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1                   IN THE COURT OF COMMON PLEAS  
2                   OF SUMMIT COUNTY, OHIO

3                   - - - - -

4       CHARLES G. PERE, et al.,

5               Plaintiffs,

6                   vs

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

7       THE LEDGES OF ROCKYNOL,  
8       et al.,

9               Defendants.

10                  - - - - -

11               DEPOSITION OF ROBBIN MOORE, R.N.

12               THURSDAY, NOVEMBER 14, 2003

13                  - - - - -

14               Deposition of ROBBIN MOORE, R.N., a Witness  
15       herein, called by counsel on behalf of the  
16       Plaintiff for examination under the statute,  
17       taken before me, Vivian L. Gordon, a Registered  
18       Diplomate Reporter and Notary Public in and for  
19       the State of Ohio, pursuant to agreement of  
20       counsel, at the offices of Tipping Co., L.P.A.,  
21       525 N. Cleveland-Massillon Road, Akron, Ohio,  
22       commencing at 10:12 o'clock a.m. on the day and  
23       date above set forth.

24                  - - - - -

25

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

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11 On behalf of the Defendant Rockynol

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19 On behalf of the Defendant Amanambu

20 Buckingham, Doolittle & Burroughs

21 BRENDA COEY, ESQ.

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

6 EXAMINATION OF ROBBIN MOORE, R.N.

7 BY MS. TRESL:

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

11 A. All right.

12 Q. Have you ever had your deposition  
13 taken before?

14 A. No, I have not.

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

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

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

24 A. Yes.

25 Q. If I ask you a question that you

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

3 A. Yes.

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

7 A. Yes.

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

11 A. Okay.

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

14 A. Okay.

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

18 A. Okay.

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

22 A. No, I have not.

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

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

4           Q.     A little bit back.

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

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

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

1 sure.

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

4 A. I was employed.

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

8 A. He was there in when, February?

9 Q. Correct.

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

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

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

19 Q. And when did you go to Robinson  
20 Memorial?

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

23 Q. You work as a med/surg nurse?

24 A. Correct.

25 Q. Is that full time or part time?

1 A. Full time.

2 Q. What shift?

3 A. Second shift.

4 Q. When you were at Rockynol in the time  
5 in question, February, were you full time  
6 employed there?

7 A. I was full time, second shift.

8 Q. Second shift. And prior, you said  
9 you graduated from nursing school. I assume  
10 that's registered nursing school?

11 A. Correct.

12 Q. What school?

13 A. Kent State University.

14 Q. Do you have your bachelor's then?

15 A. Yes, I do.

16 Q. What did you do prior to that? Were  
17 you in the medical field prior to that other  
18 than working at CVS pharmacy?

19 A. No. I did some home health aide  
20 work, but I just had a lot of life changes and I  
21 was on welfare at the time I was going to  
22 medical school.

23 Q. Nursing school?

24 A. Uh-huh.

25 Q. Did you have any special training in



1     geriatric nursing?

2           A.     Just the courses that I had taken  
3     through the university.

4           Q.     So no certifications in gerontology  
5     or anything like that?

6           A.     No.

7           Q.     What about BLS certification, are you  
8     currently --

9           A.     Yes.

10          Q.     Were you at the time that you worked  
11     at Rockynol?

12          A.     Yes.

13          Q.     Have you published anything?

14          A.     No.

15          Q.     Have you given any lectures?

16          A.     No.

17          Q.     Have you ever been disciplined as a  
18     nurse?

19          A.     No. Can I ask you a question?

20          Q.     Sure.

21          A.     What do you mean by disciplined?

22          Q.     Have you ever been asked to leave the  
23     hospital? Have you ever had to account to the  
24     board of nursing for any reason?

25          A.     No, I have never had to account to

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

6 Q. One time?

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

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

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

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

23 A. None. I had none at Rockynol.

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

1 prepare for today's deposition?

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

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

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

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

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

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

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

25 Q. Any policy and procedure manuals?

1           A.     Prior to this deposition, no.

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

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

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

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

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

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

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

1 just very quiet.

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

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

9 Q. And very quiet?

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

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

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

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

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

1 Q. What did she say had happened?

2 A. She had said that Mr. Pere had fallen  
3 and there was a lot of blood and that he had  
4 died. I had read the nurse's notes at the time,  
5 but I couldn't recall reading the nurse's notes  
6 until I read them again.

7 Q. And after you read them, do you  
8 remember anything more than what you just said  
9 that she said to you in report?

10 A. She said that 911 was called and that  
11 she had told me that Mr. Kaylor was very upset.  
12 Mr. Kaylor was his roommate at the time and he  
13 was prone to hallucinations, that's why he was  
14 brought over to us, and he was having violent  
15 hallucinations and they were concerned at the  
16 time that because he had actually seen the blood  
17 this time that there was going to be a problem  
18 between him with reality. We were trying to  
19 reorient him between the reality and the fiction  
20 of his hallucinations, so they were concerned at  
21 that point. She had said something.

22 Q. Do you know if you were successful in  
23 reorienting him?

24 A. No. He continued to have  
25 hallucinations. It was a problem. But I don't

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

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

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

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

17 A. No.

18 Q. He never had any --

19 A. He was very gentle and meek.

20 Q. I see. But we do know, and correct  
21 me if I am wrong, that he is the one who called  
22 911 initially?

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

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

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

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

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

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

21          A.     Okay.

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

25          A.     The body's inability to correct blood



1 pressure on changing positions.

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

5 A. The blood pressure drops and he  
6 becomes dizzy.

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

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

13 A. An individual patient or Mr. Pere?

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

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

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

25 MS. BREAUX: Objection.

1 A. They could fall.

2 Q. I believe Mr. Pere was hard of  
3 hearing, but let's talk globally about patients  
4 who are hard of hearing. How does a patient who  
5 is hard of hearing, how does that change the way  
6 you care for them as a nurse?

7 MS. BREAU: Objection. You can  
8 answer.

9 A. I just speak louder and ask them if  
10 they understand what I'm saying to them. And if  
11 we know whether the hearing is one side or the  
12 other, you know, we direct the speech to the  
13 other ear. And eye contact. Sometimes if they  
14 had been hard of hearing for a while, they can  
15 read lips.

16 Q. How about in a patient that you care  
17 for who has known confusion, how do you adapt  
18 your nursing care for that sort of a patient?

19 MS. BREAU: Objection. You can  
20 answer.

21 A. It's based, it's on each individual  
22 patient. It depends on the degree of confusion  
23 that they have. Sometimes even with a confused  
24 patient, as to their name, they can still  
25 function, they can still move about their room,

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

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

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

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

17 A. Can you repeat the question?

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

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

1 two person?

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

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

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

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

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

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

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

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

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

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

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

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

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

1 about?

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

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

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

10 A. Can you repeat the question?

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

15 A. Well, if we know that, the patient is  
16 able to verbalize that they are dizzy, we are  
17 there. If we know that the patient is known to  
18 having dizziness, then, like I said, we observe  
19 and see how they do with their ADL's and we  
20 provide walkers, call lights, bed rails up that  
21 they can help to grab on to and hold on to to  
22 assist them, because we can't be in the room  
23 24/7, so we try to make the environment at least  
24 safe for them.

25 Q. When a patient is on a lot of

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

4 MS. COEY: Objection.

5 A. Yes.

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

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

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

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

25 MS. BREAUX: Objection.



1 MS. COEY: Objection.

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

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

7 MS. BREAUX: Objection.

8 MS. COEY: Objection.

9 Q. You can answer.

10 A. Yes.

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

15 MS. BREAUX: Objection.

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

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

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

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

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

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

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

16 MS. BREAUX: Objection. You can  
17 answer.

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

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

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

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

14          Q.       And how commonly do you use bed  
15    alarms?

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

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

25          Q.       So that was my next question. You

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

3 A. Not specifically, I have not, no.

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

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

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

13 MS. BREAU: Objection.

14 A. Based on the fall risk assessment.

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

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

22 Q. How about a falls prevention program?

23 A. Yes.

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

1           A.     For Rockynol?

2           Q.     Correct.

3           A.     I would have to look at the policy  
4     and the procedure book for that because it's  
5     been so long ago that I have been there, I don't  
6     have the specifics.

7                     Keep the patient safe from harm. I  
8     mean, that's the basics of most of it.

9           Q.     And the physical therapist plays a  
10    role in the falls prevention program; is that  
11    correct?

12          A.     I know they are involved, but I don't  
13    know -- I would have to guess at an answer and I  
14    don't want to do that.

15          Q.     That's fine. Let's start with the  
16    falls risk assessment, if your counsel wants to  
17    give you a copy or I can provide you a copy.

18                   MS. BREAUX: I don't have copies with  
19    me.

20                   MS. TRESL: Maybe I am not being  
21    specific enough. Let her see your copies.

22                   MS. BREAUX: I do have a copy.

23          Q.     When I went through this, now,  
24    obviously, I have a fairly good handle on  
25    Mr. Pere, because I represent his interests.

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

5 A. Correct.

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

8 A. Right, correct.

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

12 A. Correct.

13 Q. So you are familiar with this form?

14 A. Right.

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

23 MS. BREAUX: Objection.

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

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

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

9 MS. BREAU: Objection.

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

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

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

3 MS. BREAU: Objection. I'm just  
4 going to object to all questions related to this  
5 document.

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

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

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

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



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

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

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

10 MS. BREAUX: What is it?

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

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

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

17 MS. TRESL: That's fine.

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

21 A. I am familiar with the document.

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

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

1 the admitting package.

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

4 MS. BREAU: What sentence are you  
5 referring to?

6 THE WITNESS: Number seven.

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

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

16 A. Right.

17 Q. So by reading --

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

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

25 This caregiver plan of care, where

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

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

13 Q. And I believe that's dated January  
14 30th, 2002; is that correct?

15 A. Correct.

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

20 A. It says supervision.

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

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

25 Q. And how would you determine what was

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

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

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

10 MS. BREAU: Objection.

11 Q. You can answer.

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

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

22 MS. BREAU: Objection. You can  
23 answer.

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

1 assistance was needed.

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

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

11 A. No, I'm not familiar.

12 Q. You have not seen it?

13 A. No.

14 Q. What about the acute care plan?

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

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

19 A. Yes.

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

23 MS. BREAU: Objection to this  
24 document.

25 A. Monitor versus assessment. Oh,

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

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

12 MS. BREAUX: Objection.

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

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

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

25 Q. And if you knew that it was chronic,

1 would that change anything?

2 A. Yes.

3 Q. And what would it change?

4 A. It would just change, if you knew it  
5 was a chronic dizziness problem, the patient  
6 would be instructed not to get up without first  
7 waiting for assistance. And using the call  
8 light, making sure that the call light was  
9 within reach at all times.

10 Q. And what if that same patient had  
11 intermittent bouts of confusion, would you be  
12 able to rely on the fact that they would use the  
13 call bell if they needed to?

14 MS. BREAUX: Objection.

15 A. It would not be 100 percent reliable,  
16 no.

17 Q. Would you have then a plan that you  
18 would follow based on that?

19 A. I don't know.

20 Q. Would a bed alarm be something that  
21 might be considered in a patient who has  
22 confusion and dizziness?

23 MS. BREAUX: Objection.

24 A. A bed alarm I feel would be  
25 appropriate if they had confusion all the time

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

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

7 MS. BREAUX: Objection.

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

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

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

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

23 A. Correct.

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



1 patient at the time?

2 A. At the time.

3 Q. And if I could just turn your  
4 attention to the MDS. And I'm assuming -- I'm  
5 just going to give you a copy.

6 Now, typically, is this filled out by  
7 the admitting nurse? I didn't think so. This  
8 looked to be filled out by someone different.  
9 Who fills this out?

10 A. The MDS nurse.

11 Q. Tell me what her role is at Rockynol,  
12 if you know. Does she care for --

13 A. I don't know technically, you know,  
14 what her position is and her duties, but she  
15 would, after going through the chart, help make  
16 assessments for care plans as to the type of  
17 care needed for the patient. I think it's an  
18 insurance thing.

19 Q. Assurance?

20 A. Insurance.

21 Q. Is she in a fairly reliable position  
22 to help make these assessments? In other words,  
23 is this something that you would rely on her  
24 assessment and her MDS?

25 A. Yes.

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

8                   MS. BREAUX: Objection.

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

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

20                  MS. BREAUX: Objection.

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

23          Q.     Well, elaborate. You tell me.

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

1 patient doesn't seem to know.

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

6 MS. BREAUX: Objection.

7 A. Restate your question.

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

14 A. We do see that.

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

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

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

1 do they do?

2 MS. BREAUX: Objection.

3 A. They can get up and go without  
4 assistance.

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

7 A. Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22                 (Recess had.)

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

1 look like what we have been talking about?

2 A. Yes.

3 Q. And for the record, that would be  
4 what are these, nursing notes? The top of the  
5 page dated 1-30-02 and the second page is  
6 2-01-02.

7 A. Correct.

8 Q. In relation to the nurses' station,  
9 where is room 122-2, assuming there is a nursing  
10 station?

11 A. There is a nursing station. Room  
12 122-2, is that his room?

13 Q. Correct.

14 A. It is out the door and -- well, the  
15 nurses' station is like here, okay. There is --

16 Q. Why don't you draw me on a piece of  
17 paper. Because when I look at the record, I  
18 won't know where here is. We can give it to  
19 Vivian and she will have it for us.

20 A. This is to the best of my  
21 recollection, okay?

22 Q. Great.

23 A. The nurses' station is this room  
24 here, which is off of a hallway.

25 Q. Okay.

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

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

7           A.     This is a common area.

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

10          A.     This is nurses' station.

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

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

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

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

21          Q.     Like five or like 40?

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

24                     - - - - -

25                     (Thereupon, MOORE Deposition

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

3                   - - - - -

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

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

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

17          A.     Do you have a copy?

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



1           A.     The nurse who filled out this  
2     documentation --

3           Q.     Right.

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

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

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

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

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

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

1 A. Up and assist, if needed.

2 Q. So you would --

3 A. Because otherwise it would say up  
4 with assistance.

5 Q. So this is more of a PRN you are  
6 saying?

7 A. Right.

8 Q. The doctor believed that based on  
9 Mr. Pere --

10 MS. COEY: Objection.

11 A. I can't say what the doctor believed.

12 Q. But to the best of your knowledge, in  
13 looking at this order, you take it to mean that  
14 he could be up without assistance?

15 A. Correct.

16 Q. And how that was determined, if he  
17 needed assistance, when he needed assistance,  
18 was up to the nurses who were caring for  
19 Mr. Pere; is that correct?

20 A. Right. The primary caregiver at the  
21 time.

22 Q. And the primary caregiver, just tell  
23 me before we get into this, it would be a nurse  
24 and then do you have a CNA helping you or do you  
25 have -- how does that care --

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

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

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

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

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

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

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

5 1-31- I guess '02. It says '01  
6 there. 8 p.m. Resident incontinent of stool.  
7 Refused care. Robbin Moore, RN.

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

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

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

18 A. On this sheet, yes.

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

25 A. I cannot recall his current state. I

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

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

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

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

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

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

22 MS. BREAU: Objection.

23 A. It can be.

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

1 stool?

2 A. Yes.

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

10 A. I document it as such --

11 Q. So your answer is yes.

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

13 Q. Sorry.

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

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

21 A. Possibly.

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

1 frequent?

2 A. It's frequent.

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

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

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

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

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

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

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

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

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

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

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

18 Q. Okay. Without his brief on.

19 A. Right.

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

25 A. I don't recall. Rephrase your



1 question.

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

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

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

14 A. Correct.

15 Q. But we can agree, then, I believe,  
16 from what we just discussed, that on 1-31, at  
17 2002, between 8 p.m. and 10 p.m., there was an  
18 indicia of suspicion that was perhaps even  
19 heightened by 10 p.m., that perhaps this patient  
20 was intermittently confused; is that correct?

21 A. That's correct.

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

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

4 MS. BREAU: Objection.

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

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

15 A. Correct.

16 MS. BREAU: You are assuming that  
17 that being circled is incontinent?

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

20 THE WITNESS: I assume it's  
21 incontinent.

22 MS. BREAU: It could be something  
23 else.

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

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

7                   MS. BREAU:  Objection.

8           A.     The bottom line?

9           Q.     Correct.

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

12          Q.     Just read what you can.

13          A.     Alert and confused, but pleasant.

14          Q.     Thank you.  Now, your shift  
15     begins -- actually it looks to me and you tell  
16     me if this is correct, it looks to me like at 6  
17     p.m., I don't know whose name that is, but it  
18     looks to me like you were also on that 3:00 to  
19     11:00 shift, because I believe you told me you  
20     worked evenings?

21          A.     Correct.

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

25          A.     Correct.

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

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

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

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

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

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

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

1 that correct, or whatever that person's name is?

2 I apologize.

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

7 A. Right.

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

11 MS. BREAU: If you know.

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

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

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

23 Q. Correct.

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

1 pharmacy. R. Moore, RN.

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

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

16 A. Correct.

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

23 MS. BREAUX: Objection.

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

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

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

10 MS. BREAU: Objection.

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

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

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

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

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

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

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



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

9                   MS. BREAU:  Objection.

10            Q.     If it ever happens.

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

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

24                   MS. BREAU:  Wait for a question,  
25     Robbin.

1 THE WITNESS: I'm sorry.

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

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

15 MS. BREAUX: Objection.

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

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

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

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

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

6 A. Yes.

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

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

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

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

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

1 the seed of doubt planted in your mind?

2 A. No. This is the nursing  
3 documentation.

4 (Record read.)

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

7 A. No, not from that time frame.

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

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

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

19 A. No.

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

25 MS. BREAUX: Objection.

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

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

19          A.     Right.

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

25                    Reading the English language,

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

5 A. It is possible.

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

10 A. No.

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

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

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

24 A. It's not documented, correct.

25 Q. If you had felt, or whoever was on

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

5 MS. BREAUX: Objection.

6 A. Yes.

7 Q. And Michael coming on from 11:00 to  
8 7:00, based on the report that he had been given  
9 for the past 24 hours, nothing was preventing  
10 him from getting a bed alarm; is that correct?

11 MS. BREAUX: Objection.

12 A. Correct.

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

15 A. Correct.

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

22 MS. BREAUX: Objection.

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

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

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

5 MS. BREAUX: Objection.

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

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

10 Q. And it would contribute in what way?

11 A. State of mind.

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

15 MS. BREAUX: Objection.

16 A. I can't say with any certainty.

17 Q. I'm not asking you to say with any  
18 certainty. As a reasonable and prudent nurse  
19 caring for a nursing home patient, the previous  
20 24 hours documentation, sitting there naked for  
21 two hours in his stool, refusing to be cleaned  
22 up, sitting there without a brief on --

23 A. Okay.

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



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

3 MS. BREAU: Objection.

4 Q. -- presumably incontinent, bedside  
5 commode --

6 MS. BREAU: Objection.

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

9 MS. BREAU: Objection.

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

13 A. It would seem so.

14 Q. Thank you.

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

17 (Recess had.)

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

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

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

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

8           A.     No.

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

12          A.     No, I did not.

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

15          A.     No, I have not.

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

18                 EXAMINATION OF ROBBIN MOORE, R.N.

19    BY MS. COEY:

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

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

25          A.     No, I did not.

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

5           A.     Correct.

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

11          A.     Correct.

12          Q.     And PRN for the record stands for?

13          A.     As necessary.

14                 MS. COEY: I have no further  
15    questions.

16                 MS. BREAUX: We will go ahead and  
17    read.

18                         - - - - -

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

20                         (Signature not waived.)

21                         - - - - -

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25

1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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ROBBIN MOORE, R.N.

18

19

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

22

23 Notary Public

24

25 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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