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
THE LEDGES OF ROCKYNOL,
et al.,
Defendants.

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DEPOSITION OF KELLY M. PRICE, R.N.
FRIDAY, NOVEMBER 14, 2003

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Deposition of KELLY M. PRICE, R.N., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Cynthia A. Sullivan, a Registered Professional 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 2:05 p.m. on the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiffs:
Becker & Mishkind, by
JACQUELINE D. TRESL, ESQ.
The Skylight Office Building
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1220 W. 2nd Street
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant Rockynol:
Tipping Co., L.P.A., by
ALISON M. BREAUX, ESQ.
525 N. Cleveland-Massillon Road
Suite 207
Akron, Ohio 44333
330-670-8400

On behalf of the Defendant Dr. Amanambu:
Buckingham, Doolittle & Burroughs, by
BRENDA COEY, ESQ.
4518 Fulton Drive, NW
P. O. Box 35548
Canton, Ohio 44735
330-492-8717

KELLY M. PRICE, R.N., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF KELLY M. PRICE, R.N.
BY MS. TRESL:

Q. Hi, Kelly. We met just a little bit ago. Have you ever had your deposition taken before?
A. No.
Q. I'm going to give you a few guidelines. This should be fairly straightforward, and you should be out of here fairly quickly.
For the record, if you're going to answer yes or no, say yes or no rather than nod or shake your head so that Cynthia can get it down on the record.
A. Okay.
Q. If you don't understand something that I've asked you, will you stop and say you don't understand?
A. Yes.
Q. If you answer the question, I'm

going to assume that you understand the question; okay?
A. Okay.
Q. For the record, would you state your name and address?
A. Kelly Price, 3546 Torrey Pines Drive, T-O-R-R-E-Y, Pines Drive, Fairlawn, 44333.
Q. I believe you are a registered nurse?
A. Correct.
Q. Tell me just a little bit about where you went to school and when you graduated.
A. I graduated in 1998 from the University of Akron.
Q. So you have a Bachelor's of Nursing?
A. Yes.
Q. Are you BLS certified?
A. Yes.
Q. Are you ACLS certified?
A. No.
Q. First of all, your job, are you still at Rockynol?
A. Yes.
Q. Your job at Rockynol it would look

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to me is not as a floor nurse; is that correct?
A. Correct.
Q. Describe to me your job at Rockynol.
A. It was as an MDS coordinator.
Q. You say was. Is that no longer correct?
A. Correct.
Q. What period of time was your title the MDS coordinator?
A. It was during this period of time that Mr. Pere was there, but it was officially September of '01 to -- and I don't know the approximate transition date. I transitioned into a different role the summer of '02. I would say roughly July, but I'm not exactly sure when.
Q. Before you describe your duties then as MDS coordinator, what did you do prior to September of '01?
A. I was the assistant director of nursing at another facility.
Q. Then you transitioned into a new role in approximately the summer of 2002, and what would that be?
A. Assistant director of nursing at

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Rockynol.
Q. Are you currently the assistant director of nursing?
A. (Indicating.) Currently, I'm a marketing sales associate.
Q. That's a no?
A. That's a no. I'm a marketing sales associate at Rockynol.
Q. So your job there now is to do what?
A. To make a long story short, my job is to basically admit people into independent apartments or assisted living.
Q. So you have moved away from the skilled facility --
A. Yep.
Q. -- more to the ambulatory residents who can do more on their own sort of facility?
A. Sort of. I don't know that you could say it quite like that.
Q. Well, describe it for me.
A. I guess I have more of an administration role, I guess, and I was doing that in The Ledges before, I guess, as the assistant director of nursing. It wasn't so much direct hands-on care. Likewise, my role

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now in marketing isn't, you know. But yes, it's a little maybe more removed from residents. I'm not seeing them in the facility now. I'm seeing them in their homes and the environment they are in prior to coming into Rockynol.
Q. Describe your role then as MDS coordinator. Tell me what you did and what your responsibilities were.
A. My responsibility was to coordinate the plan of care for the residents. My responsibility was for the residents. There was another MDS coordinator, so I was responsible for the first floor residents, their plan of care, and then completing the assessment, the MDS assessment, and completing the MDS in the computer.
Q. Is this like a one-shot assessment, or is this an ongoing involvement that you have?
A. I'm not sure.
Q. In other words, I'm assuming from what I'm looking at which are the records, and we'll get into that more, but I just want to understand sort of standing back, it looks to me that you see the patient either as he's being admitted or very soon after he has been

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admitted. Then you complete this and your role is done and you go on to the next patient as opposed to you do this and you see them in three more days and you see them in three more days and you see them in three more days?
A. If I can speak to Mr. Pere as an example --
Q. Sure. That would be great.
A. -- he was a Medicare patient, so Medicare sets certain guidelines for how often you have to complete the assessment.
Q. So theoretically, you may be completing it every three days or every two weeks or every two months?
A. It isn't those time frames, but yes, there is a pattern.
Q. In Mr. Pere's case, do you know the next time that he would have been assessed this way?
A. Yes. It would have been called a 14-day assessment.
Q. At the time that was your job? Your only job was to do these reassessments, to do the initial assessment and the reassessment?
A. Correct.

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Q. We'll come back to that specifically. Did you have any other duties while you did this? Did this keep you busy full time? This was your responsibility?
A. I'm remembering now I did do restorative nursing as well.
Q. What is that?
A. It's a nursing rehabilitation program, and that is differentiated from like a therapy rehabilitation program. It's nursing where you try to keep the residents as functional as possible so they don't lose their independence. So I worked with the restorative nursing assistants.
Q. Were you actually at the bedside, or was this more of an administrative job?
A. More of an administrative job.
Q. This MDS coordinator was more of an administrative job?
A. Yes, but there's contact with the residents and their families.
Q. We'll get back to that. Have you ever been disciplined as a nurse?
A. No.
Q. You have never had any difficulties

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at Rockynol with disciplinary issues?
A. With myself?
Q. Yes.
A. No, not that I know.
Q. In terms of today's deposition, what did you review for today's deposition?
A. The care plan that I had done for Mr. Pere.
Q. Did you take any notes as you were reviewing this?
A. No.
Q. Did you bring anything with you today, any notes that you took?
A. This wasn't for today, no, just blank pieces of paper.
Q. Did you look at his medical records in general terms or just this document?
A. I had looked at the medical record back at the facility, but I don't think I looked at anything. I think I just primarily -- and I read the nurse's notes as well, or the nurse's notes that -- I can't think of what else. I had his whole medical record back at the facility that I looked through.
Q. You did that to prepare for today's

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deposition?
A. Correct.
Q. How long ago did you do that?
A. Probably a week ago. What's today? Friday, yeah.
Q. Do you remember Mr. Pere independently of this? If I said to you do you remember him in your own memory other than what you documented, can you remember him?
A. Yes, but I don't know what is from looking, you know, from the chart and what would be from what I've heard from other people. I don't know what's independently mine, you know.
Q. Well, tell me some of the things --
A. I remember him being tall. I'm sure everybody said that.
Q. How tall was he?
A. I think 6'3" was maybe the official. I can't remember.
MS. BREAUX: Everyone said he was tall.
MS. TRESL: I'm trying to determine how tall.
A. I think he was slender. I think he was a slender man. So whenever I think someone

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is slender, they appear taller as well.
Q. When you say you're not sure but it may have been things that other people have told you, what sorts of things are you thinking about when you say that?
A. Nothing specifically, I guess. I'm just trying to think if I can picture him and is it just what I've -- as I've thought about this along the way, that it's just a creation in my mind. I don't know what he looks like.
I can tell you he had dark hair, and he may or may not have had dark hair because that's something that I don't know because he wasn't there for very long.
Q. When you heard there was a lawsuit from Mr. Pere, did you say to yourself, oh, I remember him, or did you have to do some digging before you remembered him? Did the name stand out, the circumstances, who he was?
A. Yes.
Q. Why is that? Do you know why?
A. Because the morning of his death, I actually was going into work that day, so I had gotten to work like around 11:00 or noon that morning, and I remember hearing.

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Q. We'll come back to that. Other than reviewing the medical records and talking to your attorney, have you talked to anybody about this case in preparing for your deposition today?
A. Say that again, please.
Q. Other than talking to your attorney, did you talk to anyone else, oh, I'm going to have my deposition taken, or someone told you they were going to have their deposition taken before you came today?
A. Yeah. I told my husband.
Q. I mean in terms of people at Rockynol. Let me be more specific.
A. My supervisor at work now needed to know.
Q. Can you tell me what you said to her and what she said back?
MS. BREAUX: Objection. You can answer, Kelly.
A. I just said that I had to go give a deposition.
Q. Did you talk to Dr. Amanambu at all about this case?
A. No.

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Q. Did you talk to any of the nurses on the floor about this case?
A. Recently?
Q. Since his death.
A. Yes.
Q. Who did you speak to about his death?
A. Susan Perrin.
Q. Can you tell me about that conversation, what you can remember and when it occurred?
MS. BREAUX: Objection.
A. We had a conversation that Saturday, the Saturday of his death, that morning when I came into work, but I can't recall what she said. I can't recall the details.
Q. We're jumping ahead, but let's since we're on this issue. Tell me how you learned about his death. You came in and what happened?
A. I don't remember. Somehow I found out that he had passed. I don't know from whom first. It could have been Susan. It could have been another nurse. As far as who else, I don't know.
Q. Were you on the floor when they told you, or is this information that came up to you in your office where you do your MDS's?

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A. Well, I walk through the main hallway to get to my office, and my office is right near the nurse's station, so it could have been either or. It's all one and the same.
Q. Do you recall your reaction when you heard?
A. Alarmed because of the suddenness, I believe, of his death. That's probably it.
Q. Did you talk to anybody about how this had happened that you recall, what caused him to fall or what caused him to die?
A. Say that again.
Q. Did you ask anyone what caused this or how this happened?
A. What caused this, no. I'm trying to think if we talked about cause.
MS. COEY: By cause, you're not talking about medical cause?
MS. TRESL: No.
A. What are you talking about?
Q. Let me just approach it from my own point of view. I would think that this was a big event. Granted, maybe it's not, but to me it would be if I was a nurse caring for this patient or if I was involved in his care. To me if a patient fell at the end of the bed and died, it would be big news. I would ask a lot of questions. People, we would be talking about it. It just seems to me that people would actually be talking about it.
What I'm trying to get from you is that you find out about it, and I'm sure it just wasn't, Mr. Pere died at the foot of his bed, and what did you have for breakfast.
A. No.
Q. I'm trying to determine did you ask how did this happen, what happened, did someone volunteer, or did someone just say, oh, he died?
A. No.
Q. That's what I'm trying to get from you in whatever way you want to explain it to me.
A. I think it was just that sense of alarm as well. I'm sure we did talk about what happened. Again, I don't remember. I did read the chart, and that is what I am remembering, but I can't say for sure that was what was said because that's all I know today is what I have

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read in the chart, some of the details.
Q. Tell me from what you read and putting everything together what you understand to have happened.
A. That he was -- and I don't think that was clear in the chart. I know there was a wheelchair there and there was a bed, so as to which he was sitting in, I'm not sure. He fell to the floor, and there was -- the nurses had seen there was blood on the floor. Let's see, what else?
He was sitting, he fell, blood, blood on the floor, 911 was called. The roommate was there. The roommate was there, and I remember the roommate. That's really all.
Q. You have no reason to understand whether he tripped, whether he passed out, whether he was hit over the head with a two-by-four?
A. No.
Q. All you know is that he was found on the floor in a pool of blood?
A. That's correct.
Q. As the person who is responsible, I'm assuming you are the liaison to Medicare as

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the MDS person?
A. I don't understand the question.
Q. You filled this out for Medicare, I believe you said --
A. Correct.
Q. -- in Mr. Pere's case?
A. Correct.
Q. I assume then you are like his designated MDS coordinator since you filled this out?
A. Right.
Q. Do you have any responsibility, any connection to Medicare in terms of what's happened to him at the end of this?
A. Do I have any connection with Medicare?
Q. Do you have to fill out a form? Do you have to explain to them what happened to their patient?
A. No. This is it.
Q. This is it?
A. (Indicating.)
Q. Do you have a form that you fill out since you would have had to reassess him in 14 days to say I don't have to reassess him in 14

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days because he's dead?
A. You do a discharge, a one-page thing that he died.
Q. And send that to Medicare?
A. Correct.
Q. Is that on the chart?
A. Yes.
Q. Can you find that for me?
A. Sure.
Q. This would be here (indicating), and I think most of this stuff is in the back, but just help yourself.
A. It's this right here (indicating).
Q. What sets it aside? How did you know that? Discharge tracking form for nursing home resident, minimum data sheet, and in the bottom right hand it says MDS 2, September 2002.
A. That's right.
Q. So after Mr. Pere expired, you filled this out and sent this to Medicare so they would know that he was no longer alive; correct?
A. Correct.
Q. It does not look like anywhere in here you describe what happened or the cause of

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death or anything.
A. No.
Q. Do you send a death certificate with this?
A. No.
Q. So it's just as if he has been discharged and not necessarily expired?
A. I'm not sure. It has been a while. You code as to their discharge status, whether they went home as an example, whether they went back to the hospital as another example, and then you just mark deceased.
Q. Since that's marked eight, that means that's what happened to him?
A. Correct.
Q. Thank you. Let's talk about the minimum date sheet just in general. First of all, on this basic assessment tracking form there's a lot of people who have signed. How do you determine who signs this and what their role is?
A. The people that sign it are people who have contributed information to the MDS. Do you want me to tell you who?
Q. Yes. I would like to know. I would

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like to know what each of those individuals contributed rather than their names.
A. Okay. It's a social worker, and they have initialed what sections they are responsible for. It's a social worker, activities director, dietician, and director of rehabilitation.
Q. Can we tell from there who contributed to section G?
A. Section what?
Q. G.
A. Yes. That's me.
Q. What about -- let me see here.
MS. BREAUX: Can we go off the record for a minute?
MS. TRESL: Sure.
(Discussion off the record.)
Q. Section G then, you said you were responsible for that. Section H, how about that section? Who was responsible for that?
A. That is me.
Q. First of all, other than to document for Medicare, what was the purpose of you doing a minimum data sheet, or is that the only purpose?

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A. It is for Medicare, but you do assessments for non-Medicare. The purpose is to develop a care plan for each resident.
Q. So then the initial duty then is to Medicare, and the secondary but I'm assuming equally important duty --
A. Yeah. I'm sorry I interrupted. I guess not secondary. It is primary. For this one it was a Medicare requirement. However, this was not a comprehensive assessment.
You can see at the top it is called a full assessment. The comprehensive would come later, and that is the one that more specifically develops the care plan.
Q. So things that appear in here are given how much weight in terms of developing the care plan until the comprehensive care plan can be completed?
A. There's no measure. I don't know that I can answer that in terms of quantity.
Q. Let me ask you this way. When I've asked the nurses whose depositions I have taken previously, basically this document has no impact on their radar screen whatsoever.
MS. BREAUX: Objection. If you can

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answer.
Q. I'm trying to determine how much of a role in terms of you being the person that's filling it out do you see it as being helpful or relevant or important to the nurses actually caring for the patients on the floor, or is this just something that's for insurance and that's pretty much its role?
A. It's both. It serves as guidance on the care, and it is a Medicare requirement, both.
Q. So if nurses who are caring for the patient are telling me that this isn't really something they utilize in terms of developing their nursing care plan, that would not be your understanding of its purpose, one of its two purposes?
A. Say that again, please.
Q. Sure. The nurses who are caring for Mr. Pere, I refer them to this, and I say, well, what about this and what about this, and they say that's not something that we worry about. It's for insurance. It doesn't impact on us. We go on what we see in our assessments. This doesn't count.

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You as the person preparing it, is it your understanding that the data that you're taking time to compile here and put on the record is something that the nurses are to be utilizing and using as they develop their care plan as one tool at their disposal?
MS. BREAUX: Objection. You can answer.
A. I develop the care plan usually with input from those that I mentioned before, the social worker.
Q. Right.
A. I'm not sure how to answer that question.
Q. Let me just keep reasking it.
A. I keep losing the question within all the words.
Q. Let me just try and see if we can get to it. Is your responsibility in compiling this -- let's just put Medicare aside. Let's not make that an issue so we don't complicate it.
Is this supposed to be the beginning of the care plan for Mr. Pere when he comes in? This is a Bachelor's trained nurse who is

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developing and asking these questions, and this is like, okay, nurses who are caring for him, here's where we start with our care plan?
A. Yes.
Q. So then looking at it from their point of view, that is something that they can be relying on as they begin to develop their care plan as they get to become more familiar with the patient, yes or no?
A. Please, repeat.
Q. Sure.
(Record read.)
A. The nurses don't -- they don't know how to interpret this, if you're talking about the charge nurses, the nurses on the floor, the direct caregivers. They don't use this form.
Q. So how then when you say that you're in charge of developing the nursing care plan, how then can that information be something that can be digested, if you will, by the floor nurses?
A. We put a care plan into place.
Q. Where in the record would I find the care plan that was put into place?
A. This was a five-day assessment. The

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full care plan is not completed until the 14-day, the comprehensive assessment, when that is done.
Q. Go ahead.
A. But there are care plans that may be put in place prior to that. It doesn't mean you have to wait for 14 days. A lot of times the social worker may put a care plan on as she sees fit. You have up to 14 days because it changes often.
Q. Show me in the record what you would consider to be a care plan that was implemented.
A. Sure. Like here is one (indicating) from a social worker. There's one. Here is one on admission. There's the dietician's. These are all care plans (indicating).
Q. We'll refer to those then. We went through these yesterday, so let's go through them together. Maybe your counsel can give you a copy because this is all I have.
MS. BREAUX: What are you referring to?
MS. TRESL: Let's start with adjustment to nursing home. Actually, let's just skip that one. Let's go to the immediate

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needs care plan at risk for accidents and injury.
MS. BREAUX: Is this it, Jackie?
MS. TRESL: This is it.
MS. BREAUX: I'm going to state an objection to all questions relating to this document. Go ahead.
Q. Who signed this care plan at the bottom?
A. That's me.
Q. So you prepared this immediate needs care plan?
A. Correct.
Q. How did you come up with this care plan? What information did you use to fill this out?
A. I would use the information that I had at that time, whatever would be from the medical records including hospital records, and in conversation with the direct care staff, their input as well.
Q. So when you're filling this out then, I can assume from what you just said that you have reviewed his medical records let's say from before he came to Rockynol if they're

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available?
A. I usually do not have the information before someone comes to Rockynol.
Q. Didn't you say you use the medical records information?
A. Yes.
Q. What medical records information are you referring to then?
A. Transfer records from the hospital, any other records that the hospital may send with the person when they are admitted.
Q. Under the goals that you filled out on this, can you tell me what you checked?
A. The goal would be to be free of falls.
Q. Do you have any idea why you checked that?
A. That's a goal for everyone. We want to keep them safe and free of falls.
Q. So if I looked at almost all the immediate needs care plans that you filled out, most of them would have a check for free of falls?
A. That's correct.
Q. So there's no special emphasis put

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on someone who has a history of falls or who doesn't have a history of falls, we just don't want anyone to fall?
A. The special emphasis is usually included in the interventions, but yes, we do not want anyone to fall.
Q. So if we knew that Mr. Pere had fallen 15 times before he came to Rockynol in the two weeks before he came, and we know that for all patients you're checking free of falls or most patients you're checking free of falls, where would we look in this record to see that we knew that Mr. Pere was especially at a high risk of falls because he had a history of falling?
MS. BREAUX: Objection. Go ahead.
A. Where would you see it?
Q. Yes.
A. Anywhere on here.
Q. Do we see anywhere in here that it's reflected, assuming that I'm correct, that he had a long, long history of falls before he came to Rockynol? Do we see anywhere in your documentation that you were aware of that?
A. No.

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MS. BREAUX: Objection.
A. No.
Q. And if you had been aware of that, where would we see that in this care plan?
A. Probably in the problems/needs section.
Q. What would you have checked had you known that he had a long history of falling?
A. I would have written it in, history of falls, just like I did for a diagnosis of Parkinson's disease.
Q. Is that something that you typically ask, do you have a history of falling, to his family or to him, or do you just think that maybe you'll find it out as the medical records come? How is that something that you determine?
A. It can be -- it usually is found from -- well, it can be found from anywhere, but typically the medical records.
Q. If the patient has been falling for the two weeks previous to him coming to you, is that something that you generally know at the time that you are doing your MDS sheet and compiling this care plan, or is that information that you usually get two, three, or five days

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later?
MS. BREAUX: Objection. Go ahead.
A. Say that again. I apologize.
Q. If you have a patient that you're admitting and just hypothetically he has fallen ten times in the last two weeks let's say, is that information that you ascertain when you're doing your MDS and you're compiling your at risk for accidents care plan, or is that something that kind of evolves over the next two, three, four, or five days that you discover?
MS. BREAUX: Objection. Go ahead.
A. It can be either. It can be found immediately, or it can be something that is learned later from family.
Q. So then there's no mechanism whereby when a patient comes in if they have had a lot of falls and a lot of problems with those kinds of issues, there's no mechanism in place where you establish that fairly early on in the admission gathering process?
A. There's a fall risk assessment that is done on admission.
Q. Let's refer to that then.
A. Okay.

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Q. I think your counsel will provide that to you while I look for it. For the record, this would be the fall risk assessment. At the bottom it has low risk, moderate risk, and high risk, and it says Rockynol Retirement Center up at the top left corner.
MS. BREAUX: I'm going to object again.
Q. Explain to me how this fits into the answer to my last question.
A. What was your last question?
MS. TRESL: Would you read my last question and her answer, please?
(Record read.)
Q. And is this the document that you're referring to?
A. This is the document that is completed on admission.
Q. This is the document whereby you try and determine if people have had a lot of history of falls; correct?
A. Yes. It's one of the ways.
Q. If you can, read for me in that first column under the fall history what is checked in terms of his history of falls.

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A. Multiple history of falls.
Q. Does that put him at a heightened possibility that he may be at risk for falls?
A. Yes.
Q. How is that implemented then into your care plan that we were referring to just a little bit ago which is the immediate needs care plan at risk for accidents and injury?
A. How does it fall into place?
Q. Yes. Where in this document that you have filled out that you have signed your name to is there evidence that you knew that he had a multiple history of falls?
A. There isn't specifically written out, but I recognized that there was a need to do the care plan, and this was initiated. The dates are the same. I couldn't tell you whether I did it at the same time as this nurse completed that or following the time the nurse completed that.
Q. I guess what I'm looking for is, because it's sort of a circular process here, for everyone who comes in, more or less the goal is to be free of a fall. We don't see here in the at risk care plan that you filled out that

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you note that he has a multiple history of falls, so you have referred me to another document. Yet you're more or less responsible for initiating the care plan?
A. Correct.
Q. In a patient who has a multiple history of falls, does that put him at a higher risk for accidents and injury?
A. It may or may not. It would -- if they had a multiple history of falls, it would increase their number on this fall risk assessment. However, it could have been any reason contributing to the falls prior to the hospitalization, and then in the hospitalization it could have been corrected.
Q. Do we know, though, if it was corrected? Is there evidence here that someone said, oh, he had a multiple history of falls, but it has been corrected, and now we don't have to worry now that he has been admitted to Rockynol?
MS. BREAUX: Objection. Go ahead.
A. No. It doesn't say that on here.
Q. Is that something that is relevant in terms of developing -- just think about it

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this way. You get a brand new patient that you don't know, he's 85 years old, he's very tall, and he has got a multiple history of falls. You complete a very in-depth minimum data set, which we will go through, but take my word for it and we can determine it later, where you repeatedly talk about the need for supervision, supervision, supervision, twos and threes, twos and threes. Perhaps I'm reading it incorrectly, but let's just say that that's the argument.
You're preparing the care plan or you're initiating it through these other documents that we have talked about. I want to know where, in deposing these other nurses who cared for him, how that is imparted to them that this is a man who may be at a higher risk for falls?
A. Through the care plan would be the way because of these problems and needs that I have listed here, the orthostatic hypotension, et cetera.
Q. You're telling me to keep a clear pathway, furniture locked, keep the needed items within reach, remind the patient to use the call bell, and to receive PT and OT is a sufficient

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safety precaution for a man with a multiple history of falls?
MS. BREAUX: Objection. You can answer.
A. Would you repeat that, please? This was on the first day of admission, as I recall.
(Record read.)
A. So the assessment period was still ongoing, so initially, yes, this would be acceptable.
Q. Following the fall protocol would not be acceptable in a man with a multiple history of falls? That's a question. It's here in the intervention.
A. Okay.
Q. Would it have been inappropriate to have checked follow fall protocol in a patient with a multiple history of falls who is brand new to you that you don't know?
A. It would not have been inappropriate.
Q. Is there a reason why it wasn't checked?
A. Not that I can remember.
Q. Was there any reason not to have

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checked it?
A. Not that I can remember.
Q. In a patient with a multiple history of falls, would that be something that you might want to consider, following a fall protocol?
MS. BREAUX: Objection. Go ahead.
A. These items are all part of our fall protocol.
Q. So you're telling me that follow fall protocol should actually be at the top of this list, listed as number one, and all of these other items should be A, B, C, D, E, F, G?
A. No.
Q. My question to you, Kelly, is first of all, what is following a fall protocol? What is that?
A. It's exactly those items that are listed, and that could be why I didn't check them. The fall protocol varies from facility to facility, and this is preprinted where we select those that we want to have the staff be aware of.
Q. You want the staff to be aware of it. In his case you didn't want the staff to be aware of following a toileting plan?

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A. Not at that time.
Q. You did not want the staff to provide visual prompts to ask for help?
A. No, not at that time.
Q. You did not want them to use an electronic prompt?
A. That's correct.
Q. You did not want them to follow the fall protocol, whatever is meant by that little box?
A. No.
Q. It was okay for them to reposition the furniture?
A. On the first day it would have been.
Q. Show me on the second or third day where there's any reassessment on whether some of those boxes should have been checked.
A. Those -- the reassessment would have been done with the 14-day assessment.
Q. So from day one to day 14, no interventions are changed unless perhaps the patient falls? You just go by what you have done on the first day, and you wait 14 days to change your interventions where your goal is to be free from falls?

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A. That's the minimum to be done. That's not the standard.
Q. Can you show me anywhere in this record where anyone is reassessing his chance or risk for accidents relative to this care plan?
A. It would be -- it would be the nurse's notes.
Q. Can you show me in the nurse's notes where they are reassessing his risk for falls?
A. Let me -- there would be no -- there would be no formal reassessment of falls in terms of -- why are you giving me this?
Q. I'm going to tell you in a moment. Are you familiar with that document?
A. Yes.
Q. What is that document?
A. This is a caregiver plan of care.
Q. Who uses that?
A. Any of the direct staff. Typically, it is written in language that a nursing assistant would understand.
Q. Who puts that together so that the nursing assistants can understand it?
A. It would either be -- it would be the supervising nurses. Any LPN or RN can do

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this.
Q. Where do they get this information so that can be filled out?
A. From the resident, from the family, from the chart.
Q. So they're asking the resident or family the transfer mobility status?
MS. BREAUX: Objection. Go ahead.
A. No, no, that's -- there's many ways like --
Q. Well, that's what I'm trying to determine from you. I asked you how that's filled out, and you said the family, the patient, or the chart. I'm asking you specifically, transfer mobility status, did they learn that from the patient, the chart, or the family?
A. Either from the chart or from observation of the resident.
Q. Would that be initially, or would that be as the days go on? Is that something that's started the first day, the second day, or the third day?
A. It's typically started at the beginning of their stay and can be updated as

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needed.
Q. If it were updated, would I see that in the record that it was being updated?
A. Often -- sometimes, yes. Sometimes we would date it. Sometimes people just would write something in. The nursing staff would observe something and write something in.
Q. Can you look in the record to see if that was ever done or if it was updated?
A. It doesn't look like -- this was on -- I don't know. I don't know.
Q. That's fine.
A. There's no way of telling whether this one was updated other than having a date of January 30th.
Q. Let's go through your minimum data sheet. Specifically, I would like to look first of all at -- well, let's just go in order of what I have highlighted, section C under hearing.
So that I know that I'm reading this correctly, when you assessed Mr. Pere in his full assessment form, how did you assess his hearing?
A. Hears in special situations only.

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Speaker has to adjust tonal quality and speak distinctly.
Q. That says to me, the lay person, that he has maybe some hardness of hearing; is that correct?
A. Yes.
Q. If a person has some hardness of hearing and nursing staff are giving him instructions, is it possible that he will miss some of the verbal messages that he is getting?
MS. BREAUX: Objection. Go ahead.
A. It could be possible.
Q. Do we see anywhere reflected in the care plan or in the risk assessments where that is documented, that the patient is hard of hearing and it may be that he may have some special needs relative to that?
A. In the medical record?
Q. In the nursing care plan. Since you're the one who initiates the nursing care plan through your MDS, that's primarily what I'm interested in.
A. I would need to look.
Q. Please, do.
A. Could I have something to look at?

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Q. Would you like the acute care plan? Would you like the one that we just looked at? Here, you tell me. I mean, you have that.
A. This was completed on 2-2, so there would not be a care plan at that point.
Q. What was completed on 2-2?
A. This MDS assessment.
Q. Okay. So you filled out this at risk for accidents and injury on the first day before you started the minimum data sheet, or did you not complete this? It's dated 1-29.
A. That's correct.
Q. So you filled this out two days before you completed the minimum data sheet?
A. Right.
Q. So at the time that you filled this out, you were not aware that he had a hearing problem?
A. I may not have been. I can't recall.
Q. Would that be something that would be important in terms of deciding if he was at risk for accidents or injury?
MS. BREAUX: Objection. Go ahead.
A. Vision seems to be more of a risk

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factor for accidents or injuries, something would get in your way that you wouldn't see.
Q. So you're disagreeing with the care plan that puts vision and hearing side by side as one of the problems that need to be related to the patient?
A. No. Hearing could be a risk factor if -- I don't know -- if someone yelled, hey, stop, look where you're going, and they didn't hear and kept going.
Q. It wouldn't be a problem if someone were giving you directions on how to sit on the side of the bed because you had orthostatic hypotension and you were perhaps missing the message on your safety and you were standing up too quickly, hearing would not be important in that scenario?
MS. BREAUX: Objection. Go ahead.
A. Yes. It would be.
Q. You weren't able to determine this or didn't have the time to determine it or weren't able to follow through to determine it when you were putting his immediate needs care plan together for him?
A. I can't recall.

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Q. In your MDS you noted that he had I believe number three, and we can certainly flip over there, but you can take my word for it if you want.

Bowel incontinence you marked as a three and bladder incontinence as a three. My section H says that that means that he's frequently incontinent, and based on this MDS, it looks like you assessed that he was frequently incontinent of both bowel and bladder. Would you disagree with that?

A. No.

Q. Is there a reason why under problems/needs related to at risk for injuries incontinence is not checked?

A. Yes, because on the day of admission, it must not have -- it could have not been to my attention. Only after doing my assessment on the 2nd would I have known that.

Q. So you're telling me then that as you're compiling your immediate needs care plan, it's not important enough to gather all this kind of data that is related to needs and problems? It's not important to determine if they are hard of hearing or have incontinence

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when you're compiling this immediate needs care plan at risk for accidents and injury?

A. It is important. It just may not have been available at that time.

Q. You had no duty to determine which of those were important considerations in his care plan?

A. I mean, there may not have been any documentation to say that he was incontinent at that time. He could have been -- let me go back to this.

Frequently incontinent could mean that he was continent on one day and incontinent the next.

Q. Is your testimony that you filled this out on February 2nd, 2002?

A. What's that?

Q. Your MDS.

A. Yes.

Q. What is the day that Mr. Pere died?

A. I believe it was 2-2.

Q. So on the day that Mr. Pere died, you were filling out his minimum data set?

A. Right, because I was there and working that day.

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Q. You were not working on the day that he came in that you filled out his at risk for accidents immediate needs care plan?

A. I believe I was as well.

Q. Is there a reason why you didn't fill out the minimum data set on the day that he was admitted?

A. Is there a reason that I didn't? Yes, because usually you wait five days to complete it.

Q. Okay. So you're telling me that when you admit a patient and you're in charge of preparing your care plan and the goal is to keep them free of falls that you compile this at risk for accidents and injury, and in terms of inquiring about the problems and needs related to these problems that we just discussed, you get what you get when the patient first comes in, and five days later you'll do a more complete screening to determine the level of supervision they need?

MS. BREAUX: Objection. You can answer.

Q. I'm just trying to determine, Kelly, that you have a very lot of old and frail

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people.

A. Uh-huh.

Q. There are lots and lots of problems going on. The number one goal for everyone seems to be keeping them free from falls. Things like frequent incontinence and hearing problems, at least from my perspective, are very, very important in terms of patient safety.

Now, when I ask you why these things aren't checked, you say, well, you were going to wait five days, the information wasn't available to you, and there's a variety of reasons why you say that. My concern is that this is immediate needs. That means right now in your face this is what this patient needs so he doesn't have a fall.

If there are things going on that aren't checked here, can we agree that it's less likely that your care plan is going to reflect interventions that are specific to the problems that that patient experiences?

MS. BREAUX: Objection.

A. Can you repeat the last two sentences?

(Record read.)

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MS. BREAUX: Do you want to rephrase the question?
Q. Not a problem. Not a problem. We can be here all day. That's not a problem.
First, let me clarify because we've kind of been all over the place.
Your testimony now is that this minimum data sheet is not filled out until five days after the patient is there. It's not something that you fill out on the first day.
A. Correct.
Q. So on the first day when you're in charge of setting up the care plan for the patient, the sheet that you fill out is the immediate needs care plan; is that correct?
A. That's correct.
Q. Underneath the immediate needs care plan says at risk for accidents and injury; correct?
A. Yes.
Q. And I believe that we agreed that being free from falls is a goal for all patients and it's very important?
A. Yes.
Q. So important that I believe you said

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that on just about everybody's care plan that box is checked?
A. Yes.
Q. When I asked you how the special risks of that patient are reflected, you referred me to the interventions?
A. Correct.
Q. My question is, is it important to know if a patient has significant hearing problems in terms of their risk of falls?
A. It is one of the factors that could contribute.
Q. Is it important? Is it something that should be documented?
MS. BREAUX: Objection.
A. Is it important? Is it something that should be documented? It is important.
Q. Should it be documented?
A. Should it be documented where?
Q. Right where your finger is.
A. Yes.
Q. Is it important if a patient has significant incontinence of bowel and bladder in terms of their at risk for accidents and injury?
MS. BREAUX: Objection.

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A. What was the question, is it important?
Q. Yes.
A. Yes.
Q. Why is it important if the patient is incontinent? How does that relate to the risk for accidents or injury?
A. How is it important?
Q. How does it relate?
A. Incontinence relates to falls in terms of being in a hurry, that type of thing.
Q. So can we agree that that's an important problem and that if a patient has it in terms of their being at risk for accidents, it should be documented?
MS. BREAUX: Objection. Go ahead.
A. Yes.
Q. Is it documented on this record?
A. It is not documented on the immediate needs care plan.
Q. Is there anywhere that it's documented that he has frequent incontinence until we get to your minimum data sheet?
A. Can I see just this one page?
Q. You sure can.

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A. I don't think I have it, no.
Q. So you are looking at the acute care plan, and tell me -- keep looking.
A. Additionally, on the acute care plan an intervention is to monitor for risk for falls.
Q. So we can agree looking at the record under the acute care plan dated 1-29, which is the day of his admission, that we don't see that there's a problem or a need related to incontinence; correct?
A. Correct.
Q. We don't see that there's a problem or a need related to hard of hearing; correct?
A. Correct.
Q. We don't see anywhere in here, and stop me if I'm wrong, that he has a multiple history of falls?
A. No.
Q. Can we agree that a multiple history of falls until we know whether or not they have been resolved may put him at a higher risk to have falls when he's at Rockynol?
MS. BREAUX: Objection.
A. It may.

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Q. Now, let's go back to this, although this probably becomes less important. So all of this that you filled out you filled out after he was dead?
A. Yes, with the information, however, accompanying from -- information prior to 2-1. That was my observation period.
Q. Where would we find the notes that you put together relative to your observation period?
A. The notes?
Q. I'm assuming when you say this was compiled during or after an observation period, is there a way that you could remember what you were observing, or do you just remember in your brain and you sit down at your minimum data sheet and just type it out?
A. I would get information from the chart or from conversations with the staff.
Q. So you're saying then from the 29th until the 2nd you're gleaning things from the chart and from the staff. That he needs a high level of supervision, if I can refer you to G, and H, that he's frequently incontinent, that he's hard of hearing, that overall change in

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needs has deteriorated, that would be section Q; these are all things that you're determining in your observation period as you prepare to finalize your MDS sheet on the 2nd? Is that correct? Was that a yes?
A. It was not an answer yet.
Q. Okay.
A. Yes. Some things come from the chart. There are different time frames, and many of these questions -- this is an involved process, and it changes all the time, every section. Some of the information is from the time period when the resident is in the facility.
Q. The question is, though, and I understand that it's a complicated document and it's a complicated process and human beings are very complicated, but my very simple question is, this document was prepared when Mr. Pere was dead; we can agree on that? Unless you wrote it at 7:00 in the morning on the 2nd, you dated it on the 2nd, and presumably your shift doesn't start until 8:00.
A. The information was entered into the computer on the 2nd.

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Q. Who entered the information on the computer?
A. I did.
Q. So we can agree that for this document, at the time it was completed on the computer Mr. Pere was dead; correct?
A. Correct.
Q. Backing it up, I believe what you're telling me is that the data that you entered after Mr. Pere was dead you had collected from whatever sources from the day of his admission until the day you sat down to prepare this report; correct?
A. Correct.
Q. So during that observation period, you were observing that he had a level of incontinence of bladder and bowel that you rated as a three. In terms of support for transfer, you gave him twos and threes. In terms of locomotion off the unit, you gave him threes and twos. Toilet use, threes and twos. His overall change in care needs had deteriorated. He needs more support. He's on antidepressants, et cetera, et cetera.
My point is that you're recognizing

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-- I mean, in section G, I'm assuming this is G, change in ADL function has deteriorated. So you independently of the nurses caring for Mr. Pere from all of the sources that you're looking at are saying this is a man who needs a lot of supervision, he's deteriorating in many areas, and he is persistently incontinent of bowel and bladder?
MS. BREAUX: Objection.
Q. All I need is a yes or no. I understand it's a complicated process.
A. No. That's not what I'm saying.
Q. Just to answer my question then, and you can elaborate how you want, is my statement correct that these numbers that you're putting in here are information that you're gathering over a period of time from the first day you met him on the 29th to the day you sat down at your computer on the 2nd and entered it into the computer?
A. Yes.
Q. So we can agree this is an evolutionary process of assessment that's going on with you from all these sources?
A. Yes.

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Q. We can agree that after Mr. Pere is dead, in looking at your minimum data sheet, this is a man who you determined through these multiple sources of data needed a great deal of supervision in transferring, in ambulating, in bowel and bladder, in deterioration in mood and ability to do activities of daily living? All you need to do is look at your numbers and see what the numbers are and say yes or no.

MS. BREAUX: Objection.

A. No.

Q. Then let's go through them.

A. The reason being is you said --

Q. Let's do section G. Perhaps I'm misreading it. Maybe I'm not reading the form correctly. Let's go to toilet use.

Now, explain to me when you give a three for self-prep, it looks to me like that is saying he needs extensive assistance, but perhaps I'm reading it incorrectly.

A. It is for self-performance, and it's for his performance over the last seven days, and it would be, yes, extensive.

Q. For support it looks to me like he needs limited assistance.

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A. He would need one-person physical assistance, but he could have needed it once during the last seven days. It is coded for the most support provided over all the shifts during the last seven days. You code it regardless of the resident's self-performance classification.

If he required one-person physical assist one time or more in the last seven days, you put section G -- I don't know what letter that would be -- I, toilet use. In the column B you would put a two there.

Q. Let's draw your attention to transfer. For support we have him listed as a three. That looks to me like it's a two-person physical assist. Would you agree with that under transfer?

A. Yes.

Q. We can go through every one of these little boxes if you like because I have all day and all evening, but what I'm trying to say is when I look at this document and review it, your assessment that you did over the course from the 29th to the 2nd says to me that the information you're gleaning is that this is a man who needs significant support, has significant issues of

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hearing, deterioration in ADL, who needs significant help in transferring, in toileting, in eating, in dressing, in locomotion, and I'm just asking you if I'm reading that incorrectly.

Under bathing we have physical help that he needs.

A. Everybody is different. This is the help --

Q. That's not the question. That's not the question, Kelly.

A. Okay.

Q. The question is, in looking at this document, it looks to me like you are noting that he needs a lot of assistance, that he's deteriorating, not improving, that he is hard of hearing.

I understand that everybody is different, but we're only looking at Mr. Pere, and we're only looking at the documents that you've compiled. This doesn't look like a man who is on the mend and who is very independent and doesn't need much assistance.

You wrote it. Does this mean that he is very independent and does not need much assistance?

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A. It does not mean that he is very independent.

Q. What does it mean?

A. It means that there's a certain level of assistance that in different ADLs that he does need.

Q. Can we say that in absence of looking at the acute care plan and all these other things that we've looked at that nowhere is it really reflected that he needs all of this help?

I'm asking you. I mean, interventions, we've gone through all the care plans. We've talked about everything in terms of the fall protocols. You're gathering information that says that he needs a lot of help and that he's deteriorating. I don't see that reflected that the nurses knew that. I don't see any change in care plan, I don't see any fall protocols in place, and when I ask them about it, they don't refer to this. So I want to understand.

A. Right. This was not evaluated until that, I don't know what day, the fifth day.

Q. I don't think it was the fifth day.

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But even if it was the fifth day, you were gathering that information from somewhere?
A. Right.
Q. I don't see that the nurses were gathering the same information that you were gathering because there's no change in anything as these things -- no one notes that he's hard of hearing. No one notes that he's confused. No one notes a lot of these issues that we just talked about.
Yet when I look at this, this seems to be fairly significant in a man who needs a lot of supervision and a lot of help.
A. There's a level of assistance.
Q. Is that reflected anywhere in the care plan? If he needs a high level of assistance because he is all these things that we talked about, hard of hearing, incontinent, dizzy, confused, and he has only got a low risk of falls, where is that reassessed so that someone says, hey, maybe he has a moderate risk of falls or maybe --
MS. BREAUX: Objection.
Q. -- he has a high risk of falls? Where is that reflected in these care plans?

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A. It's not.
Q. Should it be?
MS. BREAUX: Objection.
A. Up until the 14th day it could be.
Q. Up until the 14th day it doesn't need to be reflected in the care plan?
A. No.
Q. What is the answer to the question? Should somewhere in the nursing care plan that the nurses are looking at every day, should it be reflected that he needs a high level of care and he's at high risk of falls because of the things we just talked about?
MS. BREAUX: Objection. You can answer.
A. Yes.
Q. Yes, it should be reflected?
A. Yes.
Q. If it's not reflected, does that fall below what you would expect from nursing care at a nursing home whose number one concern is to keep a patient free from falls?
MS. BREAUX: Objection.
A. No. It does not fall below.
Q. So it's acceptable that a care plan

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that started at day one that leaves out pretty significant incontinence, hardness of hearing, all the supervision that's needed, the fact that the patient is allowed to ambulate on his own, come and go as the notes reflect, and I'd invite you to read them if you like, there's no disconnect, there's no responsibility for the nurses to know that in fact all these other special needs are going on with him?
MS. BREAUX: Objection.
Q. It's not significant in the care plan that he has frequent incontinence, that he has hearing problems, that maybe additional interventions might be needed? This document stands on its own until 14 days have passed unless the nurses, I don't know, intervene?
A. It may stand alone.
Q. And that's acceptable?
A. Yes.
Q. Why is that acceptable?
A. Because it is. Because I did not do this full assessment until the 2nd.
Q. I understand that, Kelly. He was dead. I understand that.
A. Right.

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Q. But you were making observations over that period of time compiling this, and I don't see anywhere reflected in these care plans -- what is the point of a care plan? Maybe if we go back to very elemental concepts. What is the point of having a care plan for nursing?
A. To coordinate the care.
Q. Why are we trying to coordinate the care?
A. To give individualized care.
Q. Why do we want to give individualized care to a patient like Mr. Pere?
A. Because everybody has different needs.
Q. What would one of Mr. Pere's needs be?
A. That he needs therapy could be one of his needs.
Q. How about free of falls since that was the box that was checked on the care plan that we talked about?
A. Certainly, that would be a goal of his.
Q. Would that have been something that should be reflected on the nurse's care plan

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because the care plan is about individual needs and continuity of care?
A. Repeat that, please.
Q. Is that something that should be reflected in the care plan?
A. Yes.
Q. Is it reflected in the care plan?
A. That he be free of falls?
Q. The conditions by which he is changing, the hard of hearing, the incontinence, the confusion, anything that's documented in the nursing notes.
Is there any place on the nursing care plan where you see this continuity in communicating the observations that you make, and everyone sees he needs lots of supervision and there's a lot of stuff going on with him that might put him at risk for an accident or injury in his immediate care plan?
Is there anything that prevented somebody from going back on the 30th or the 1st and checking hearing problems, incontinence? Is there any thought to maybe not repositioning his furniture, maybe providing visual prompts to ask for help in a patient like Mr. Pere?

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Is it like you come in on the first day, this is what's presented, and that's it for 14 days unless something big comes up and something changes?
A. No.
Q. You think that it's okay that the care plan does not reflect these changes that you were observing that you used for your minimum data sheet?
MS. BREAUX: Objection.
Q. That's acceptable nursing care?
A. That's not what I'm saying. I did not make these observations -- I think I don't even -- maybe I'm inappropriate in saying this. I did not come in on Saturday, and I don't -- I don't know how to say this.
This assessment is representative of what was uncovered in the chart and things that I talked about with staff, so whenever I completed this document on the 2nd -- I mean, the nurses already knew this information. This is what I would have gathered from their documentation.
So on the 2nd when this resident is deceased, you wouldn't find what I took from

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there in the chart. You wouldn't find anything like that because he was deceased.
Q. At some point is this information that the nurses know that they're sharing with you, is that something that needs to be changed let's say in terms of his fall assessment risk? Does somebody maybe need to mark checks in his box to check that he has dizziness?
MS. BREAUX: Objection.
A. Would you repeat that?
Q. I can say it. That's fine.
When I asked the nurses about the care plan, they tell me it's based on what they observe. You tell me that the care plan is initiated when he comes in. Nurses are telling you all kinds of things that help you fill out this minimum data sheet.
I don't see anywhere that it's reflected in Mr. Pere's care plan that he's at an increased risk for falls based on the new knowledge that has been unearthed by you through staff, the incontinence, the hard of hearing, the dizziness, and the confusion.
All I want to know is as that information unfolded, I believe that we agree

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that that puts him at an increased risk for falls.
We can go through it again; the hardness of hearing, the incontinence, the dizziness, the confusion. Would you agree that those things put him at an increased risk for falls?
A. Yes.
Q. Can you agree by looking at the records, and you are welcome to look at my chart, that there is nowhere reflected that someone said, gee, new pieces of the puzzle which are available have become known to us, and maybe we had better rethink that he may be at an increased risk for falls?
MS. BREAUX: Objection.
Q. Apart from this (indicating). This has nothing to do with my question. I'm saying in the care plan for him. You initiated the care plan, you started it, so unfortunately you have to be one of the people that gets questioned about it.
Is there anywhere in the records that the observations that you used for this, put this apart (indicating), observations that

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are readily available because you gleaned them from somewhere, so presumably you said you got them from the nurses, is there anywhere reflected that as people got to know Mr. Pere better that his status as a fall risk, low, moderate, or high, was based on these observations?
MS. BREAUX: Objection.
A. No.
Q. Should it have been?
A. Should it have been reflected on the fall risk assessment?
Q. Somewhere in this medical record should it have been reflected that he may not any longer be a seven as this information became available; his bowel incontinence, his bladder incontinence, his hardness of hearing, his confusion, his history of multiple falls, his dizziness, his vertigo, his syncope?
MS. BREAUX: Objection.
Q. And maybe it's not important, and I'm just off the mark here.
A. No. It is important, but that information would be found in the nurse's notes.
Q. If I look in the nurse's notes and

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there's no documentation that he is being reassessed, monitored for risk of falls, to use some of the nurses' language here, if that's not reflected in the nurse's notes, is that something that falls below the standard of care for nursing?
MS. BREAUX: Objection.
A. If it's not reflected in the nurse's notes?
Q. Yes.
A. It has nothing to do with the standard of care. If something was observed and documented, it would be there. If it wasn't observed and documented, it's not there.
Q. If it's observed and documented that he's frequently incontinent, that he's dizzy, he's confused, and his gait is unsteady, et cetera, and it's documented in there -- let's just say it is -- does that increase his risk for falls?
MS. BREAUX: Objection.
A. Yes.
Q. Does that make him at a higher risk for falls?
MS. BREAUX: Objection.

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A. It may or may not. It would on a fall risk assessment.
Q. If he had been listed as a moderate risk or high risk, would it have changed the kind of interventions that you checked initially on your acute care plan?
In other words, when you filled this out on the 29th, if you would have checked the box confusion, hearing problems, incontinence, and balance problems, because we know he had orthostatic hypotension and we know by definition as a nursing diagnosis orthostatic hypotension gives you balance problems, so if on the day you filled this out, Kelly, you were able to check confusion, hearing problems, balance problems, and incontinence, and you knew the incontinence was both bowel and bladder, would you have checked any additional interventions, or were those interventions sufficient?
MS. BREAUX: Objection.
A. It would depend on how he was -- how he was presenting. Again, without -- I would say it was sufficient.
MS. TRESL: No further questions.

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MS. COEY: I have no questions.
MS. BREAUX: We'll read.
- - - - -
(Deposition concluded at 3:35 p.m.)
(Signature not waived.)
- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 72 and note the following corrections:

PAGE LINE REQUESTED CHANGE

_____
KELLY M. PRICE, 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, Cynthia A. Sullivan, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named KELLY M. PRICE, 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 24th day of November 2003.

Cynthia A. Sullivan

Cynthia A. Sullivan, Notary Public
Within and for the State of Ohio
My commission expires October 6, 2006.