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IN THE COURT OF COMMON PLEAS

OF SUMMIT COUNTY, OHIO

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CHARLES G. PERE, et al.,

Plaintiffs,

vs

Case No. 03-07-3984
Judge Burnham-Unruh

THE LEDGES OF ROCKYNOL, et al.,

Defendants.

- - - - -

DEPOSITION OF ROBBIN MOORE, R.N.

THURSDAY, NOVEMBER 14, 2003

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Deposition of ROBBIN MOORE, R.N., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Tipping Co., L.P.A., 525 N. Cleveland-Massillon Road, Akron, Ohio, commencing at 10:12 o'clock a.m. on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff

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On behalf of the Defendant Rockynol

Tipping Co., L.P.A.
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On behalf of the Defendant Amanambu

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ROBBIN MOORE, R.N., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF ROBBIN MOORE, R.N.

BY MS. TRESL:

Q. Robbin, we met a little earlier. I'm Jackie Tresl. I represent the Pere family, John and Gene, his wife.

A. All right.

Q. Have you ever had your deposition taken before?

A. No, I have not.

Q. For the record, state your name and address.

A. Robbin A. Moore, 417 South Chestnut Street, Ravenna, Ohio, 44266.

Q. Just a few ground rules. Your attorney probably went over this with you, but I would like to remind you. First of all, you understand you are under oath to tell the truth; correct?

A. Yes.

Q. If I ask you a question that you

don't understand, will you stop me and tell me you don't understand it?

A. Yes.

Q. And if you answer the question, may I assume that you understand what I was asking you?

A. Yes.

Q. I ask that you say yes or no rather than shaking your head or going uh-huh or uh-ugh so that Vivian can get it down correctly.

A. Okay.

Q. I will ask that you let me finish asking my question before you answer.

A. Okay.

Q. And I will try and give you the same courtesy, not to interrupt until you are done answering.

A. Okay.

Q. You said you have never had your deposition taken before. Have you ever been involved in a lawsuit?

A. No, I have not.

Q. Tell me a little bit about your employment, where you work right now, where you worked in the last ten years, let's say.

A. I graduated nursing school in 1999. Do you want me to go prior to that or just from since nursing school?

Q. A little bit back.

A. While I was in college I worked at CVS pharmacy as a pharmacy tech and I was there for two years prior to finishing school. And then out of graduation I worked at Crown Center Nursing Home in Hudson. I worked there for a year and from there I went to an agency and worked the agency work for a couple months, maybe six. I would have to write it all down and get the exact dates. And then I went to work for Rockynol and worked for them for approximately 18 months, and then I went to Robinson Memorial where I'm presently employed as a med/surg nurse.

Q. What year, what month and year basically did you start at Rockynol, if you remember?

A. I don't know the exact date. I don't recall the exact date. I don't even recall the month. Because I worked for Rockynol as an agency nurse, so at the time I was there, and I actually started full-time employment, I'm not

sure.

Q. At the time you cared for Mr. Pere, were you agency or employed there?

A. I was employed.

Q. Do you know approximately how long you had been employed there when you were taking care of Mr. Pere?

A. He was there in when, February?

Q. Correct.

A. It might have been a year. It might have been a year. They can probably provide you the exact hire dates.

Q. I was going to ask you if you have a resume. Perhaps you could provide that to your attorney and your attorney could provide that to me.

A. I don't have one, but I could have one made up.

Q. And when did you go to Robinson Memorial?

A. I started at Robinson in May of 2002 because May of 2003 it was one year.

Q. You work as a med/surg nurse?

A. Correct.

Q. Is that full time or part time?

A. Full time.
Q. What shift?
A. Second shift.
Q. When you were at Rockynol in the time in question, February, were you full time employed there?
A. I was full time, second shift.
Q. Second shift. And prior, you said you graduated from nursing school. I assume that's registered nursing school?
A. Correct.
Q. What school?
A. Kent State University.
Q. Do you have your bachelor's then?
A. Yes, I do.
Q. What did you do prior to that? Were you in the medical field prior to that other than working at CVS pharmacy?
A. No. I did some home health aide work, but I just had a lot of life changes and I was on welfare at the time I was going to medical school.
Q. Nursing school?
A. Uh-huh.
Q. Did you have any special training in

geriatric nursing?
A. Just the courses that I had taken through the university.
Q. So no certifications in gerontology or anything like that?
A. No.
Q. What about BLS certification, are you currently --
A. Yes.
Q. Were you at the time that you worked at Rockynol?
A. Yes.
Q. Have you published anything?
A. No.
Q. Have you given any lectures?
A. No.
Q. Have you ever been disciplined as a nurse?
A. No. Can I ask you a question?
Q. Sure.
A. What do you mean by disciplined?
Q. Have you ever been asked to leave the hospital? Have you ever had to account to the board of nursing for any reason?
A. No, I have never had to account to

the board of nursing for anything. That's why I wasn't sure about your question, how clear. I mean, I have been given like our little write-ups, you know, for medication error or something, I signed one of those.

Q. One time?

A. There was one at Crown Center. I am thinking back.

MS. BREAUX: I'm going to object to the relevance of that. You can answer.

A. There was one at Robinson Memorial, but it wasn't a medication error, it was the way that our MAR's are, you have to put a line through whether you gave the med and you circle it whether it wasn't and I circled that it wasn't that I had called pharmacy and it wasn't available, but we are supposed to put another circle to indicate to give it the next time and I did not do that. The pharmacy was aware we did not have the medication to give.

Q. Any situations like that while you were at Rockynol?

A. None. I had none at Rockynol.

Q. For today's deposition, other than talking to your attorneys, what have you done to

prepare for today's deposition?

A. I have read over the notes to try to refresh my memory on who the patient was, because when I was first contacted, the name wasn't even familiar to me. Other than meeting with our attorneys, I really haven't done anything.

Q. Did you talk to your director of nursing from Rockynol?

A. I just called -- no, the director of nursing is Carrie. I don't know what her married name is. She was not available to me.

Q. Who did you call to discuss today's deposition?

A. I spoke with Mary Williams. Not in regard to today's deposition, but just to the fact that I had gotten the letter from Tipping and Company and asked her what it was in regard to and that was it. Our conversation wasn't but five minutes.

Q. Did you review any medical literature for today's deposition?

A. No, not medical stuff. We just had the notes that we had gone over, that was it.

Q. Any policy and procedure manuals?

A. Prior to this deposition, no.

Q. I'm assuming from what you just told me that you have no independent memory of Mr. Pere?

A. I didn't recall his name, but I did recall after speaking with Mary Williams the incident about his death. I remembered that incident. I remember hearing about it, so that's how I made the connection between his name and him.

Q. When you made that connection, did you remember any of the issues that were related just to your care of him?

A. No. At that time, I did not have the copy of my notes and so I had no recollection.

Q. And after reviewing your notes, do you have any independent recollection of him?

A. It's really minimal. I had two interactions that are documented. One actual interaction that's documented and the other one is about following through with a fax from the doctor.

The only thing I can recall about him, per se, himself, as an individual, was I remember he was a very tall gentleman and he was

just very quiet.

Q. Why do you remember specifically that he was very tall?

A. That's just -- I just remember that he was tall, because our aides are shorter than I am and I remember when they were beside him, they were like under his armpit, and it was just -- that's all I remember is that he was tall.

Q. And very quiet?

A. Yeah. He was not very social as far as coming out of his room and wanting to make friends. He was just happy to be in his room. So I wish I could be more specific, but I didn't have very much interaction with him.

Q. How did you learn about Mr. Pere's death, since you sort of touched on that a little bit?

A. When I came in to work. I believe I worked the day of the accident on second shift.

Q. And tell me a little bit about how you learned about his death; who told you, what was said.

A. I was in report. We were getting our shift report and the RN supervisor at the time had said what had happened in the morning.

Q. What did she say had happened?
A. She had said that Mr. Pere had fallen and there was a lot of blood and that he had died. I had read the nurse's notes at the time, but I couldn't recall reading the nurse's notes until I read them again.
Q. And after you read them, do you remember anything more than what you just said that she said to you in report?
A. She said that 911 was called and that she had told me that Mr. Kaylor was very upset. Mr. Kaylor was his roommate at the time and he was prone to hallucinations, that's why he was brought over to us, and he was having violent hallucinations and they were concerned at the time that because he had actually seen the blood this time that there was going to be a problem between him with reality. We were trying to reorient him between the reality and the fiction of his hallucinations, so they were concerned at that point. She had said something.
Q. Do you know if you were successful in reorienting him?
A. No. He continued to have hallucinations. It was a problem. But I don't

think that they were associated back to the blood issue with Mr. Pere, because, like I said, he was having hallucinations prior to coming to the Ledges. When he left us, let me just say, when he left us, he was still having hallucinations.

Q. Do you know if he went home after that?

A. I think I left employment. I think Mr. Kaylor was still at the Ledges when I left employment. I mean, I know what they had anticipated, what they were going to do with him, but I don't know whether or not that's what happened.

Q. Did Mr. Kaylor ever have any violent outbursts other than in his mind?

A. No.

Q. He never had any --

A. He was very gentle and meek.

Q. I see. But we do know, and correct me if I am wrong, that he is the one who called 911 initially?

A. I know that only from reading that and what the supervisor told me. I did not have any firsthand knowledge.

Q. Did you talk to Mr. Kaylor after the next day or the days following about what he had witnessed and what he saw?

A. Just briefly. Just, you know, to see if he was okay, you know, ask him if he had any questions and he said that he didn't. I didn't ask him any details about what had happened, because I felt that the supervisor already had done that, but I was there to just see if he was okay. You know, we try to do other things to entertain him to try to keep him busy and we tried not to let him be alone too much.

Q. So did you give him another roommate fairly quickly?

A. That, I don't know. You would have to check with them.

Q. Before we get into your records, I want to ask you some basic medical principles and then we will do your records and we will be done, okay?

A. Okay.

Q. A few just basic principles from a nursing standpoint. Tell me as far as a nursing diagnosis what orthostatic hypertension is.

A. The body's inability to correct blood

pressure on changing positions.

Q. And what effect does orthostatic hypertension have on a patient when he stands up?

A. The blood pressure drops and he becomes dizzy.

Q. And how does that affect, if you are caring for a patient with orthostatic hypertension, if it does affect, the way you care for him?

MS. BREAUX: You can go ahead and answer. Objection.

A. An individual patient or Mr. Pere?

Q. An individual patient. These are just basic medical principles.

A. I as a nurse would assess the patient's ability to change position and would instruct them on how to get up at the side of the bed and sit for a few minutes before they would attempt to stand up so that the body has a chance to acclimate the blood pressure.

Q. And if they don't sit at the edge of the bed and acclimate themselves or their blood pressure, what could happen if they --

MS. BREAUX: Objection.

A. They could fall.
Q. I believe Mr. Pere was hard of hearing, but let's talk globally about patients who are hard of hearing. How does a patient who is hard of hearing, how does that change the way you care for them as a nurse?
MS. BREAUX: Objection. You can answer.
A. I just speak louder and ask them if they understand what I'm saying to them. And if we know whether the hearing is one side or the other, you know, we direct the speech to the other ear. And eye contact. Sometimes if they had been hard of hearing for a while, they can read lips.
Q. How about in a patient that you care for who has known confusion, how do you adapt your nursing care for that sort of a patient?
MS. BREAUX: Objection. You can answer.
A. It's based, it's on each individual patient. It depends on the degree of confusion that they have. Sometimes even with a confused patient, as to their name, they can still function, they can still move about their room,

they can still do things. If the confusion is to getting up and being really confused to where it affects balance and mobility, then you offer stand-by assistance or hands-on assistance, whatever is needed. It's individual, you know, care. You do that initial assessment and then you go from there.

Q. If you have a patient that you know has intermittent periods of confusion, how do you determine when you offer that assistance for the things that they might need?

MS. BREAUX: Objection. You can answer. I'm just going to state a basic continuing objection to all of these.

MS. TRESL: To nursing care, that's fine.

A. Can you repeat the question?

Q. Sure. In a patient who you know has intermittent periods of confusion, I believe your testimony was that you offer assistance relative to their individual confusion.

How do you determine if they have intermittent periods of confusion? What kind of assistance do you offer in terms of people in the room, caregivers in the room, one person,

two person?

A. It's just the interaction with the patient. I deal a lot, I still have a lot of geriatric patients up at the hospital and observation is a good way to tell whether or not -- observation is a function ability role. As far as confusion, that's the mental status of the patient, and to get a better handle on that, you have to have the verbal interaction with them. And then you base it on what kind of answers you get.

It's not always a good situation with a confused patient to try to keep reorienting them to the present, because it creates a state of anxiety and sometimes you just go with their confusion to help them, to help keep them calm, and you can sometimes on a confused patient that has agitation, you can get, you can make marks with them or get them to do what they need to do by jumping into their state, their mental state. And we do that quite frequently. I do that quite frequently, I should say.

Q. And how do you determine -- I'm just curious, when you have a patient that has periods of confusion, how do you know when it's

okay for them to be alone, when their confusion won't affect, let's say, their activities of daily living? How do you balance that?

A. Just through observations. Getting to know the patients. That was one thing that you could do, that was one of the things that I really liked about the nursing home setting is that you got to know the patient on a one-to-one basis so you know what they were capable of and weren't capable of.

Q. In general, how long does it take you to get sort of comfortable with knowing their limitations?

A. After the initial assessment, you have some idea on what you feel that you might be comfortable with. If we have a patient who exhibits the same behavior day after day, you get comfortable very quickly. If it's someone who in the morning they are fine and in the afternoon they are confused, or people with like sundowners, that, you know, it takes a while, because their moods are constantly changing, so it takes a little while to get to know them.

I would like to think that it was probably -- and I'm saying probably because I

saw the patients when I worked at Rockynol five days a week. So I got to see them more often sometimes than the family members. And I took the time to just get to know them and get to know the family members, and I get a lot of information back, feedback from the family, you know, on what they feel the patient is capable of.

And we use the term residents at Rockynol rather than patients. Because that was their home versus the hospital.

Q. Did you feel as if you had gotten to that level of knowing Mr. Pere in the time that you worked with him, if you can remember?

A. No. I had only been in the room with him, according to my documentation, the one time. And I always go in and introduce myself, no matter whose room I go into, and I would do it even day after day, because they don't always remember who you are. And the one time that I was in the room, there was family in with him, and I cannot recall being in his room at any other time.

Q. So I think you are saying you hadn't developed that level of comfort that we spoke

about?

A. No. I didn't know him well enough, no.

Q. Back to more global nursing care issues, dizziness. When you have a patient that has intermittent or chronic dizziness, how does that affect your nursing care?

MS. BREAUX: I renew my objection. You can answer.

A. Can you repeat the question?

Q. That's fine, you are doing great. When you have a patient that has intermittent dizziness, how do you alter, fit your nursing care around that nursing diagnosis?

A. Well, if we know that, the patient is able to verbalize that they are dizzy, we are there. If we know that the patient is known to having dizziness, then, like I said, we observe and see how they do with their ADL's and we provide walkers, call lights, bed rails up that they can help to grab on to and hold on to to assist them, because we can't be in the room 24/7, so we try to make the environment at least safe for them.

Q. When a patient is on a lot of

medication, antihypertensives, antidepressants, sometimes those cause dizziness, would you agree?

MS. COEY: Objection.

A. Yes.

Q. Does your nursing care change at all relative to that or are medications more left to the doctors discretion?

A. Prescribing of the medications is left to the doctors. But if we see an ill effect from -- especially if a patient is on multiple medications, it's very hard for me as a nurse to say, oh, it's this specific medication.

But if we see adverse effects, we would notify the doctor that, you know, he is behaving differently or that he is complaining, and a lot of times it's just like the nausea and vomiting, so we just monitor for effects. We monitor for the effectiveness of the medication through vital signs.

Q. And would confusion and dizziness potentially be one of those adverse effects that you might notify the doctor if you thought they were related to multiple medications?

MS. BREAUX: Objection.

MS. COEY: Objection.

A. I would notify the doctor of the confusion or dizziness even if I did not think it was related to the medication.

Q. Can we agree that a patient who is dizzy has an increased risk of falling?

MS. BREAUX: Objection.

MS. COEY: Objection.

Q. You can answer.

A. Yes.

Q. Globally, not specifically to Mr. Pere, how do you decrease the risk of falls in a nursing home since, as you said, you can't be with him 24/7?

MS. BREAUX: Objection.

A. In Rockynol, particularly, if a patient has had a history of a fall, we use bed alarms. Or the fall risk assessment that's done upon admission, if they score high on that, then we put our precautions into place immediately.

Q. Do you know if Mr. Pere had those precautions in place?

A. I know the fall risk assessment was done on him. I don't believe he warranted those precautions. I mean, as in the alarm. He did

not warrant an alarm, a bed alarm at that point.

Q. But you did tell me that there were two ways that you determined if a patient warranted a bed alarm. The first was if they had a history of falls; correct?

A. If they had a fall, not a fall previously. If they had fallen in the nursing home. Even we can have a patient who does not have a high risk for falls that has a fall, and then we put a bed alarm on them at that point. And the other one is with the fall risk assessment.

Q. And what if they had falls previous to Rockynol that you were aware of, would that make them a candidate for bed alarms or not?

MS. BREAUX: Objection. You can answer.

A. I believe that is covered in the fall risk assessment section that says previous falls, and then there is a score that you are given, so you do take that into account, but it does not necessarily mean an automatic alarm.

Q. Just educate me a little bit about bed alarms. Where are they and how do they work?

A. The MDS nurse has them in her office and we have access to them that we can get them at any time. And it's a mechanism that is placed on the bed; it's by velcro, and there is a string. And then it clips on to the patient. And as long as they are in bed, it allows them the mobility to turn without it going off.

But if they attempt to get out of bed, the string becomes disconnected from the alarm, which is most of the ones I have seen have been a magnetic piece, and then the alarm goes off. It alarms us the patient is trying to get up without assistance.

Q. And how commonly do you use bed alarms?

A. I don't understand what you mean. They are common in the fact that we do use them. They are a deterrent, but they are not necessarily on every patient. I lost my thought, I'm sorry.

I can't give you like the percentage, like we use them 75 percent of the time. You know, we always seem to have enough of them on the facility.

Q. So that was my next question. You

have never needed one and gone to the MDS nurse and she doesn't have one for you?

A. Not specifically, I have not, no.

Q. And they are frequently on patients, you just don't know how many, the percentage?

A. Right. It depends on the degree of help needed for the patients in the nursing home, which changes all the time, so I don't know the percentage.

Q. So a patient who has dizziness and confusion and a history of falls might be a candidate for a bed alarm; is that correct?

MS. BREAUX: Objection.

A. Based on the fall risk assessment.

Q. We will get to specifics. Some terms that I came across when I was preparing for today's deposition: Risk factor intervention strategy. Did you have that at Rockynol at the time that you were there that you were aware of?

A. I may not recognize it in those terminologies, but we do have a care plan.

Q. How about a falls prevention program?

A. Yes.

Q. Tell me a little bit about the falls prevention program from a nursing point of view.

A. For Rockynol?
Q. Correct.
A. I would have to look at the policy and the procedure book for that because it's been so long ago that I have been there, I don't have the specifics.
Keep the patient safe from harm. I mean, that's the basics of most of it.
Q. And the physical therapist plays a role in the falls prevention program; is that correct?
A. I know they are involved, but I don't know -- I would have to guess at an answer and I don't want to do that.
Q. That's fine. Let's start with the falls risk assessment, if your counsel wants to give you a copy or I can provide you a copy.
MS. BREAUX: I don't have copies with me.
MS. TRESL: Maybe I am not being specific enough. Let her see your copies.
MS. BREAUX: I do have a copy.
Q. When I went through this, now, obviously, I have a fairly good handle on Mr. Pere, because I represent his interests.

This checklist did not seem to accurately reflect where he was when he was admitted. I'm assuming because you did not fill this out -- is that correct?

A. Correct.

Q. -- you can't really address the particulars of this?

A. Right, correct.

Q. But I would like to just ask you sort of generally, you do fill these out if you are the admitting nurse?

A. Correct.

Q. So you are familiar with this form?

A. Right.

Q. In a patient who comes in with confusion -- and just take my word for it, he did, for the purpose of this question, and if I turn out to be wrong, then the question that you answer won't matter. But assuming that he is alert, with confusion, is there a reason why the mental status box would not be checked when he came in?

MS. BREAUX: Objection.

A. That would have been the admitting nurse's assessment after speaking with the

patient. She may not have felt that it was necessary.

Q. So if you were doing an initial assessment and you talked to the patient, at the time the patient seemed alert, you would be comfortable not checking this without finding out if he had had periods of confusion prior to admission?

MS. BREAUX: Objection.

A. Personally, I would go on my assessment right there at the time. You know, I asked person, place, time and circumstances. If a patient can answer those effectively, then, no, I would not write with intermittent confusion if there was none present. It is my understanding that you go on your initial assessment of the patient and not on the history of, except under fall history.

Q. And if you are caring for the patient and, let's say, 24 hours have gone by and you see in the records that there are intermittent periods of confusion that nurses are observing, then does some nurse, is it the admitting nurse, is it the nurse of that day, does someone have a duty to come back and then check the boxes, as

the status of the patient's mental status is better known?

MS. BREAUX: Objection. I'm just going to object to all questions related to this document.

MS. TRESL: That's fine. You can go ahead and answer.

A. The original fall assessment sheet, from my understanding, is not gone back and revised. A new assessment, if there continues to be a problem, would take place instead, and also, with each, if a patient has a fall, that's what these additional columns are for. If they have a fall, then we would reassess at the time and see if the score has changed.

Q. I see. So your understanding then is as the admitting nurse admitting the patient, as you admit them, you do this initial assessment, and the assessment in terms of their fall that they're likely that they will be at higher risk for fall is not changed again on this piece of paper until they actually fall at Rockynol?

A. Not on the piece of paper. But that's not to say that we are not aware of some problems. If we see there is a problem, because

it's communicated through shift, if there may be a potential problem, we speak with the doctor and the unit coordinator and then they determine at that point what the next step is.

Q. I think we will just leave it at that.

I would like to go to side rail assessment if we could discuss that. If you have a copy of that.

MS. BREAUX: What is it?

MS. TRESL: Side rail assessment. You can use my copy.

Q. As a nurse filling this out, explain to me what that means.

MS. BREAUX: I'm going to object to this document, as well.

MS. TRESL: That's fine.

Q. First, let me ask you, are you familiar with that document as part of the Rockynol chart?

A. I am familiar with the document.

Q. Is that something that you would typically fill out, I'm assuming if you were the admitting nurse?

A. As the admitting nurse, it's part of

the admitting package.

Q. If you could just explain what that sentence means. I want to understand globally.

MS. BREAUX: What sentence are you referring to?

THE WITNESS: Number seven.

A. Aware of inability to stand -- a patient, those that have limitations, that's the way I would interpret that sentence.

Q. So again, this is the nurse asking the patient, do you know whether or not you are able to stand and that would be the patient answering, not the nurse going back and looking at a history, it would be your initial assessment, communicating?

A. Right.

Q. So by reading --

A. I don't know how she got that answer. You know, I don't know if she asked him. I don't know if it was just an observation or how she got the answer.

Q. For the record, that would be the side rail assessment dated 1-29-02 by L. Lord, LPN.

This caregiver plan of care, where

does this fit in -- I apologize because you are the first nurse we have in this case, so you are sort of the person that has to educate me. Where does this caregiver plan of care come into --

A. These were kept in like a cardex so that any of the nursing staff could reference it to see what kind of care the patient needed; whether it was a stand-by assist, whether it was assist by two, whether they were independent, what kind of help they needed with food and with eating.

Q. And I believe that's dated January 30th, 2002; is that correct?

A. Correct.

Q. And could you just tell me reading across there, in terms of transfer and mobility status, what does that caregiver plan of care say?

A. It says supervision.

Q. And as a nurse at Rockynol, just educate me as to what that means.

A. For me it would mean observation or assistance, whatever was deemed necessary.

Q. And how would you determine what was

deemed necessary in a patient that you hadn't known for very long?

A. I would watch the patient first to see what they could do for themselves and then offer assistance if it was needed.

Q. And a patient who when you were observing was confused, markedly confused, globally, what would you do for a patient like that based on the caregiver plan of care?

MS. BREAUX: Objection.

Q. You can answer.

A. I would use verbal queues to see if they needed it. Mental confusion does not necessarily mean they weren't able to ambulate. You can have a completely confused patient who is able to walk around and it does not necessarily mean they are going to have falls.

Q. And what if you took that same patient with a lot of complaints of dizziness, would that change then? How would you assess that?

MS. BREAUX: Objection. You can answer.

A. Again, it would be through observation and to be there to assist if

assistance was needed.

Q. Thank you. And if I could just, this immediate needs care plan at risk for accident and injuries and followed by the acute care plan, both dated 1-29, we will do them both at once.

Can you tell me there in the goals, is this typically something you would fill out as the admitting nurse of a patient of Rockynol? Are you familiar with this document?

A. No, I'm not familiar.

Q. You have not seen it?

A. No.

Q. What about the acute care plan?

A. That is put on the charts of every patient.

Q. So you would be responsible for this if you were the admitting nurse?

A. Yes.

Q. And can you tell me here under interventions, can you read them off for me for the record.

MS. BREAUX: Objection to this document.

A. Monitor versus assessment. Oh,

monitor vital signs and assess, orient to room, call lights, routine. Administer medication, monitor risk for falls. PT, physical therapy. OT, occupational therapy. And ST, which I would assume is speech therapy.

Q. I would like to just discuss in a little more detail monitor risk for falls. If you were the admitting nurse and you were writing monitor risk for falls, what would that typically mean in terms of how you cared for the patient over a period of time?

MS. BREAUX: Objection.

A. I would monitor his risk of falls through his ability to transfer, to stand up, the gait, whether or not there was any leaning while he was walking, or complaint of dizziness.

Q. So if he complained of dizziness, how would that change, if at all, the way you were monitoring his risk for falls?

A. I would have him just slow down and stop and see if the dizziness was a chronic problem or if it was intermittent, if it was just passing, just to try to get him to a safe point so he could continue.

Q. And if you knew that it was chronic,

would that change anything?
A. Yes.
Q. And what would it change?
A. It would just change, if you knew it was a chronic dizziness problem, the patient would be instructed not to get up without first waiting for assistance. And using the call light, making sure that the call light was within reach at all times.
Q. And what if that same patient had intermittent bouts of confusion, would you be able to rely on the fact that they would use the call bell if they needed to?
MS. BREAUX: Objection.
A. It would not be 100 percent reliable, no.
Q. Would you have then a plan that you would follow based on that?
A. I don't know.
Q. Would a bed alarm be something that might be considered in a patient who has confusion and dizziness?
MS. BREAUX: Objection.
A. A bed alarm I feel would be appropriate if they had confusion all the time

without periods of orientation, because they wouldn't understand safety-related issues.

Q. But if sometimes they could understand them but sometimes they couldn't and they were dizzy, they would not be a candidate for bed alarms?

MS. BREAUX: Objection.

A. I don't know what Rockynol, where they make the determination. A lot of times we would have what we would call nursing judgment, and if our patient was confused, for me, because I worked evenings, if I had a patient who is confused in the evening and I felt that it warranted the device, I would put it on a patient.

Q. So you don't need a physician's order then for a bed alarm?

A. No. Well, we have, I think it's 24 hours in which to get the order.

Q. And the registered nurse can make that decision on her own without going to a charge nurse; is that correct?

A. Correct.

Q. So it's an independent nursing judgment for the nurse who is caring for the

patient at the time?
A. At the time.
Q. And if I could just turn your attention to the MDS. And I'm assuming -- I'm just going to give you a copy.
Now, typically, is this filled out by the admitting nurse? I didn't think so. This looked to be filled out by someone different. Who fills this out?
A. The MDS nurse.
Q. Tell me what her role is at Rockynol, if you know. Does she care for --
A. I don't know technically, you know, what her position is and her duties, but she would, after going through the chart, help make assessments for care plans as to the type of care needed for the patient. I think it's an insurance thing.
Q. Assurance?
A. Insurance.
Q. Is she in a fairly reliable position to help make these assessments? In other words, is this something that you would rely on her assessment and her MDS?
A. Yes.

Q. One thing I didn't ask you. What effect does chronic -- speaking globally, a patient you have that is elderly at Rockynol or a geriatric patient, who suffers with chronic bladder incontinence or bowel, what effect does that have on the way you care for them as a nurse?

MS. BREAUX: Objection.

A. We offer the patients to wear a brief that is changed so that they don't have urine and stool everywhere, and then our skin care protocol kicks in when there is somebody who is incontinent; like a barrier type of cream to prevent skin breakdown.

Q. Is there any correlation in a patient you are caring for with chronic incontinence in terms of maybe restlessness to try to maybe get to the bathroom, or are they generally comfortable just staying in their brief in bed?

MS. BREAUX: Objection.

A. It depends on the mental status of the patient.

Q. Well, elaborate. You tell me.

A. A more alert patient would be uncomfortable in the situation. A confused

patient doesn't seem to know.

Q. So you don't notice any correlation between a patient trying to get up to the bedroom who has frequent incontinence versus a patient who does not?

MS. BREAUX: Objection.

A. Restate your question.

Q. Sure, I will put it in terms of myself. I was thinking if I was going to be incontinent or noticed I was incontinent, naturally I would find myself jumping out of bed to try to get to the rest room. In terms of gerontology patients --

A. We do see that.

Q. Tell me how you see that. How is that manifested?

A. They verbalize they need to go to the bathroom and even though you tell them you have a brief on, it's okay, they insist that they want to use the bedpan or get up and go to the bathroom, and we offer a bedside commode or assistance walking to the bathroom.

Q. And if someone is not there at the time, because you can't watch them 24/7 as you said, and they have that urgency, typically what

do they do?

MS. BREAUX: Objection.

A. They can get up and go without assistance.

Q. So I think we have established that this is the MDS; is that correct?

A. Correct.

Q. Minimum data sheet. You are familiar with this?

A. I am not familiar with the sheet, no.

Q. Is this something that would be on the patient's record that you were caring for?

A. The MDS's were available on the floor, yes.

Q. But that's not something you typically relied on in your nursing care; is that correct?

A. It was not part of the immediate charting that I looked at, no.

Q. At some point, does the nurse caring for the patient look at this or is this more just really an insurance document?

A. I mean, I have looked at them. I mean, I have read through them. If I have a patient who is having difficulty that I feel

there might be some changes, I will pull them down and look at them to see where they were beforehand. Or most of the times, I would just call the MDS nurse -- we had two of them there on the floor -- and ask them their opinion on what we should do.

Q. And if the MDS nurse assesses a certain level of help that a patient needs for assistance in mobility, is that something that is reliable, do you believe, or is she basing it on something that is not the same sort of data that you rely on?

A. You would have to ask her directly. I'm not sure what she bases her assessment on versus what my assessment is based on.

Q. I think those are all the global charting questions.

You have your notes in front of you. Did we give them to you?

A. I didn't bring them, I'm sorry.

Q. That's just fine. I have plenty.

(Recess had.)

Q. I put in front of you my copies of what I believe are your two sets of entries. Confirm that for me, if you would. Does that

look like what we have been talking about?
A. Yes.
Q. And for the record, that would be what are these, nursing notes? The top of the page dated 1-30-02 and the second page is 2-01-02.
A. Correct.
Q. In relation to the nurses' station, where is room 122-2, assuming there is a nursing station?
A. There is a nursing station. Room 122-2, is that his room?
Q. Correct.
A. It is out the door and -- well, the nurses' station is like here, okay. There is --
Q. Why don't you draw me on a piece of paper. Because when I look at the record, I won't know where here is. We can give it to Vivian and she will have it for us.
A. This is to the best of my recollection, okay?
Q. Great.
A. The nurses' station is this room here, which is off of a hallway.
Q. Okay.

A. The main doors are down here, okay? There is an entertainment center here. I believe the room in question is right about here.

Q. And if you would put entertainment there for me.

A. This is a common area.

Q. Okay. And maybe put the nurses' station there.

A. This is nurses' station.

Q. And then how many rooms are between, if you remember, the common area and 122-2?

A. I believe his is the first room. This is like a wall. And I think right here is emergency doors, fire doors, and I believe it's the first room.

Q. And how many rooms more or less are there in this hallway?

A. I can't recall the exact number of rooms.

Q. Like five or like 40?

A. Maybe like 12. I don't know exactly the number of rooms.

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(Thereupon, MOORE Deposition

Exhibit 1 was marked for purposes of identification.)

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Q. One more question before I get into the notes -- I keep saying I am going to -- but I wanted to ask you. Dr. Amanambu, or all doctors, in general, who determines -- does the doctor sort of tell you, nursing, the level of activity that he expects his patient to be at or is that a decision that nursing makes and if they need some guidance contacts the doctor?

A. I don't recall exactly how it is at Rockynol, whether activity level is actually like a nursing order at Rockynol or not.

Q. Well, I can show you and maybe if I show you --

A. Do you have a copy?

Q. I'll show you what I'm basing it on and you tell me. I'm assuming because his name is at the bottom and it says physician admission orders, I'm assuming that, and you tell me, is this the doctor writing this or is this the nurse writing this, which is a check by "up and assist" on the physician admission orders dated --

A. The nurse who filled out this documentation --

Q. Right.

A. -- I'm sorry, I am trying to remember. I am so used to getting written orders.

Q. Sure, just take your time and maybe you can help explain it to me because I'm not sure if it's nursing or the doctor.

A. I believe this looks like it was probably filled out by the nurse, but the doctor signed, so that would be his okaying everything that has been checked on here. This was a standard form that we used for all patients at Rockynol.

Q. And so then flipping back to where we started, this would be then Dr.-- the doctor was --

A. That would be considered a doctor's order.

Q. And he would be saying that it was okay for Mr. Pere to be up. And when he is up, he needs assistance or he can be up and sometimes have assistance? As a nurse, what would you say that meant?

A. Up and assist, if needed.
Q. So you would --
A. Because otherwise it would say up with assistance.
Q. So this is more of a PRN you are saying?
A. Right.
Q. The doctor believed that based on Mr. Pere --
MS. COEY: Objection.
A. I can't say what the doctor believed.
Q. But to the best of your knowledge, in looking at this order, you take it to mean that he could be up without assistance?
A. Correct.
Q. And how that was determined, if he needed assistance, when he needed assistance, was up to the nurses who were caring for Mr. Pere; is that correct?
A. Right. The primary caregiver at the time.
Q. And the primary caregiver, just tell me before we get into this, it would be a nurse and then do you have a CNA helping you or do you have -- how does that care --

A. They had patient care assistants. I don't know what their official title was at Rockynol. I can't recall. But they are certified nurses aides, and they are just per -- I'm sorry, I am losing my -- it's like a ratio, so many patients per nursing assistant. So how many are available depends on the census at the time, how many patients are in there.

Q. Can an LPN also do what you are doing? Are the roles interchangable and the CNA's work under them?

A. The roles are interchangeable as far as an RN could do the LPN position, but the LPN could not do the RN position.

Q. It came up, and I'll ask the person who wrote that, but I wanted some education on that. Thank you.

If I can turn your attention to the page in front of you which is dated 1-30-02 and if you would just read for me on the record everything that you wrote, including your signature, the time, the date on that first page for the record.

A. January 31st, 2002, 5 p.m. Resident in room. Greeted me warmly. Family member

expressed concern over resident supposing to have Ted hose. Told her that we were aware and are trying to get the order clarified. She expressed gratitude. Robbin Moore.

1-31- I guess '02. It says '01 there. 8 p.m. Resident incontinent of stool. Refused care. Robbin Moore, RN.

8:30 p.m. Supervisor aware. Robbin Moore, RN.

10 p.m., resident up in bed. No brief on. Stool on sheets. Resident said it could wait until a.m. Told him no, it can't wait and we will need to care for him tonight. Resident agreed to let us help him. R. Moore, RN.

Q. And that's the only writings you have on this paper, this sheet in front of us?

A. On this sheet, yes.

Q. If we can just go over this line by line. At 5 p.m., it would appear from your writing that you did not notice any confusion. Or maybe let me ask you. Based on this note, would you say that you noticed any confusion with Mr. Pere?

A. I cannot recall his current state. I

mean, on recollection, I would just have to go based on my writing that if there was confusion and I noted it, it would have been documented.

Q. Then at 8 p.m., incontinent of stool, refused care, does that tell you in reading the record whether there was any level of confusion?

A. No, because that happens all the time. Confused, alert. It's not necessarily a state of mind that is to one specific case of patients.

Q. So it is consistent with a patient who is alert and oriented to choose to stay incontinent of stool?

A. In a patient who is alert and oriented who has become incontinent of bowel and bladder, they are sometimes embarrassed by the fact that that has happened and does refuse care.

Q. Can the refusal of care to be cleaned up of stool, in choosing to stay in stool, can that be an indication of confusion?

MS. BREAUX: Objection.

A. It can be.

Q. Do you sometimes see it in patients who are confused who choose to stay in their

stool?

A. Yes.

Q. And as the reasonable and prudent nurse who is always assessing, because we know that one of the interventions is monitoring for risks of falls, which is being ever vigilant for signs of confusion, is that something that would be noteworthy to you as you're assessing your patients?

A. I document it as such --

Q. So your answer is yes.

A. No, I wasn't done with my sentence.

Q. Sorry.

A. I documented the incontinency of stool so that if the patient is confused, that they would have information to use for their MDS and plan of care.

Q. So when you are writing that, you are thinking then that this may be a sign of confusion?

A. Possibly.

Q. At 8:30 p.m. you made your supervisor aware. How often are you making your supervisor aware of things that happen in patient care? Is this an unusual thing for you to do? Is it very

frequent?

A. It's frequent.

Q. And do you know what, in trying to recall from your record, what it is that you would have contacted her about and made her aware about?

A. The reason I would have contacted the supervisor was sometimes just someone else approaching the patient and offering assistance, they are receptive to. So, I mean, you just reapproach, if they refuse, you just reapproach and try in different ways to get them to agree to go be cleaned up.

Q. So it's your recollection, as best you can from this record, that the reason you called the supervisor is you wanted the supervisor rather than another nurse or another CNA to go, the supervisor to go in and see if you can convince Mr. Pere to get him cleaned up?

A. I don't know if I called the supervisor to tell them or if the supervisor was just there on the floor and the supervisor was aware, but they do offer assistance.

Q. But we can agree from this note, supervisor aware, that we really don't know

whether or not she offered her assistance or why she was called, just that she was aware of what you documented at 8 p.m.?

A. Right, that he was incontinent of stool and was refusing care.

Q. Now, at 10 p.m., we have that the resident is up in bed without his brief on. Does that tell you anything about the level of alertness in this patient?

A. It tells me that he was trying to get out of it and that he was aware of the stool situation.

Q. When you say are up in bed, I sort of envision that he is standing in the bed. What would you mean by that documentation?

A. He was sitting on the side of the bed.

Q. Okay. Without his brief on.

A. Right.

Q. In reading this, to the best of your recollection, would you say that you had a heightened indicia of suspicion that perhaps he either had some confusion or he was currently confused?

A. I don't recall. Rephrase your

question.

Q. In reading this, as the nurse who wrote it, when I am reading it, sitting back, it sounds to me, here is a man sitting up in bed naked in his stool who has refused to be cleaned up for two hours. I'm reading that thinking, hum, maybe he is a little bit confused. But I didn't write the note, you did.

A. I believe it was written with that intention; that he could possibly be confused.

Q. And it sounds like then it ended nicely and that he agreed to let you help him and you did help him?

A. Correct.

Q. But we can agree, then, I believe, from what we just discussed, that on 1-31, at 2002, between 8 p.m. and 10 p.m., there was an indicia of suspicion that was perhaps even heightened by 10 p.m., that perhaps this patient was intermittently confused; is that correct?

A. That's correct.

Q. Now, I know you didn't write this note, but if we could just follow through to sort of close this issue up. At 4 a.m., the person who took over the care from you, I

believe his name is Michael Carroll, if you can read to me what he writes at 4 a.m. on the first line.

MS. BREAUX: Objection.

A. Alert, some confusion noticed. Skin pale, warm and dry. Up to bedside commode. Incontinent, I believe that's what it stands for.

Q. That's fine. So we know here just from 8 p.m. to 4 a.m., that this is a man who has had some confusion documented, some confusion, you are thinking, earlier on your shift, and we know he has been incontinent twice; correct?

A. Correct.

MS. BREAUX: You are assuming that that being circled is incontinent?

MS. TRESL: I'm not assuming anything. She read that into the record.

THE WITNESS: I assume it's incontinent.

MS. BREAUX: It could be something else.

A. You will have to ask Michael, as well.

Q. We certainly will. Since you are doing such a great job, if you can read the next line following your shift at 1:45 p.m., I believe that's a p.m., it almost looks like it has to be. Can you read that into the record for me?

MS. BREAUX: Objection.

A. The bottom line?

Q. Correct.

A. No complaint of pain or discomfort. I don't know what that word is there.

Q. Just read what you can.

A. Alert and confused, but pleasant.

Q. Thank you. Now, your shift begins -- actually it looks to me and you tell me if this is correct, it looks to me like at 6 p.m., I don't know whose name that is, but it looks to me like you were also on that 3:00 to 11:00 shift, because I believe you told me you worked evenings?

A. Correct.

Q. So even though this person who looks like J. Cuzl documents, you are also there at the time, presumably?

A. Correct.

Q. Would you have been aware at all at what would have been going on with Mr. Pere, since you documented at 11:00 o'clock on him?

A. You would need to check the -- I could have been aware.

Q. And what would we need to check to see if you were involved in his care at that point?

A. At what role I was, because I did charge nurse duties quite frequently at the facility. And as a charge nurse, I would have been the one to have seen him passing medications.

Q. So can we surmise, and obviously this is open to getting the appropriate documentation, but because you were getting a fax for Ted hose and you were on that shift, do we presume then that you were the charge nurse over this J. Cuzl?

A. No. Because either the LPN or the charge nurse could have gotten that order off of the fax machine and just followed it through.

Q. So we don't know then from this record whether or not you would have been aware of the dizziness episodes charted by J. Cuzl, is

that correct, or whatever that person's name is? I apologize.

In other words, at 6 p.m. J. Cuzl is documenting that he has dizziness episodes and you are also caring for him or at least you are charting on that same shift.

A. Right.

Q. Can we draw any conclusions as to whether or not you would have been aware that he was having dizziness episodes?

MS. BREAUX: If you know.

A. Yeah, I just -- if James has documented it. If I was the charge nurse at the time and James documented it and it wasn't something that I observed myself and he didn't tell me, then I would not have been aware. And I can't say whether I was aware or not, specifically. I do not recall.

Q. Just for the record, to close it up, just read the other documentation that you put into the record.

A. On 2-1-02 at 11 p.m.?

Q. Correct.

A. Order faxed for Ted hose. On in the a.m., off in the p.m. Measurement sent to

pharmacy. R. Moore, RN.

Q. Now, if I can just -- you sort of bookend -- your documentation sort of begins the story and ends the story where I would like to focus on in terms of what we talked about earlier in terms of reevaluating the risk for falls. Obviously you didn't write the initial assessment, so you can't comment on that.

But I believe you told me, and stop me if I'm putting words in your mouth, that this is sort of an evolutionary process where you interact with the patient to see if they are dizzy, stumbling, have gait problems in terms of thinking about do you need to change their risk for fall; is that correct?

A. Correct.

Q. Based on what you just read being the one side followed by what Mr. Cuzl wrote, followed by what Mr. Carroll wrote, followed by the end of your shift, are things beginning to unfold to make the nurse think that any of this might need to be reassessed?

MS. BREAUX: Objection.

A. It would have to depend on what they mean by confusion. It could be as simple as

they didn't know the time of night, to a much more exaggerated extreme, and since there was no documentation, I cannot recall with certainty what was meant by this.

Q. If knowing what was meant by that was the difference between implementing a management program for falls, then where would we go to find that since that seems to be vital information?

MS. BREAUX: Objection.

A. I don't know specifically where we would go to find it on this patient.

Q. So if you have 24 hours of documentation of confusion and dizziness, typically how long does that documentation then continue before someone decides to maybe consider bed alarms, or putting them at a higher risk for falls, or does that not happen until they fall and then you go back to the fall risk assessment?

A. I don't believe there is a specific time frame in which we are looking at, and as I said prior, the bed alarm, it can always be applied as a nursing judgment. If at any point any of these nurses felt that he was a danger to

himself or risk for injury, they could have applied the bed alarm.

Q. But yet you told me that there was no indication of the level of confusion and what was really going on, so how is that passed along from shift to shift, so that the next nurse begins to sort of think this happened on this shift, this happened on this shift, so therefore maybe I need to start thinking about bed alarms?

A. We just would give a verbal report and -- we would give the verbal report, and it would depend on the detail that was given in report. And I can't recall what specifically was said. So I don't really have an answer to your question.

Q. If at 11 p.m. you were preparing to give report to Mr. Carroll, and presumably you remembered from your shift the night before him sitting naked on the edge of the bed, and two hours of sitting in his feces, refusing to be cared for, it being monumental enough or significant enough to make your supervisor aware, and then presumably you would have gotten report from day shift, who got it from night shift who said it was confusion and said he was

incontinent, and day shift who said he was alert and confused, and then the beginning of your shift, your nurse, your colleague said that there is some dizziness, as you are beginning to give your report at 11 p.m., presumably to Mr. Carroll, when does the discussion begin to take place that maybe this is significant dizziness and confusion?

MS. BREAUX: Objection.

Q. If it ever happens.

A. I don't recall. I can't say with certainty, so I don't know. And you know, even though Michael was the nurse coming on, the LPN gives report to the LPN, the RN gives report to the RN, so I'm not even sure who, between the two of us, who Michael would have gotten his report from.

Q. I guess though I am not speaking specifically what you remember, because we know you don't have any extra memory. I am saying you as a nurse, giving this to Bob Jones, a new patient comes in, you have had this episode of two hours of him --

MS. BREAUX: Wait for a question, Robbin.

THE WITNESS: I'm sorry.

Q. If you understand where I'm going. I can go through it and repeat the whole thing. Making it any patient, who you said in the beginning it's very important that you establish sort of where they are at mentally. You can't know that until you work with them.

You said in an initial visit that isn't enough, it needs to go on and on a bit. Is a 24 hour period with these sorts of facts something that you begin to say, you know, the risk for fall is enhanced because he is confused and he is dizzy and he is incontinent and he is trying to go to the potty?

MS. BREAUX: Objection.

A. It would plant a seed of doubt that I would have to question. Like if it continues and if you got the 24 hour period and it continued past.

Q. And when that seed of doubt is planted then, what do you typically do with that seed?

A. Observe more closely what's going on with the patient. Interact with him verbally, try to find out if he is aware of the

limitations. If he is aware of his dizziness, is he aware of what to do when he gets dizzy.

Q. Let's do that piece by piece. You said one of the things, you would observe them more frequently, I believe you said?

A. Yes.

Q. And can we say from the time that you wrote your order to be faxed or in point of fact from the last order that discusses actually the patient, which is 6 p.m., until the time that he is found on the floor at 7:50, can we say that he was being observed more frequently in terms of what is documented?

A. Yes, because this is just the nursing documentation. This is not the care, the resident care assistance, the PCA's.

Q. Can you show me somewhere in the record where there is documentation by the CNA's or PCA's that he was being seen more frequently based on the seed of doubt that may have been planted for you?

A. It's not here. There is nothing here.

Q. So there is no documentation that in fact he was being seen more frequently based on

the seed of doubt planted in your mind?

A. No. This is the nursing documentation.

(Record read.)

Q. Is there any documentation that he was being asked those things?

A. No, not from that time frame.

Q. And if this was a concern that his confusion and dizziness were maybe making him at a higher risk for falls, is this something that should have been asked?

A. If the nurse that was working with him was aware of his dizziness, they should have -- I can't say what they should have done. You know, just what I would have done.

Q. Well, I'm asking you what you would have done. We don't know who gave report to Mr. Carroll.

A. No.

Q. But let's assume that you gave report because it was 11 p.m., and you are handing over care to the next shift. Would you have said to Mr. Carroll, he has had some periods of dizziness this shift?

MS. BREAUX: Objection.

A. If I had been the one who had given report, I would have told Michael that -- we go through each of the patients. We give a little snip on each one of them, and I would have brought to light the confusion. And I don't know how involved I was, because 3:00 to 11:00, 11:00 to 7:00, most of the patients are sleeping and so that would be Michael's assessment on how the patient handled the night. I can only report on how he was on my shift and I can't anticipate, you know, how he was going to be on night shift.

Q. And I appreciate that. But my understanding is that based on what you were observing over the last 24 hours, one of the two things you would have done besides checking on him more frequently, is to ask them whether they were aware of their dizziness, their confusion?

A. Right.

Q. We know at 3 a.m., we know that at some point in this shift, Mr. Pere is awake, presumably because I don't think you can be responsive and pleasant and be asleep. Although you might be able to be.

Reading the English language,

responsive and pleasant alludes to me that it was possible for Mr. Carroll to ask him the things that you just pointed out based on your seed of doubt; correct?

A. It is possible.

Q. Is there any documentation that any time after report was given on 11:00 to 7:00 shift, that he was seen more frequently? I believe the answer to that is no.

A. No.

Q. And the second question, is there any documentation that it was discussed with him the things that you would have discussed based on what you had seen in the past 24 hours?

A. There is no indication that that was done. It just may not have been a good time to do -- you know, I don't know where the patient was. I don't know if he was awake. I don't know if he was up and going to the bathroom. I have no idea if Michael just woke him up for the assessment.

Q. But we can agree that it's not documented?

A. It's not documented, correct.

Q. If you had felt, or whoever was on

3:00 to 11:00 on 2-1-02, that he was at increased risk for fall at any point, you were able to go get a bed alarm to put it on his bed; is that correct?

MS. BREAUX: Objection.

A. Yes.

Q. And Michael coming on from 11:00 to 7:00, based on the report that he had been given for the past 24 hours, nothing was preventing him from getting a bed alarm; is that correct?

MS. BREAUX: Objection.

A. Correct.

Q. And they are available on night shift; is that correct?

A. Correct.

Q. If the acute care plan, which we discussed earlier, said monitor risk for falls, can we agree based on the 24 hours that we just reviewed in terms of the records that there is no documentation that he was being monitored for a risk of fall based on what was being observed?

MS. BREAUX: Objection.

A. No, I don't think we can assume.

Q. Is there any documentation in the record that based on the acute care plan, which

is to monitor risk for falls, that you said should be evolving as you get to know the patient, is there any documentation that he is being monitored for risk of falls?

MS. BREAUX: Objection.

Q. A change in his mentation and his stooling habits?

A. It would all add up to his risk of falls, yes. It would all contribute.

Q. And it would contribute in what way?

A. State of mind.

Q. Based on the 24 hours that we just discussed, does it put him at an increased risk of fall?

MS. BREAUX: Objection.

A. I can't say with any certainty.

Q. I'm not asking you to say with any certainty. As a reasonable and prudent nurse caring for a nursing home patient, the previous 24 hours documentation, sitting there naked for two hours in his stool, refusing to be cleaned up, sitting there without a brief on --

A. Okay.

Q. -- sitting in his stool, refusing to be cleaned, significant enough to make your

supervisor aware, confusion in the middle of the night --

MS. BREAUX: Objection.

Q. -- presumably incontinent, bedside commode --

MS. BREAUX: Objection.

Q. -- confused again, and some dizziness at 6 p.m. --

MS. BREAUX: Objection.

Q. -- does that put him at a higher risk for fall as a reasonable and prudent nursing home nurse assessing this 85-year-old patient?

A. It would seem so.

Q. Thank you.

MS. TRESL: If you give me a minute to check my notes.

(Recess had.)

Q. Just one quick question and I think I'm done. I think I know the answer, but just so I'm sure.

It looks to me that the 11:00 o'clock note, I don't know if you need it or not, with the Ted hose, it looks to me like you did not have any contact with the doctor, but tell me about that.

A. A lot of our contact through the doctor was through faxes. We would send a fax to the doctor's office and then they would respond by fax and so it's considered an order when you receive it.

Q. So this interchange then, you do not recall specifically talking to Dr. Amanambu?

A. No.

Q. Do you recall at any time talking to Dr. Amanambu from the time Mr. Pere came to the time he expired?

A. No, I did not.

Q. And have you talked to him since that relative to Mr. Pere?

A. No, I have not.

MS. TRESL: No further questions. I think our colleague has one.

EXAMINATION OF ROBBIN MOORE, R.N.

BY MS. COEY:

Q. My name is Brenda Coey and I represent Dr. Amanambu.

At any time while Mr. Pere was a resident, did you personally place a bed alarm on him?

A. No, I did not.

Q. Whenever a physician gives an order and that order is as needed, is it the practice of the facility to follow it by the initial's PRN?

A. Correct.

Q. Looking back then at the physician's orders that were reviewed with you earlier, that second page, where it says up and assist, just for clarification, the letters PRN do not follow up and assist; correct?

A. Correct.

Q. And PRN for the record stands for?

A. As necessary.

MS. COEY: I have no further questions.

MS. BREAUX: We will go ahead and read.

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(Deposition concluded at 11:50 p.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 74 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

ROBBIN MOORE, R.N.

Subscribed and sworn to before me this day of , 2003.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ROBBIN MOORE, R.N. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 19th day of November, 2003.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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EXHIBITS