.
5. Fri.
6. Sat.
7. Sun.

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 foriegn 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: ___

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 (Aggress., 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 everyday. She will be returning to Eastwood this afternoon via ambulette.

FAXED

Lake County Board of Mental Retardation - Developmental Disabilities

SUPPORTED LIVING/RFW PROVIDER CONSUMER INCIDENT REPORTING FORM

CONFIDENTIAL

ORIGINAL

Consumer Name: LORAA MOELLER Consumer SS# 270641069 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: 2/3/00

B. Time: 22:00 Military

C. Day of Week
1. Mon.
2. Tues.
3. Wed.
(4) Thurs.
5. Fri.
6. Sat.
7. Sun.

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 foriegn object
8. Unexplained body mark
9. Missing/AWOL
10. Physical Assault
11. Verbal Threat/Assault
12. Sexual Assault
13. Sexually explicit behavior
(14) Other: ill-vomiting

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: Kitchen
12. Other:

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 (Aggress., 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.**

Staff was informed upon arrival of shift, that resident had returned from hospital/A 2/2/00 and that she had been vomiting. Resident was seated at Kitchen table sipping ginger ale then 2hrs later STAFF assisted client in Changing her clothes due to spots of vomit on her clothing. Staff ask client if she was o.k 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 o.k or felt in pain. Client stated she only felt tired ~~Lab~~ Lab personal arrived and was unable to draw blood from Client. Lab personal stated due to her hospital visit her veins were "blown out" Staff took clients Blood pressure. Blood pressure read 9%0 Staff called nurse (TW) Nurse instructed Staff to take clients temperature. Her temperature was 99.8 Staff informed nurse that Client had a brown Colosing 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 @ 10:00 Time: 22:00 Military Signature/Title: Marquita Barton RCW

FAXED

Lake County Board of Mental Retardation - Developmental Disabilities
SUPPORTED LIVING/RFW PROVIDER
CONSUMER INCIDENT REPORTING FORM

CONFIDENTIAL

ORIGINAL

Consumer Name: Tonia Noelle Consumer SS# 270 64 1009 Department Code # FCW

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: 2/4/00

B. Time: 9 :00 Military

C. Day of Week
1. Mon.
2. Tues.
3. Wed.
4. Thurs.
5. Fri.
6. Sat.
7. Sun.

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 foriegn 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: Bedroom
12. Other:

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 (Aggress., 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.

This morning TM came into living room covered in brown vomit, asking for help + saying that she was very tired. A (PC) helped TM back into her room and helped her clean up - A then called JW to notify - JW asked me to dress TM so she could take her to Dr. I did this, then TM wanted to lay back down in bed. Appx ½ hr later TM walked into kitchen + sat at table asking for something to drink - TM had a few sips of water + began vomiting again - JW talked to Dr. Hung to have TM admitted to Hosp. Dr Hung said to get Magnesium Citrate to clean her out - JW left to purchase medicine - A (TL) walked TM back to bed - When JW returned A (PC) got potable Toilet for TM + proceeded to help JW with TM. TM needed to be held up she was so weak - JW told me (PC) to call 911 - as TM was vomiting out of nose + mouth at this time. LB was notified - TM'D seemed to expire at this time - Ambulance came + tried to resuscitate when paramedics left they said TM was DOA - TM transported by ambulance to Lunsen Hosp

Date Completed: 2/4/00 Time: 9 :00 Military Signature/Title: Tracy Chew