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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

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ROBERT MORTON, ADM., OF THE ESTATE OF EUGENE MORTON, et al.	)	
Plaintiffs,	)	CASE NO.: 37075
V.	)	JUDGE CAROLYN FRIEDLAND
MANORCARE HEALTH SERVICES, INC., et al.	)	
Defendants.	)	

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ORAL AND VIDEOTAPED DEPOSITION OF SHIRLEY STOKLEY, R.N.

JULY 22, 2000

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ORAL AND VIDEOTAPED DEPOSITION OF SHIRLEY STOKLEY, R.N., produced as a witness by the Plaintiffs, and duly sworn, was taken in the above-styled and numbered cause on the 22nd day of July, 2000, from 13:23:50 to 16:16:20, before Peggy Peacock, CSR in and for the State of Texas, at the Jones Building, 202 West Houston Street, Marshall, Harrison County, Texas, pursuant to the Ohio Rules of Civil Procedure.

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COPY

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APPEARANCES

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ALSO APPEARING:

MS. JULEE RACHELS, CLVS
VIDEOGRAPHER

VIDEOGRAPHER: This is the oral and video deposition of Shirley Stokley, R.N. We're on the record at 13:23:50.

SHIRLEY STOKLEY, R.N.

was called as a witness by the Plaintiffs, and having been first duly sworn, testified as follows:

EXAMINATION

BY MR. KULWICKI:

Q. Mrs. Stokley, why don't you please introduce yourself to the members of the jury by stating your name and telling us where you live?

A. My name is Shirley Stokley and I live in Winnsboro, Texas.

Q. Mrs. Stokley, how are you occupied? What do you do for work?

A. I'm a registered nurse.

Q. And how long have you been a registered nurse?

A. Since 1986.

Q. We're here today to ask you about your findings from an assessment that you did of records relative to Eugene Morton and his residency at Manorcare Rocky River in Rocky River, Ohio, and also to assess the training program and compliance with industry standards by Manorcare personnel. Are you prepared to do that today?

A. Yes, sir.

Q. Okay. Let's begin by having you tell us a little bit about your background and your qualifications.

A. Okay.

Q. How long -- you've worked in nursing since 1986?

A. Yes, sir.

Q. And as part of your nursing duties, you were a state surveyor in the State of Texas?

A. Yes, sir.

Q. Why don't you tell us what years you were a state surveyor and then tell us a little bit about what was involved with that job -- that job position.

A. Well, I worked for the State of Texas as a surveyor and an investigator for six years beginning in 1989 to 1995. That involved surveying nursing homes for federal and state compliance with the rules and regulations of long-term care, investigating incidents and accidents that occurred to the residents that lived in those facilities.

Q. Okay. You also had a job position as a Director of Nursing at a nursing home?

A. Yes, sir.

Q. And actually at a couple of nursing homes?

A. Yes, sir.

Q. Could you tell us what that job involved and what your job duties were as a Director of Nursing?

A. As a Director of Nurses, I was required to insure

that the patients or residents -- clients -- got the proper care that they were supposed to get according to standards, to implement plans of care -- develop and implement plans of care, assess every resident in the home. I was responsible for making sure that all the patient -- the caregivers were certified, that they gave the care that they were supposed to give, that the nurses were proficient in following up and making sure that the patients got the kind of care that they were supposed to.

Q. Mrs. Stokley, have you testified as an expert witness before in a case involving questions about care provided in a nursing home setting?

A. Yes, I have.

Q. And how many times have you so testified?

A. Half a dozen or so, probably.

Q. Now, when you've given testimony in the past, have you testified on behalf of the defendant, or the nursing home, as well as on behalf of the patient or the patient's family?

A. Right. Both.

Q. Okay.

A. Both.

Q. Thank you. Can you tell the members of the jury how I located you here in Texas?

A. I have a friend that I work with sometimes that I believe that you were talking to and became aware of -- of

what I do.

Q. Okay. You -- your friend does not have an expert witness service, or anything of that nature, and do you adver -- is that true?

A. Yes, that's true.

Q. And do you advertise your services in any way?

A. No, I don't.

Q. Okay. Still talking about your credentials and qualifications, Mrs. Stokley, have you had experience in training nurses' aides to care for Alzheimer's patients?

A. Yes, sir, I have.

Q. And have you had experience in preparing Care Plans for Alzheimer's patients?

A. Yes, sir.

Q. In your job, your various jobs in the nursing home industry, including as a state surveyor and as a Director of Nursing, have you become familiar with industry standards that apply to nursing homes?

A. Yes, sir.

Q. Okay. And what degrees do you hold in terms of your nursing background?

A. I have -- of course, I'm a registered nurse, and I have my Bachelor's of Science in Nursing.

Q. Okay.

A. I also have some certification in investigative back

whenever I was with the state. I'm a certified investigator.

Q. Okay. Thank you. Now, we're here in Marshall, Texas, I believe?

A. Yes, sir.

Q. Okay. And you don't travel, I understand?

A. No, sir. I -- I do not fly.

Q. And can you tell the members of the jury why you're not available to come to trial in this matter?

A. In '76, I had a horseback injury which did brainstem damage and messed up one of the nerves in the ears and, therefore, the inner ear problem keeps me from flying. The doctors have told me not to.

Q. Are you currently engaged in the active practice of nursing?

A. Yes, sir, I am.

Q. And can you tell us about that?

A. I'm a staff nurse at Presbyterian Hospital in Winnsboro. I work on the Acute Care Unit. And also -- they also have a Skilled Unit, and I work there, too.

Q. Tell me about the Skilled Unit. What are your job duties with respect to that?

A. The Skilled Unit is -- is similar to a Medicare Unit on -- in a nursing home.

Q. All right. I want to now turn to some definitions before we get into the materials at hand here. Can you tell

us in the nursing home setting what the term "skilled care" means?

A. Skilled care is for patients that need things like hydration, pressure ulcer treatments, wound care, special -- if they have special types of dementia, things of that sort. They -- they just require a lot of extra care that only a licensed person can give.

Q. Okay. And in the nursing home setting, can you tell is what the term "long-term care" means?

A. Long-term care refers to anyone that lives in a -- or, usually, any -- they're normally elderly little folks that need major assistance with care like bathing and feeding and grooming and activities, and things of that sort. They don't necessarily have to be elderly folks, though. There are some folks that are disabled that are in there that require the special care.

Q. One more term that I'd like you to define for us is "Alzheimer's disease". Can you tell us what that condition is?

A. Alzheimer's is a dementia that is due to the deterioration of the brain -- atrophy of the brain.

Q. Thank you. And you used the term "dementia". Can you tell us what that term means as a medical term?

A. Dementia is -- usually means that people that use their cognitive abilities and are not able to usually reason

or -- well, okay. They -- it's not necessarily an atrophy of the brain or anything. It's just a deterioration of the ability to reason, cognitive -- losing their cognitive impairment, and things of that -- along that line, like organic brain syndrome.

Q. Okay. Let me ask you about one more term. What are "pressure sores"?

A. Pressure sores are sores or decubiti that develop on the pressure points of the body due to lack of movement, being against a surface that doesn't give and the skin can't give and, therefore, you've got that pressure on that -- on that particular pressure point, sores develop and skin condition breakdown.

Q. Okay. You mentioned a term "decubiti". Is that short for decubitus ulcer?

A. Decubiti is more than one. Yes, sir.

Q. Okay.

A. Decubitus ulcer.

Q. And are "decubitus ulcers'', is that just another term for pressure sores?

A. Yes, sir.

Q. One final term and then we'll turn to some general concepts of Alzheimer's care. What does the term "contractures" mean?

A. Contractures, that's where the -- the extremity has

lost its ability **to be** able to extend and contract and it will -- that muscle in there will contract up and -- going back to a fetal position. And unless that area is worked with, that muscle and those tendons and everything don't stay extended like -- like they would normally **do**. They just ...

Q. Okay. Okay, Let's turn now to the materials that you've reviewed in preparation for your opinions today, and why don't I just quickly run through those and make sure I've got everything that you've reviewed. Have you reviewed records of Manorcare relative to the admission of Mr. Morton that ran from April of 1998 to August of 1998?

A. Yes, sir.

Q. And I guess we ought to also talk about what you haven't reviewed. You have not reviewed, however, his records from his admission in 1997 I gave you?

A. No, I have not.

Q. Have you reviewed records relative to Mr. Morton's last admission to the Cleveland Clinic Foundation immediately preceding his admission to Manorcare Rocky River?

A. Yes, sir.

Q. And did you review the deposition transcripts of Lynette Foster, Nurse Ward, Director of Nursing McClusky and Social Worker Rafici?

A. Yes, sir.

Q. Did you review Mr. Morton's death certificate?

A. Yes, sir.

Q. Did you review the incident report regarding his assault on May 21, 1998, that was prepared by Manorcare?

A. Yes, sir.

Q. Have you reviewed promotional literature prepared by Manorcare?

A. Yes, sir.

Q. Did you review the June 4, 1998, letter prepared by Marian Morton to various Manorcare officials?

A. Yes, sir.

Q. Did you review Lynette Foster's personnel file?

A. Yes, sir.

Q. And how about the defense expert, Dr. Robert -- or Richard Wagar. I'm sorry, I can't recall. Dr. -- well, in any event, Dr. Wagar's report?

A. Yes, sir.

Q. All right. Now, let's turn to Alzheimer's, care of Alzheimer's patients, and I'd like to have you talk a little bit and sort of educate us about some of the general issues that involve -- that are involved with the care of Alzheimer's patients. First of all, let me just ask generally: Are patients with Alzheimer's dementia at risk for falls?

A. Yes, they are.

Q. And why is that?

A. Well, part of it is because of their cognitive

abilities. They -- a lot of it -- a lot of times the little residents aren't steady on their feet, they have an unsteady gait. They don't understand that they need to hold onto the side rail, they don't understand that they have to go around things instead of trying to go through them. So, there's just -- and a lot of Alzheimers pace. And during that pacing, they will like get really, really tired. They don't understand that they're tired and they'll just give out and fall sometimes. I mean, there's -- they are at high risk for falls.

Q. Are Alzheimer's patients at risk for malnutrition, dehydration and/or weight loss?

A. Yes, sir.

Q. And why is that?

A. Well, dehydration because they don't understand that they need to stop and get a drink. A lot of -- a lot of them don't understand that they're even thirsty. But if you hand them a glass, you know, they'll drink -- or plastic container -- they will -- they will drink.

As far as malnutrition, it is very difficult to get, in the latter stages of Alzheimer's, especially, to get these little folks to sit down and stay put. So, most of the time you want to give them finger foods so that they can eat while they're moving because they understand that they can do that, but they don't understand the eating.

If you do have to sit them down, then there -- there needs to be a program to where they're not easily distracted where, you know, you give them just like one bowl at a time where they don't have to make a decision and that way they can stay concentrated on that one thing that they're doing.

Q. Are patients with Alzheimer's at risk **for** assault by caregivers?

MR. FIFNER: Objection.

Q. (By Mr. Kulwicki) You can answer.

A. Yes.

Q. And why is that?

A, Well, part of that **is** because when they don't understand things, they have a tendency to strike out in order to maintain some type of control over the situations. And so when they're striking out, sometimes caregivers, if they're not trained appropriately, do not understand that it's not striking out toward them. That it's just striking out in general. And sometimes the caregivers will strike back or they will be very harsh, or whatever, because they don't understand what's happening.

Q. Okay. What is the purpose of having a Care Plan in caring for patients with Alzheimer's disease?

A. Well, it's extremely to have a -- it's extremely important to have a Care Plan when you're caring for any type of patient, especially the Alzheimer's. One of the things

with that is that you -- whenever the patient first comes in, or the resident first comes in, which I'd rather refer to them as, a complete assessment needs to be done, not only on their physical status but their mental and psychosocial status, too. And then as the -- after the assessment is done, you assess the needs of that person and thereby, based on the needs that that person has, you have to develop interventions and meet goals in order to help that patient have the best quality of life that they could possibly have.

Q. Thank you.

MR. KULWICKI: We're on the phone. Dr. Irwin, can you still hear us?

DR. IRWIN: Yes, I can just fine. Thank you.

MR. KULWICKI: Thank you.

Q. (By Mr. Kulwicki) Nurse Stokley, *is* it important that the Care Plan for a patient with Alzheimer's disease be individualized for that particular patient?

A. Certainly.

Q. Why is that?

A. Well, because everyone that's in the nursing home is -- are -- they're separate little individual people and they all have different needs, different care needs. And so in order to be able to assess and meet those needs, they have -- those interventions have to be individualized to -- to meet that patient's needs, or that resident's needs.

Q. Now, we've been talking about Care Plans here and we really haven't told the jury what a Care Plan is. Can you tell us what -- what a Care Plan is?

A. Well, a Care Plan states what -- the problem is identified. Such as, "Patient has a high risk of falls. Resident has a high risk of falls." Then you developed -- you develop interventions on how you're going to prevent that person from falling or how -- how are you going to meet the needs of that little resident. Then, and -- and they're very specific.

They're like one, two, three, we're going to be right there and monitor and assist the patient with walking and provide extra caregivers and keep him within vision, different things like that. And then you have a goal that you look at in **30** days. Were those interventions appropriate, were they met, did this patient actually not have any falls? And if they did have problems along that line, then you have to go back in, reassess the patient, do new interventions to find out how you're going to meet a goal so that that patient or that resident can have the very best quality of life that they can possibly have.

Q. Now, in what we've marked as Plaintiff's Exhibit 1, which is a copy of the records that we have obtained from Manorcare relative to Mr. Morton's admission, there are a series of forms called MDS forms, or Minimum Data Sets. Can

you tell us what Minimum Data Sets are?

A. Okay. A Minimum Data Set is a -- an assessment tool that's required by the federal government that puts the care needs of that resident in a number form with the questions that are asked on the form so that they -- the -- it's now used for reimbursement. During '98 it was not used for reimbursement, but that's where they were going with the Minimum Data Set, to make sure that everybody is assessed the same way and that everybody gets the same care needs addressed in the Minimum Data Set as far as reimbursement goes now at this time.

Q. Is the MDS the same thing -- or in 1998 -- let's focus on our case. Were Minimum Data Sets in 1998 the same thing as a Care Plan?

A. **No.**

Q. And how were the two things different?

A. Well, the minimum -- again, the Minimum Data Set is a -- a required form by the federal government. And all it does **is,** it goes down and it asks these questions and you answer the questions according to the assessment that you did on the patient and their basic needs. The Care Plan is your working blueprint of how you're going to take care of that one little resident that's in that home.

Q. Okay. **All** right. Let's talk about the elements of a good Care Plan. Should a Care Plan for an Alzheimer's

patient address safety?

A. Certainly.

Q. And why is that?

A. Well, because safety is one of the number one issues on Alzheimer's residents.

Q. Can you tell us about some of the -- you mentioned falls earlier. Are there other safety issues that are particular to Alzheimer's patients?

A. Yes, sir. There's wandering; of course, falling; inappropriate -- some inappropriate behavior. Some little Alzheimer's residents like to sleep in other people's beds instead of their own. They don't understand. It's just a bed. Incontinence is a problem with little Alzheimer's residents, too.

Q. Okay.

A. I mean, there's just -- .

Q. Let me -- let me get to incontinence in a second. But, again, talking about elements of a good Care Plan, should it give special attention to skin, feet, teeth, the peroneal area and bowels?

MR. FIFNER: Objection, leading.

Q. (By Mr. Kulwicki) You can answer.

A. Well, certainly. I mean, that's -- that's just a given. In any type of assessment that you do for a resident and develop a Care Plan for that resident, it's a head-to-toe

assessment addressing all of those issues.

Q. Why are those particular areas of the body important?

A. Because that's where the breakdown of the skin and infections begin.

Q. We mentioned the "peroneal area". What is that? Where is that? Anatomically, where is that located?

A. Well, the peroneal area is usually the genitalia area.

Q. Okay. Should a good Care Plan address nutrition and hydration?

A. Certainly. That's -- that's part of general nursing.

Q. Why is that important with Alzheimer's patients?

A. Well, because little Alzheimer's residents don't take the time to sit and drink anything. They don't take the time to sit and eat. And it's extremely important that you maintain hydration, you maintain nutrition on the people that don't know that they're hungry or thirsty.

Q. Does a well-devised Care Plan for an Alzheimer's patient address their physical activities?

A. Certainly. It -- it should address if they're pacing. A for instance: If they're pacing, then that is -- although that's a normality for that patient, that creates a whole new problem for the caregivers. And the interventions

need to be addressed such -- so that caloric intake is improved and hydration is improved and greater supervision and incontinent care is given and the general appearance is maintained because some folks will, you know, pace without clothes. You know, you've got to be there to help guide the folks and show them and help them and do for them because they can no longer do for themselves.

Q. Should a Care Plan for Alzheimer's patients address their exercise or their ability to move about?

A. Yes.

Q. And why is that important?

A. Well, that's important because you're trying -- one of the things is that you've got to -- okay. Let me back up. A Care Plan for their activity and their -- their mobility status -- the decline in Alzheimer's patients sometimes can be very subtle. And so mobility, a lot of times, is where you're going to first start seeing a little bit of a decline -- a declination in that. So, if you -- if you haven't addressed that as an issue, then you don't even know what you're looking for. So, the activity needs to be noted very detailed in the nurses' notes and in any type of activity director or activities -- organized activity that they're going to, or anything else, what they're doing and how they're doing, to help what cognition that they do have left.

Q. Okay. All right. We've talked about some specific

elements of a Care Plan. Let me now turn to how often the Care Plan should be performed or updated. Is there a need for on-going assessment of the Care Plan?

A. There's always a need for on-going assessment, which then brings in the Care Plan. All Care Plans are based on the assessments that you do. And everyday in a nursing home, every shift is assessing that patient for changes and conditions of any sort.

The Care Plan, I believe according to industry standards, is that every 30 days needs to be looked at and updated. And then once after 90 days, it's quarterly, and things of that sort, if there's no change. However, there is such a change usually in the Alzheimer's residents that that's usually done monthly. It really needs to be done, and most Alzheimer's units do that usually weekly based on a nursing summary of some sort because those changes are so subtle that -- that that Care Plan needs to be revised so that if the interventions aren't working, what can we do?

I mean, you don't need 90 days to figure out that an invention is not working and then reimplement that same intervention. If it didn't work within two weeks, it's probably not going to work. So, you've got to update the Care Plan because, again, it's a blueprint of what you're doing for that patient to help improve their -- that resident to improve their quality of life.

Q. With regard to the Care Plan, is it important to thoroughly and accurately keep records on the patient relative to how the patient is doing?

A. Well, of course, because -- and that comes back to your general nursing notes and detailed notes on what's happening with that patient on an hourly, almost, basis.

Q. Is it particularly important with Alzheimer's patients?

A. Well, particularly with Alzheimer's patients because of their subtle deteriorations.

Q. Okay. All right. Now, you talked about some of the different behaviors that Alzheimer's patients might engage in, such as wandering or being combative. Is it important for a Care Plan to address these behaviors?

A. Certainly.

Q. And why is that?

A. Well, wandering can add to combativeness behavior and altercations with other residents, for one thing. But wandering, in particular, you -- you've got to keep the resident safe and you need to know their pattern and what they do and how to redirect them and how to provide interventions so that -- that they're not hurting themselves, wandering into places that they don't need to be, getting into altercations. And you've got to keep the patient safe -- the resident safe.

Q. You mentioned the term "interventions". What do you mean by that particular term?

A. Interventions are what you're going to do to prevent that person from getting into harm. What you're going to do to help that patient become better and protect them and prevent them from -- well, from harm.

Q. What are different types of interventions that -- the categories of interventions that are used with Alzheimer's patients? Diversional and directional or redirectional?

A. Diversional.

MR. FIFNER: Objection, leading. Move to strike.

A. I'm sorry. Diversional, redirection. There's -- there are several different types of interventio classifications that are used. Diversion usually is where you're going to attempt to interest that person in some other realm into where -- besides where they're going. Redirection is whenever you're going to take them and not literally grab hold of them, but kind of assist them away from their current activity.

Q. (By Mr. Kulwicki) Is it important to address the interventions in the Care Plan?

A. Well, the intervention, that's the whole purpose of the Care Plan.

Q. Okay. Are there techniques for promoting greater

independence of Alzheimer's patients?

A. Well, yes.

Q. And is it helpful for the Alzheimer's patient to have greater independence?

A. Yes.

Q. And why is that?

A. It's important for -- for them to maintain their -- their individuality and as much independence as they possibly can to maintain who they are.

Q. Okay. Now, we've been talking sort of generally about care of Alzheimer's patients. Why don't I have you give us some specific examples of interventions that can be used to help promote independence of Alzheimer's patients, and let's say, for instance, for dressing themselves. What sort of interventions might be used for that?

A. Well, one of the -- one of the things that -- that's usually used are clothes that have snaps, because buttons are difficult, or even Velcro. The Velcro is used a whole lot. Especially do not -- don't use belts, you know, use the little Velcro or snaps that go on the side of the trousers for the men. Non-skid soles on the -- on the shoes to -- to help them to get a better grip when they're walking and make their -- their walking a little bit more stable and help them, you know, not slip.

Q. Can you give us some examples of interventions that

promote greater independence for eating and assessing -- advancing their nutrition?

A. Well, there are several things. One is a scoop plate that has the sides curved up so that the food stays down in the plate and they don't have to chase it around. Another is a large -- the large handles on the spoons and the forks for better grip. The finger foods being available at all times for them to -- to eat while they pace. Individualized areas or trays where they only receive one entree, so to speak, at a time *so* that they don't have decisions that they have to make.

Q. Okay. Can you give us some examples of interventions that can be used to assist the Alzheimer's patient who has incontinence as a problem?

A. Yes, sir. There are a lot of those, especially toileting programs. Although the little resident may not remember that he needs to go to the bathroom every two hours, the staff knows he needs to go to the bathroom every two hours because that's the way bladders work. So, you put them on a toileting program so that whatever cognition that they may have left helps them to remember that.

You assess them to know that if they have like, for instance, a bowel movement after a meal, that so many minutes after that meal, then you **go** ahead and take them to the bathroom so that they remain continent and they maintain some

of their dignity.

Q. Thank you for those examples. You've given us a handful of examples for various of the effects of Alzheimer's. Are there -- are there more examples?

A. Oh, there are bazillions [sic] more.

Q. Okay. All right. Let's turn now to Alzheimer's care. Is there -- are there indicators of good quality Alzheimer's care? In other words, are there ways that you can tell that a particular patient is -- is being cared for well?

A. Well, yes.

Q. And how do you do that?

A. Well, by their general demeanor, their -- their activity participation, their -- the way that they ambulate, if they're dry or not from incontinent episodes, are they -- their general appearance as far as clean clothes, clean shaven, showered, how they interact with -- with other residents, how they interact with the staff. Just kind of a non-agit -- are in a non-agitated state.

Q. Are there physical attributes with regard to, you know, their physical condition?

A. Well, certainly. They are well-nourished, they're not dehydrated, they don't have any pressure sores or skin tears or bruises.

Q. Okay.

A. Things like that.

Q. All right. And let me just mark as Plaintiff's Exhibit 2 -- I've marked a book that's identified as Key Elements of Dementia Care published by the Alzheimer's Association. Nurse Stokley, is that book a reliable and authoritative source of information regarding Alzheimer's care?

A. Yes, it is.

MR. FIFNER: Objection.

Q. (By Mr. Kulwicki) Can you tell us if that book was published prior to Mr. Morton's admission to Manorcare?

A. It was published in 1997.

Q. Okay. All right. I'm going to ask you to set that aside and we're going to -- we're going to turn to Mr. Morton's assess -- or Mr. Morton's care at Manorcare.

MR. FIFNER: Let's go off the record on the video.

VIDEOGRAPHER: Standby. We're off the record at 13:58:46.

REPORTER'S NOTE: The following objection was made off the video record.

MR. FIFNER: I only want to make an argument on this. My objection to the use of Exhibit 2 *is* that although she personally has identified it as authoritative literature, I don't think there's anything in this witness's background or credentials that allow her to declare it as such. In other

words, I don't think any person off the street can come on in and declare a particular text as authoritative and have that stand up. That's my argument. I don't think she's got the background and the qualifications.

MR. KULWICKI: Well, that's fine. John, are you still there?

DR. IRWIN: Yes, I am, Dave.

MR. KULWICKI: Okay. I just ask periodically because you are silent and if we lose you, we're not going to know.

DR. IRWIN: I understand. If I lose you, I'll know immediately and I'll call back.

MR. KULWICKI: Very good.

DR. IRWIN: But I'm hearing everything just fine. Thank you.

MR. FIFNER: I guess we have that turned off, don't we?

VIDEOGRAPHER: Yes, sir.

MR. KULWICKI: And for the record, I disagree. I think the witness has testified to a fair amount of qualifications regarding Alzheimer's care and assessment of that care.

MR. FIFNER: Just so that I remember, I mean, she's testified she was a surveyor and she's testified she was a D.O.N. We haven't got into it yet, but I think her grand

total of D.O.N.ing hasn't been any more than 14 or 15 months, and I don't even think it's been that long. I don't even think it's been that long.

MR. KULWICKI: We're off the record for now. John, I'm getting my mic changed; so, hang lose.

DR. IRWIN: All right.

(Off video record from 13:58:46 to 14:05:11)

VIDEOGRAPHER: We're back on record at 14:05:11.

Q. (By Mr. Kulwicki) Mrs. Stokley, just briefly before we turned to the Care Plan in question, in your capacity as a state surveyor, did you gain experience in assessing the adequacy and appropriateness of Care Plans?

A. Yes, sir.

Q. Okay. And likewise, did you obtain experience in that regard in your capacity as a Director of Nursing for various nursing home facilities?

A. Yes, sir.

Q. Okay. Let's turn now to the Care Plan in this case -- or Care Plans. First of all, can you tell us what the status of Mr. Morton was upon his admission to Manorcare in April of 1998?

A. Yes, sir. He was a ambulatory little resident that suffered from dementia and benign hypertrophy, prostate problems, and I believe he had hypertension. May I look?

Q. Sure.

A. Yeah, hypertension.

Q. Okay. And did you review the Care Plans that were prepared for his care that are dated April 2 of 1998 through April 27 of 1998, and the second one dated May 1 of '98 through June 3 of '98?

A. Yes, sir, I did.

Q. Do you have an opinion based on your experience in preparing and assessing the adequacy of Care Plans for Alzheimer's patients to a reasonable degree of professional probability as to whether or not those Care Plans in this case were adequate or appropriate for this patient?

A. Well, it's my opinion that they were probably not adequate for Mr. Morton due to -- they didn't address the -- his potential problems. You have to -- in order to prevent a problem, you have to recognize that there -- that a person has a potential for that problem and develop interventions to prevent that problem from occurring.

Q. Okay. And do you have an opinion to a reasonable degree of professional probability as to whether the inadequacy of these Care Plans or their implementation resulted in patient neglect?

A. I felt like -- I do feel like that it is my opinion that they probably did lead to neglect because they didn't address all the -- all the issues that -- that would help this

little -- this little resident, you know, maintain a better lifestyle and to -- you know, to the fullest of his ability.

Q. Now, you talk about probable or future problems that are not addressed by the Care Plans. Did these probable or future problems that you speak of, did those come to fruition or did they actuate -- become reality?

A. They actually -- they became reality.

Q. Okay. Now, let's talk about these Care Plans and why you feel they were inadequate or inappropriate. Let's start with the first Care Plan and let's focus on the issue of falls. In your review of Plaintiff's Exhibit 1, did you see that there was an assessment made of the patient and his risk for falls?

A. Yes, I did.

Q. And do you recall what that assessment showed as the patient's risk for falls? And I can hand it to you, if you'd like me to. This (indicating) is the Admission - Special Assessment section of Plaintiff's Exhibit 1.

A. Well, it shows that he was at a high risk for falls.

Q. When was that assessment performed?

A. 4/2/98.

Q. Now, was his risk for falls addressed in his care plan?

A. No. I don't recall. Where are the Care Plans at over here?

Q. Care Plans are marked as -- let me just get this back. They're in Plaintiff's Exhibit 1 marked as Care Plan 1 and 2.

A. They did address the risk for falls.

Q. And what is the assessment for that particular risk?

A. Well, that was done on 4/2. But as far as an intervention, they don't have any interventions here saying how they're going to prevent this patient from falling.

Q. And did your review of the records, in fact, disclose whether the patient ever actually suffered a fall?

A. Yes, sir. He did suffer a fall.

Q. And can you tell us about that?

A. Yes, sir. On -- it's okay to look at these (indicating) again?

Q. Sure.

A. On 5/1/98, he fell out of his wheelchair with his glasses on and he had a deep laceration on his forehead and several more lacerations about his nose area.

Q. Okay. Now, does the Care Plan, the first Care Plan, address nutrition and hydration?

A. Yes, it does.

Q. And is it adequate or appropriate?

A. No, sir.

Q. And in what ways?

A. Well, it doesn't address his needing to have finger

foods or the problems of how they're going to get him to eat. Let me look here. Or -- I'm sorry. I keep using the "um" and I really don't intend to. They don't -- they don't say how they're going to help this fellow gain weight or maintain at the weight that he has. They don't talk about any type of special feeding programs or special areas for this patient to sit and eat or finger foods to give him while he paces, or anything of that sort.

Q. Okay. And does it address monitoring the patient for weight loss?

A. I believe it says that they're going to do a weekly weight loss, a weekly weight, or maybe that's -- that's on the second one. They do address that they're going to weigh him monthly, I believe, on that very first Care Plan. And whenever he started to lose weight, I mean, they saw right away that he was losing weight. They didn't go ahead and do an acute care plan to show that -- what they were going to do to prevent it from happening until he had already lost quite a bit of weight.

Q. Okay. What was his weight on admission?

A. Okay. Hang on, I've got that. On admission, he weighed 129.4 pounds.

Q. And what was the degree of weight loss that the patient suffered?

A. By 6/1/98, he had lost 11.5 pounds.

Q. What are different interventional therapies that Manorcare could have used to avoid his weight loss?

A. Prior to that, prior to 6/1, they could have put him on a multi-vitamin; put ProMod, which is a protein supplement, on his food; given him small meals; they could have given him supplements such as Boost or Glucerna or Ensure. High protein in his food. As far as that goes, a speech evaluation to find out why -- was he having any problems eating, swallowing, or anything of that sort. So, there -- there are several things. There's also medications that -- that a patient can be put on to help increase their appetite. And I did not see that -- prior to 6/1, none of that -- I didn't see that done.

Q. Okay. With regard to monitoring Mr. Morton's weight, you mentioned that it was done monthly, and is that appropriate or adequate?

A. Well, yes and no. Monthly would be adequate if you were assessing the patient on a daily basis, certainly on a weekly basis, noticing how their clothes were fitting and how were they behaving and had they -- had their activity -- level of activity increased and were they -- were they pacing more, were they more agitated. All of that should key a nurse into thinking, "Well, maybe this person is losing some weight. I might need to look at this," and how are they eating? Are they -- how much food are they consuming and what are their lab values, and things of that sort, on an on-going, day-to-

day assessment would lead someone to know whether someone was losing weight or not.

So, yes, if -- if they weren't losing weight, yeah, a monthly would be -- would be fine. But if you start noticing these things, no, you kick it up. And you don't need a doctor's order to tell you. That's a nursing judgment. if you start seeing that someone is changing like that, you just automatically start weighing them weekly and then you call the doc and say, "Hey, Doc, we may have a problem here."

Q. Now, with regard to Mr. Morton, do you have an opinion to a reasonable degree of nursing probability as to whether or not the nursing staff fell below acceptable industry standards in evaluating and monitoring Mr. Morton's weight and his intake and output?

A. I feel like that they probably did fall below the industry standards because, as can be seen by the weekly -- the weight chart, they failed to monitor his weight. They failed -- the intake and output records were inconsistently documented. So, if you have intake and output and meal inconsistency documented, then you don't know how much that person is eating or anything else. You don't have a baseline to *go* from.

Q. Is it important for an Alzheimer's patient to maintain a stable weight?

A. Certainly.

Q. And why is that?

A. Well, because as they -- as the disease process continues on down and they start more into a decline, their activity levels will -- they get to an area where they're real, real active and they start being less active, and they need the extra nutrition for the body to act -- to -- to -- the organs to work right and maintain skin breakdown -- I mean, maintain skin, keep it from breaking down, prevent infections, prevent dehydration. I mean, the whole nine yards.

Q. Okay. Now, with regard to Mr. Morton's mobility and his activity status, have you reviewed the activity sheet that is part of Plaintiff's Exhibit 1?

A. Yes, I did.

Q. And do you have an opinion to a reasonable degree of probability within your profession as to whether or not the activities as set forth in the activity sheet or in the Care Plan are appropriate and adequate for this patient?

A. Well, one thing, it's difficult to tell with the activity records the way that they're documented to really get a general opinion from that.

Q. Okay.

A. And it's not real clear what -- what organized types of activities they were providing for Mr. Morton, or it's really difficult to tell even what his general activities

were, other than wandering about the facility just kind of lost.

Q. Let me have you turn to that activity sheet in Plaintiff's Exhibit 1 under the tab noted as Activity Assessment. And I want you to assume that the "LD" that is listed there is a notation for Laurel Day which is the facilities day program for Alzheimer's patients. Can you tell us during the month of April, and I believe Mr. Morton was admitted on April 2, how many times he was in the Laurel Day Program for daily activities for Alzheimer's patients?

A. Well, during the month of April, it looks like that they had him scheduled for twice, once on the 3rd and once on the 7th, but the one on the 7th is marked out.

Q. So, one time?

A. Yes, sir.

Q. Okay. And do you have an opinion to a reasonable degree of professional probability as to whether or not that's adequate?

A. Certainly it's not adequate but, you know, there's -- if these were the activities that were given for this little person, again, the little resident was left to wander about the facility without any type of structured activities if this is actually what happened.

Q. Okay. You mentioned earlier that nutrition and mobility can affect the development of pressure sores and

contractures. Did Mr. Morton, in fact, develop pressure sores and contractures?

A. Yes, sir, he did.

Q. And, finally, with regards to the first Care Plan, does it adequately or appropriately address his combative and wandering behaviors?

A. It does address the wandering. Let me go back and see if I can find it, the Care Plan. It mentions that wandering into peers' rooms during the evening hours due to adjusting to nursing home, and that's all that it says. And the interventions talk about putting in a daily Laurel Day daily program for activity,

Q. Anything else?

A. That they're supposed to redirect him to -- out of others' rooms and into the lounge, to ask the family to bring things from his past to help him be oriented, ask the family members what kind of things he likes to do, ask the family to bring items from home that make him feel better, which is really the same thing as the other, observe him for problems with roommates and other residents, and see if there is a need for a geri-psych evaluation and invite the family to the Care Plan meeting.

Q. Would that be an adequate Care Plan for his wandering behaviors -- his wandering behaviors if, in fact, he was put in the Laurel Day Program on a daily basis?

A. If he were put in the Laurel Day Program on a daily basis, that would -- would have helped a whole lot his -- his wandering tendencies.

Q. Okay,

A. And I would like to say that the time frame -- the goal for this was to be on 7/14/98, and they do say as their last interventure [sic] -- I'm sorry, intervention over here that they -- or their last approach, as they put it here, is going to be a Wander Guard.

Q. What is a Wander Guard?

A. It's a bracelet thing that has this little magnetic thing on it that sets off the alarms on the doors whenever someone tries to leave the facility. It's either on the arm or on the ankle.

Q. Okay. Now, does the Care Plan adequately and appropriately address the combative behaviors?

A. No, sir, it does not.

Q. And why not?

A. Well, it says here that they will use medications for treatment of combativeness and motor agitation instead of trying the other types of nursing interventions prior to even getting into medications to sedate someone to keep them from being combative.

Q. Okay. Let's talk about the second Care Plan. Do you have an opinion to a reasonable degree of professional

probability as to whether or not that Care Plan is adequate?

A. Yes, sir. This Care Plan is probably not adequate either.

Q. And why is that?

A. Well, because if the interventions had been achieved and the goals had been met, then the resident would not have deteriorated in his condition and lost the weight and developed pressure sores and contractures.

Q. Okay. Let me ask you to turn now to a new topic and let's talk about the issue of patient abuse. In your duties as a state surveyor, have you had occasion to investigate allegations of patient abuse?

A. Yes, sir.

Q. And as a nursing home administrator, have you had occasion to train -- train nurses' assistants in tactics or methods for avoiding patient abuse?

A. As a nursing home corporate nurse and as a nursing home Director of Nurses, yes, I have trained nursing -- nurses' aides and licensed nurses in how to deal with combative patients.

Q. Is it important to have knowledgeable and specially-trained nursing staff to care for Alzheimer's patients?

A. Certainly.

Q. And why is that?

A. Well, because it takes a different type of technique

to deal with these -- with these little folks.

Q. **Is** it important to have adequate numbers of specially-trained nursing staff to care for Alzheimer's patients?

A. Yes, sir.

Q. And why is that important?

A. Well, that's important because these little people require a whole lot more attention than the regular people that are able to do some for themselves or able to call whenever they're needed, or even total care dependent care residents, because these little residents don't know what they're doing. They don't have anyone to help guide them and -- and keep them out of harm's way or take them to the bathroom, or anything else. And so it takes a larger number of specially-trained staff members in an Alzheimer's environment in order to help protect and care for these residents.

Q. Okay. Now, does the risk of patient abuse increase when untrained or unknowledgeable nursing assistants are involved in the care of difficult Alzheimer's patients?

MR. FIFNER: Objection.

Q. (By Mr. Kulwicki) You can answer.

A. Okay. Yes, sir, And that's because as these little people flail out, they don't -- it's not really directed toward anyone personally. It's just -- it's just part of

their disease process. Well, if you're not trained in how to deal with combative people, then you don't know that this isn't directed toward you. You don't know that you're to back off or -- or take the appropriate approaches that you would to someone in that type of situation.

Q. And from the standpoint of someone who has been a nursing administrator, do you have an opinion to a reasonable degree of professional probability as to whether stress in the workplace increases the risk of abuse?

MR. FIFNER: Objection -- let me move to strike her prior answer; objection to this one.

A. As a corporate nurse and as a Director of Nurses, there is a high probability of the potential for abuse and neglect with Alzheimer's residents with untrained staff, even with trained staff, due to the stressful environment that they're -- that they are daily having to deal with.

Q. (By Mr. Kulwicki) And are there techniques or programs or plans or protocols available for nursing homes to alleviate the stress that caregivers feel, specifically nurses' aides, in the course of caring for difficult Alzheimer's patients?

A. Yes, sir. The Alzheimer's Association provides just a humongous amount of literature on dealing with Alzheimer's residents and how to desensitize the staff, how to deal with the stress management. There are all types of programs on --

on training your staff to deal with the stress just in patient care in general.

Q. Okay. And do you have an opinion -- well, strike that. And amongst the materials that you've reviewed, I believe you've also reviewed the daily care schedules or the daily nurses' schedules for the staffing here at Manorcare during Mr. Morton's admission?

A. Yes, sir.

Q. Okay. Now, based on your review of those materials, as well as the remaining materials that you've testified to, and based on your experience, do you have an opinion to a reasonable degree of professional probability as to whether or not the training provided to the nursing staff at Manorcare was adequate for caring for Alzheimer's patients?

A. Well, it probably was not adequate because, had it been adequate, then the abuse that occurred to Mr. Morton would not have occurred.

Q. What's your basis for saying that?

A. Well, this girl, this nurse aide, Lynette Foster, I think it was, admittedly with witnesses that she abused Mr. Morton in the shower. Had she been trained to deal with combative behavior, had she been given the stress management that staff members need when dealing with Alzheimer's residents, then -- then that probably would not have occurred.

Q. Do you have an opinion to a reasonable degree of

professional probability as to whether or not the staffing, in terms of numbers of nurse assistants and other nursing personnel, was adequate for caring for Alzheimer's patients at Manorcare's facility in 1998?

MR. FIFNER: Objection.

A. Well, the industry standards indicate that there has to be enough caregivers to take care of the residents, regardless of how many it takes to take care of the residents to provide adequate care, or above adequate care, actually. And those are minimum standards, you know, that the industry has. You have to have enough staff to adequately care for those residents, to prevent them from being harmed, to make sure that they're clean and dry and fed and hydrated and taken care of for their -- to maintain their dignity and their life.

Q. (By Mr. Kulwicki) Do you think those, in your professional opinion to a reasonable degree of probability, those industry standards were complied with by Manorcare in 1998?

MR. FIFNER: Objection.

A. No, sir. They -- it is my opinion that they probably were not adhered to.

Q. (By Mr. Kulwicki) Let me ask you: You have also reviewed, as part of your materials, Lynette Foster's personnel file, correct?

A. Yes, sir.

Q. And in reviewing that file, you were aware of an incident that occurred in February of 1998, correct?

A. Yes, sir.

Q. Do you have an opinion, to a reasonable degree of professional probability based on your training and experience, as to whether or not Manorcare's -- Manorcare's response to that incident in February of 1998 was appropriate or adequate'?

A. I feel like that it is my opinion that it was probably inadequate, because had she been removed from direct patient care or had she been given the stress -- stress management and additional training that's required to deal with Alzheimer's residents, the second incident probably would not have occurred.

Q. Okay. Now, let's talk about the -- the assault in question, or the incident in question. And certainly it's to the jury to determine what happened there. But assuming Mr. Morton was struck in his chest and sustained some swelling or bruising or the results of being struck in his chest manifested on his chest, do you have an opinion to a reasonable degree of professional probability as to whether Manorcare complied with industry standards in reporting that incident?

MR. FIFNER: Objection.

A. They probably did not adhere to standards, because I

believe that the incident occurred on the --

Q. (By Mr. Kulwicki) It was May 21.

A. -- May 21st and it was not reported for several days, I believe. Another thing is that -- .

Q. And let me stop you there.

A. Yes, sir.

Q. Let me stop you. What would be in the industry standard for reporting something like that?

A. I believe that it's 12 hour -- 12 hours, 12 to 24 hours.

Q. And I interrupted you. If you would, continue with your thought.

A. Well, had they reported it, they would have been -- had to have inv stigated it. They would have to -- because they investigated it, they would have known that it was resident-to-staff abuse and they would have had to call the state, the family, the physician and do a complete investigation into it and then, according to whatever the physician wanted, then see if maybe just in case there were, you know, other injuries besides just a bruise, you know, other types of care, and certainly have developed an acute care plan along with the interventions to prevent anything from like that ever happening again.

Q. What does the term "deconditioning" mean in the nursing home context?

A. Deconditioning usually means that people just become so used to things the way that they are, that they're not used to -- that they just keep on going about that way. I mean, like if -- if you're around somebody that hurts -- just a for instance. If you're around somebody that hurts all the time, then you get used to them just hurting all the time and it's no big deal to you any longer. And there's a lot of burnout and stress problems relating from the deconditioning in the nursing homes due to that for staff members.

Q. If Manorcare represented to the Morton family that they were going to provide Mr. Morton with specialized Alzheimer's care, do you have an opinion to a reasonable degree of professional probability as to whether or not, in fact, the Care Plan or the actual care that was provided constitutes specialized Alzheimer's care?

MR. FIFNER: Objection.

A. Manorcare probably did not provide the care that they told that family that they were going to give to take care of that little resident, Mr. Morton. Because had they done that, had they given the care that they had told the family and that they advertise that they were going to do, then none of this would have ever happened. This poor little -- probably.

Q. (By Mr. Kulwicki) Okay. And if Manorcare represented to the family that they were going to provide

Mr. Morton with high-quality care, do you have an opinion to a reasonable degree of professional probability as to whether or not the care that was actually provided or the care that's referenced in the Care Plans constitutes high-quality care?

MR. FIFNER: Same objection.

A. **No,** sir. This probably does not represent high quality of care because little Mr. Morton, he developed -- he came in the facility walking about and wandering about, he developed flexion contractures, he became bedfast, he developed pressure sores, he had aspiration pneumonia, he lost weight, he was dehydrated, and that doesn't constitute -- and he was physically abused. You know, that just does not -- by a staff member, you know, and that just does not constitute high quality of care, sir.

Q. Thank you.

MR. KULWICKI: That's all the questions I have.

MR. FIFNER: Go off the record.

VIDEOGRAPHER: We're off the record at 14:39:42.

(Off record from 14:39:42 to 14:41:42)

VIDEOGRAPHER: We're back on the record at 14:41:42.

EXAMINATION

BY MR. FIFNER:

Q. Ma'am, my name is Doug Fifner. I'm here today on

behalf of Manorcare. We've covered a lot of ground and I do have a number of questions for you. In the very beginning of your testimony you talked about how you were contacted by Mr. Kulwicki. Do you remember that?

A. Yes, sir.

Q. You have a friend who's a paralegal, as I understand it?

A. Yes, sir.

Q. Is it a he or a she?

A. She.

Q. And she runs a service called Attorneys Medical Services?

A. Yes, sir.

Q. And they have a web site out on the Web?

A. Yes, sir.

Q. And the purpose for that business, as I understand it, is to find expert witnesses for attorneys who need them, right?

A. I don't know the answer to that, sir.

Q. Okay. Well, you were contacted by your friend, the paralegal, through Attorneys Medical Services, weren't you?

A. No, sir. I was introduced to Jana Beth through another friend of mine that used to be a Director of Nurses in Winnsboro.

Q. Well, how did you get consulted in this case?

A. In this case, was with Jana Beth and Mr. Kulwicki were talking together.

Q. Okay. And then they recommended you?

A. Yes, sir.

Q. Okay. And you send your bills to Jana Beth, don't you?

A. Yes, sir.

Q. Your billing is done through the corporation, or whatever it is, called Attorneys Medical Services, is it not?

A. Yes, sir.

Q. Now, you have been in the nursing business since 1986, have you not?

A. Yes, sir.

Q. What did you do before that?

A. Before that, I worked in the oilfield as a well site geologist.

Q. ***So,*** you've only been in the entire field of nursing for the past 14 years?

A. Since 1986.

Q. You were a state surveyor for Texas for six years?

A. Yes, sir.

Q. 1989 to 1995?

A. Yes, sir.

Q. You've never investigated a long-term care facility in the State of Ohio, have you?

A. Oh, no, sir.

Q. You're familiarity with state regulations is with the State of Texas regulations, is it not?

A. Yes, sir. However, if I may say, the federal regulations are for all the states.

Q. And those federal regulations are for certification and re-certification, not standard of care purposes, are they not?

A. No, sir, that's not true.

Q. Okay. We'll look at those. Now, why did you leave being a state surveyor?

A. Why did I leave being a state surveyor?

Q. Yeah. Why did you get out of that business?

A. Several different reasons. My husband had passed on and I wanted to broaden my area of expertise.

Q. Any others?

A. That's basically ...

Q. When we took your deposition, didn't you tell us that it was a negative field and you'd had enough negativity and you wanted to get out because of that?

A. That's part of it, too, yes, sir.

Q. And when you went in as a state surveyor, was your relationship with the facility administrators and Directors of Nursing one of animosity?

A. No, sir.

Q. Confrontation?
A. I hope not.
Q. Did you have any quotas you had to meet as a state surveyor?
A. No, sir.
Q. When you went in for a survey, either a complaint or an annual survey, you could look at any patient's records in the facility you wanted to, couldn't you?
A. Yes, sir.
Q. You could look either under a complaint or an annual survey at any of the care issues rendered to any of the residents in that building, couldn't you?
A. Yes, sir.
Q. Now, you then became a D.O.N.?
A. No, sir.
Q. Were you a corporate nurse then for a while?
A. Yes, sir.
Q. How many facilities in that corporation?
A. Gee, I don't have a clue. There -- several hundred.
Q. Were they all long-term care facilities?
A. Yes, sir.
Q. And who was the owner of that?
A. Unison Corporation out of Scottsdale, Arizona.
Q. And do you have -- do you -- and did you think that those long-term care facilities were well-managed?

A. Well, some were and some weren't.
Q. Well run?
A. Some were and some weren't.
Q. Did they have general corporate policies and procedures?
A. Yes, sir.
Q. Did any of those facilities have staffing issues while you were there as the corporate nurse?
A. Some did; some didn't.
Q. How many of the facilities -- were you in charge -- as the corporate nurse, were you responsible for compliance in all of the buildings?
A. In eight of the buildings, yes, sir.
Q. Of the eight buildings that you were involved in, did any of those ever receive a citation from the State of Texas for any care issues?
MR. KULWICKI: Objection, relevance. You can answer.
A. Yes, sir. One in particular did.
Q. (By Mr. Fifner) And that was despite your best efforts to high the best staff you could, --
MR. KULWICKI: Objection.
Q. (By Mr. Fifner) -- right?
MR. KULWICKI: Same objection. You can answer.
A. Yes, sir.

Q. (By Mr. Fifner) Despite your best efforts to train the staff as best you could, right?

A. Yes, sir.

MR. KULWICKI: Same objection. Let me just interject. Wait until I get an objection out so that the record is clear. Thank you.

THE WITNESS: Okay.

MR. FIFNER: I'm sorry. Are you done?

MR. KULWICKI: Yeah, I am.

MR. FIFNER: Okay.

MR. KULWICKI: Sorry.

Q. (By Mr. Fifner) And as a Director of Nursing, you were involved in particular facilities, were you not?

A. Yes, sir.

Q. How long were you a Director of Nursing in the one facility, the first facility?

A. Ten months.

Q. Why'd you leave?

A. Why did I leave? Because they were in compliance and it was time to go elsewhere and I had another offer.

Q. Any of the facilities -- did the facility -- which facility was that?

A. That was Green -- I'm sorry. Briarcliff in Greenville.

Q. Did Briarcliff in Greenville ever get any citations

while you were Director of Nursing there?

A. We -- .

MR. KULWICKI: Objection.

A. We did get one small deficiency and it had to do with a dirty medication card.

Q. (By Mr. Fifner) But you had trained people in keeping medication cards clean, hadn't you?

A. Yes, sir.

Q. You'd done in-servicing on keeping medication cards clean, hadn't you?

A. Yes, sir.

Q. And you had told them and given them literature on keeping medication cards clean, hadn't you?

A. Yes, sir.

Q. And despite all of those efforts, they still managed to get it dirty, didn't they?

A. It was a --

MR. KULWICKI: Objection.

A. -- a very minute deficiency whenever you talk about the gamut for patient care, yes, sir.

Q. (By Mr. Fifner) You still got cited despite all of those efforts, didn't you?

MR. KULWICKI: Objection.

A. Yes, sir.

Q. (By Mr. Fifner) Thank you. What facility did **you**

go to next?

A. It's a home owned by Sunrise in Mount Pleasant. Pleasant Manor, I believe it is. Pleasant -- Pleasant Oaks. I can't remember the name of it.

Q. And you were there four months?

A. Yes, sir.

Q. I think you told us earlier when we chatted that the business of giving resident care in the long-term care industry is a very stressful job, isn't it?

A. Yes, sir.

Q. Stress was one of the things that you encountered in your career in the long-term care industry, wasn't it?

A. Yes, sir.

Q. In fact, in ability to handle that stress is one of the reasons why you got out of the long-term care business, wasn't it?

A. I had a stroke and the doctor suggested that I reduce my stress. And one of the ways to reduce the stress is to get out of the long-term care industry.

Q. Did your facility where you were the Director of Nursing for that second four-month stint ever receive any citations while you were Director of Nursing?

MR. KULWICKI: Objection:

A. I don't remember, but I don't think so. I'm not real sure on that.

Q. (By Mr. Fifner) In your career as an investigator for the State of Texas, how many facilities did you enter?

A. Oh, my goodness. I have no idea.

Q. Any idea how many citations you wrote for different patient care or abuse issues?

A. I have no idea how many.

Q. Did you ever issue a citation for abuse to a facility that had policies and procedures against patient abuse?

A. Yes, sir.

MR. KULWICKI: Objection.

Q. (By Mr. Fifner) Did you ever give citations to facilities that had in-servicing to their nursing staff about patient abuse?

MR. KULWICKI: Objection.

A. Yes, sir.

Q. (By Mr. Fifner) Did you ever give citations to long-term care facilities which gave out literature on desensitization and patient abuse?

A. Yes, sir.

Q. Okay. So, when you say in this case that you believe probably that in-service training, giving of literature and better training of Lynette Foster would have probably prevented the patient abuse, the fact of the matter is, while you were an investigator for the State of Texas, you

gave citations to facilities that had done everything you thought Manorcare should have done in this case. Isn't that true?

MR. KULWICKI: Objection.

A. Yes, sir. I can say this, that while I was Director of Nurses, had an issue like this come up, my staff would have been -- because at one facility I was over, we did have an Alzheimer's Unit and there was a questionable abuse with it. And I investigated it and found that it was not, in fact, abuse.

Q. (By Mr. Fifner) So, you agree that sometimes there are allegations of abuse which, when investigated, turn out not to be abuse, right?

MR. KULWICKI: Objection.

A. Occasionally.

Q. (By Mr. Fifner) Okay. And you also accept if you were corporate nurse or -- you were Director of Nursing, right, not facility administrator?

A. Right.

Q. Okay. So, you wouldn't be involved in hiring and EEOC and all of those other problems that get inherent when you try and fire a person?

A. Yes, sir. I was the Director of Nurses in the facilities that I -- that I was at, as well as a corporate nurse. I was involved in the hiring and termination of

employees.

Q. So, you were familiar with all of the federal regulations that have to be complied with before you can fire somebody, especially somebody part of a union, right?

A. No, sir, not a union. We don't -- in Texas, we don't have unions in the nursing homes.

Q. Okay.

A. Or not here in Region 4, we don't.

Q. Okay. But you are familiar with all of those issues that arise when you try and fire somebody for unsubstantiated allegations, right?

A. I'm familiar with some of those issues, yes, sir.

Q. Okay. You were critical, as I understand it, of the first Care Plan, and we're going to talk about the one from April 'til May 1st. Are you with me?

A. Yes, sir.

Q. Now, you had indicated you had some criticisms in that there were no interventions for this resident's wandering and combativeness, right?

A. Yes.

Q. Did I understand you?

A. Yes, sir.

Q. From April 1st until May 1st, were there ever any instances when Mr. Morton got injury -- sustained an injury as a result of his wandering from April 1st to May lst?

A. May I look?
Q. Sure.
A. That's correct.
Q. Okay. You are not an M.D. or a physician, are you?
A. No, sir.
Q. You don't hold yourself out to be a specialist in the medicine of Alzheimer's, do you?
A. No, sir, I do not.
Q. Well, let's see what we can agree on then. Alzheimer's is a progressive organic disease of the brain, is it not?
A. It's a progressive atrophy of the brain.
Q. It will get worse, will it not?
A. Yes, sir.
Q. We know of no medicine, no treatment that can prevent it from getting worse, do we?
A. Not at this time.
Q. Mr. Morton had Alzheimer's, didn't he?
A. Yes, sir, he did.
Q. One would expect, would one not, as Alzheimer's residents deteriorate, initially an increase in their physical activity followed by a decrease in their physical activity, would you not?
A. Usually.
Q. You would also see in connection with that decrease

in physical activity resumption to a fetal position, would you not?

A. Not necessarily all the time, no, sir.

Q. No, not all the time, but you see a high percentage of very end-stage Alzheimer's residents very often found in a fetal position, are they not?

A. Sometimes.

Q. And that's because contractures occur inherent with the disease process, don't they?

A. Not necessarily.

Q. No way you can prevent those contractions, is there?

A. Not necessarily.

Q. So, Mr. Morton, because of his wandering, had no problems from April to May. So, was it then fair when May 1st came around to assume that whatever their plan of care was with regard to his wandering, that they were on the right track?

A. Well, no, sir.

Q. Well, I don't know about Texas, but do you know in Ohio whether or not a resident can be restrained absent a physician's order?

A. I don't know about the State of Ohio, but I know that the industry standards say that the physician has to be -- provide an order for and update that order every so often and that the nurses have to assess that patient on a 24-hour

basis for any type of restraint.

Q. Okay. **So,** restraints were not ordered in this case?

A. No, sir.

Q. So, restraint was not an option to keep Mr. Morton from wandering through the facility, was it?

A. No, sir, it wasn't.

Q. Okay. Now, the decision to address his wandering and combative conduct with medication was a decision made by the physician in this case, wasn't it?

A. Yes, sir.

Q. The physician orders the medications, correct?

A. Yes, sir. The physician orders the medication and nine times out of ten it's based on the assessment that the nurses and the information that the nurses have given him.

Q. Well, do you know what the role of Myra Gold was in this case?

A. I know that she was a nurse practitioner that was there.

Q. She was a physician's assistant.

A. Right. I think.

Q. Do you know she had an office in the building?

A. I've been told that, yes, sir.

Q. Yeah. And do you know -- you haven't read her deposition, though, have you?

A. Myra Gold -- no, sir, I have not.

Q. Okay. And do you know that she spent about 80 percent of her time in this building?

A. Okay.

Q. She was the liaison -- the liaison between the medical staff and this resident, was she not?

A. That would be what a physician's assistant or a nurse practitioner, either's, role would be, yes, sir.

Q. Now, as a result, you were critical of the original Care Plan because it didn't address Mr. Morton's combativeness?

A. Yes, sir.

Q. Are you aware of any incident or injury to any resident between April 1st and May 1st which occurred because of Mr. Morton's combativeness?

A. Well, it seems as though that the nurses, notes talk about him wandering in and out of other residents' rooms, that he was difficult to redirect, he was only eating 50 percent of his meal, he was having inappropriate behavior.

Q. So, while we're talking about it, the nursing staff was monitoring his food intake, weren't they?

A. Well, that was just one entry.

Q. Well, and they were trying to redirect him, were they not, when he had inappropriate behaviors?

A. Well, it doesn't say that. It just states the behavior that he had. It doesn't state what they did to

redirect him to keep him from doing it.

Q. But they did say they redirected him?

A. No, sir. That isn't what I just said. What I said was that they stated that he had this behavior. They didn't state what they did in order to prevent him from having this type of behavior again, or to interrupt the behavior that he was having at the time.

Q. But they did state in the note that they redirected him, didn't they?

A. No, sir. I'm sorry. I can't agree with you on that.

Q. Well, take a look at the note.

MR. FIFNER: Let's go off the record.

VIDEOGRAPHER: We're off the record at 15:00:16.

(Off record from 15:00:16 to 15:09:12)

VIDEOGRAPHER: We're back on the record at 15:09:12.

Q. (By Mr. Fifner) Ma'am, I don't want to go through all these nursing notes with you, but you've had a chance to look at the Manorcare nursing notes, haven't you?

A. Yes, sir, I have.

Q. And you saw a lot of different times when Mr. Morton was -- was wandering in and out of different rooms and different places, didn't you?

A. Yes, sir.

Q. And there certainly are occasions in the nurses' records where they indicate that he was redirected from whatever he was doing?

A. There are some redirections in there.

Q. Okay.

A. Some, uh-huh.

Q. Well, the fact of the matter is, they had to redirect him to get him out of the room that he was in, didn't they?

A. Well, no, sir, not necessarily. Little wandering residents, they wander in and they wander out without anybody's direction.

Q. Well, okay. But if they wander in and they wander back out, that's just as good as redirecting him out, isn't it?

A. It -- it depends on what happened while they were there, yes, sir.

Q. Well, you have no way of evidence or indications that anything untoward happened to Mr. Morton while he was being escorted out of a room, do you?

A. I'm not sure I understand your question.

Q. Well, your -- ?

A. Can you rephrase it?

Q. Well, your answer implied that somehow we picked up

Mr. Morton and physically drug him out of the room or something to get him to leave?

A. No, sir, I did not imply that at all.

Q. Very good. With regard to his combativeness, do you see anything that happened to Mr. Morton or any other resident between April 1st and May 1st?

A. And again, I'm going to look very quickly here. No, sir, I do not.

Q. Okay. Fair then, come May 1st to continue the same plan of care that we had in place between April and May lst?

A. Again, I would beg to differ with you there, sir, because he -- on 4/16, he was referred to this mental health place due to his increased agitation, wandering and irregular sleep patterns. So, that right there would show that the man had had some sort of change of condition. And -- and that would have been, or should have been addressed somewhere along that first month that he was there in the Care Plan.

Q. Well, whether or not it was addressed on a piece of paper, it was addressed by the nursing staff at Manorcare, wasn't it?

A. Well, it was addressed when they finally referred him, yes, sir.

Q. Sure. And on April 22nd, they referred him for a neuropsych consult, didn't they?

A. Yes, sir, they did.

Q. And as a result of that, were there any changes to the orders and changes to his medication?

A. Yes, sir, --

Q. Okay.

A. -- there was.

Q. Okay. So, you're talking about a piece of paper. I'm talking about patient care. After April 16th, the care being rendered to Mr. Morton was changed, wasn't it?

A. Sir, I'm not talking about a piece of paper. I'm talking about patient care; that it should be documented, detailed in that nurses' note exactly for the very first month that he is in there. I'm not talking about a piece of paper. I'm talking about documentation about what was actually done to take care of a resident under those people's care.

Q. And what was actually done was on April 16th, the problem was recognized. On April 26th, a neuropsych consult occurred and, shortly thereafter, the medication was changed. That's what was actually done, wasn't it?

A. That's what ultimately was done, yes, sir.

Q. Now, you indicated that he had at risk for falls.

A. Yes, sir.

Q. He was determined to be at risk for falls?

A. Yes, sir.

Q. That was while he was ambulatory, wasn't it?

A. Well, if somebody -- in answer to your question,

yes, sir.

Q. Okay. And actually, he didn't have any falls between April 1st and May lst, did he?

A. Well, on May 1st, he had a fall, yes, sir.

Q. Well, okay. But the original Care Plan, whatever they were doing to monitor him for falls -- well, let's talk about May 1st. He didn't really have a fall from a standing position, did he?

A. No, sir. He was sitting and fell forward with a laceration to his face.

Q. And there's nothing in any of these records that suggest that Mr. Morton was at risk for falling forward from a sitting position, was there?

A. No, sir.

Q. Had this ever -- this had never happened to him. He was 83 years old. This had never happened to him before in his life, had it, as near as you can tell?

A. All I know is what happened when he was in here.

Q. Sure.

A. I don't know what happened to him prior to that.

Q. You don't have any evidence in there that it ever happened to him previously, had it?

A. Not while he was in -- not in these records.

Q. And if he's going to have a restraint put on that wheelchair to strap him in that wheelchair, he's got to have a

physician's order for that, doesn't he?

A. Well, he has to have more than just a physician's order, yes, sir.

Q. He was at risk for malnutrition and dehydration and you think that wasn't addressed appropriately by the April 2nd or 3rd plan of care, right?

A. Yes, sir.

Q. Why do physicians order albumin?

A. To form a baseline of the amount of protein that's in the system.

Q. It's a pretty good indicator of nutritional status, isn't it?

A. Nutritional status, exactly, yes, sir.

Q. Right?

A. Yes, sir.

Q. And have you seen the albumin in this case that was taken and drawn on May 2nd?

A. I believe it was in there. Somewhere I had a notation about the lab values and -- .

Q. 3.7.

A. It was --

MR. KULWICKI: 3.4.

A. -- 3.4, uh-huh.

MR. FIFNER: Which one -- which date are you looking at?

MR. KULWICKI: May 2.
MR. FIFNER: Maybe I'm -- no.
MR. KULWICKI: May 1 -- May 1 is 3.7.
MR. FIFNER: I'm sorry. Okay.
Q. (By Mr. Fifner) May 1 is 3.7.
A. May 1 is 3.7? Okay.
Q. May 2 is 3.4, right?
A. Okay.
Q. And both of those are within normal limits, are they not?
A. Yes, sir.
Q. Wouldn't it then be fair to conclude that as of May lst, 1997 [sic], Mr. Morton's nutritional status was within normal limits for him?
A. Based on the protein -- on the albumin level, yes, sir.
Q. Well, the physician who ordered this had the opportunity to order anything he wanted to to ascertain the nutritional status, didn't he?
A. Yes, sir.
Q. And the only thing he ordered was the albumin, wasn't it?
A. Sir, this doesn't have anything to do with the physician ordering albumin levels or anything else. It has to do with the nurses recognizing that this is an Alzheimer's

resident that paces, that is going to use a lot of calories, that is at risk for developing dehydration and malnutrition and, therefore, taking interventions to prevent that from occurring.

Q. And my point is, that as of May 1st, 1997 [sic], his nourishment level was within acceptable limits per the albumin levels, right?

A. According to the albumin levels, yes, sir.

Q. Very good. Now, you haven't had a chance to read any of the Morton family depositions, have you?

A. Yes, sir, I did.

Q. You did?

A, Yes, sir.

Q. Did you read the deposition of the nurse, Marian, who was in the building?

A. Yes, sir.

Q. And what did -- she didn't express any dissatisfaction with the care that was being rendered in April, did she?

A. I don't believe in April she did, no, sir.

Q. Okay. And she was in the building, physically watching her father and the nurses, didn't she?

A. Yes, sir.

Q. Okay. And isn't it true that the only reason why they called the meeting in June, per Marian Morton's

deposition, was because they thought her father was more lethargic?

A. Yes, sir.

Q. Okay. They didn't -- ?

A. However -- excuse me.

Q. They didn't express care issues. Marian Morton didn't in her deposition, did she, in May?

A. No, sir. However, Mrs. Morton may not have been trained -- I don't know -- may not have been trained in dealing directly with Alzheimer's residents in an Alzheimer's-type environment like the nurses and the staff of that facility were and had been trained to deal with that type of potential problem.

Q. Mr. Morton didn't have any falls from a standing position between May and June, did he?

A. Not according to the records, no, sir.

Q. Okay. Well, according to the records, when you look at these wounds, these decubitus ulcers, the first notation of them is around May 15th, isn't it?

A. I have that. Hang on -- please, May 15th.

Q. Okay. And do you know whether or not Myra Gold had any hand in the analysis and treatment of these ulcers?

MR. KULWICKI: Objection. Her care is not an issue in this case. It's irrelevant. You may answer.

A. No, sir.

Q. (By Mr. Fifner) Okay. Do you know what was ordered?

A. To clean -- cleanse the right hip, and they ordered an I.V. of half normal Saline to go at 100 cc's an hour over a 24-hour period for lethargy.

Q. Anything else?

A. On the 15th, he was required to be fed by -- with supervision.

Q. Okay. Anything else?

A. On the 16th, they ordered Bactrim.

Q. Anything else?

A. Those -- that's just the brief notes that I had.

Q. So, when the ulcers were developed on the 15th, there were medical and nursing interventions that were immediately instituted, weren't they?

A. Yes, sir.

Q. I.V.'s were started, the patient was given Bactrim and the areas were cleansed, weren't they?

A. Yes, sir.

Q. Okay.

A. However, the point is, is that you don't wait and treat a pressure sore after it develops. I mean, you prevent them from occurring. And once they do develop, then, of course, they need to have appropriate care. But the whole point is to prevent the decubitus from developing in the first

place.

Q. But you can't prevent decubitus ulcers from developing in every circumstance, can you?

A. Yes, sir, I really believe you can.

Q. Okay. So, you think that no matter what the nutritional status, no matter what the degree of dementia, no matter how much a resident lays in one position in bed, those decubitus ulcers can be prevented?

A. There is a very high probability, in my opinion, that pressure sores can be prevented if proper interventions are given, such as: specialty beds to relieve the pressure, turning and repositioning like they're supposed to do, incontinent care being given appropriately. There's just -- skin barriers being applied to the pressure areas. I mean, once you start seeing a red place, which is the key thing, you see the red place which is a Stage 1, you stop it from getting worse by aggressively treating those areas to prevent any further deterioration.

Q. Were you taught by the State of Texas that every decubitus ulcer can be prevented?

A. I was -- I was taught by the State of Texas that most pressure areas can be prevented.

Q. And of the eight facilities that you supervised while you were a corporate nurse, any of those facilities ever have a resident develop decubitus ulcers?

A. I don't recall us having any in-house decubitus, no, sir.

Q. How about in the chain that you worked for? Any of those ever have decubitus?

A. I'm sure there probably were some.

Q. Okay. So, are you saying today that if those decubitus ulcers developed at any facility in the chain where you worked, then those nurses who worked in that facility must necessarily have been negligent?

A. I don't know if they were negligent or not. What I'm saying is that if aggressive measures are taken with people in that type of deteriorated condition, then most pressure sores can be prevented.

Q. When you were a corporate nurse, did you feel a responsibility to the residents in your chain?

A. To the residents in my eight facilities, certainly.

Q. Not to the residents in the others?

A. If I -- if I had been involved with the other facilities, certainly, but I was not involved with the other facilities. I was only involved with my eight facilities.

Q. So, therefore, you had no responsibility to notify the family or the state or anybody else that people in facilities where you were an employee were developing decubitus ulcers?

A. I don't understand your question.

Q. Well, you didn't tell any of the families in the other facilities, other than the eight where you were working in, you have no doubt but there were people that developed decubitus ulcers, right?

A. I don't have a clue.

Q. You're not going to try and tell me those facilities, that every facility in your chain was decubitus ulcer free for time immemorial?

A. No, sir. I'm going to tell you that we -- that we -- what is the right way to say that -- strived to prevent pressure ulcers from being anywhere in any of our buildings. And that, at that time, we happened to succeed in having very few pressure areas in our facilities.

Q. But you weren't pressure sore free, were you?

A. Again, sir, I don't have a clue because I don't know what was going on in the 400 or 100, or however other many facilities that there were in the -- in the corporate.

Q. Well, come June 1st when the treatment was changed, or June 2nd when the treatment for these ulcers was changed, they responded to that new, more aggressive treatment, didn't they?

A. Well, yes and no. That particular one on the right hip seemed to have. However, more pressure ulcers developed on the left hip. And then -- I'm sorry. I'm getting out of context here; so, go ahead --

Q. Okay.

A. -- with your questions. I'm sorry.

Q. Well, as Mr. Morton deteriorated as he got closer and closer to death because of his underlying disease process, wouldn't you expect him to take in less nourishment?

A. Yes, sir.

Q. Wouldn't you expect him to become nutritionally compromised?

A. Yes, sir.

Q. Wouldn't you expect him to become less and less mobile?

A. As his condition deteriorated, yes, sir. If it was -- .

Q. More and more contracted?

A. If it was not instituted by something -- if there wasn't something that precipitated that decline, yes. If it was the actual disease process itself, yes, sir.

Q. And that's what happened here, isn't it? The actual disease process here is what caused Mr. Morton to become less and less active, more and more contracted, and more and more nutritionally compromised. Isn't that the truth?

A. No, sir. I'm sorry. I don't agree with that.

Q. Okay. Isn't it true that interventions that occur with Alzheimer's residents, sometimes they work in the morning and the same intervention won't work in the afternoon?

A. Yes, sir. Now, that's correct.

Q. Okay. And if they work today, they might not work tomorrow?

A. Yes, sir, that is correct.

Q. So, if you have written on a piece of paper your Care Plan, what a particular intervention might be for a particular circumstance, that intervention might work once and then not work the rest of the month, right?

A. Yes, sir.

Q. And the nurses in the field have to use their judgment to use whatever interventions they deem appropriate to solve the particular problem, right?

A. Yes, sir. Solve the problem is up there.

Q. Okay. Well, the problem that Mr. Morton had was, he was wandering around the facility, right?

A. Yes, sir.

Q. And you can't show me one instance in these records where his wandering around the facility caused injury to either himself or another resident, can you?

A. No, sir.

Q. Another problem he had was that he was combative, right?

A. Yes, sir.

Q. And you can't show me any instance in these records where Mr. Morton's combativeness caused injury to either

himself or others, can you?

A. No, sir.

Q. One of his problems was nutritional -- perhaps nutritional compromise, right?

A. Yes, sir.

Q. And we have, at least as of May 1st, indications in the labs that he was not nutritionally compromised, right?

A. According to the labs, yes, sir.

Q. Okay. Well, you've got no better data than the labs, do you?

A. No, sir.

Q. Okay. One of his problems -- tell me this: What do you think happened in that shower room between Mr. Morton and Ms. Foster?

MR. KULWICKI: Objection, improper question.

A. Sir, all I know is what her deposition -- not her deposition, her statements to the state said.

Q. (By Mr. Fifner) And what do you think happened?

A. Well, that he became combative and she was trying to control him and she hit him in the chest and pinched his thigh.

Q. Okay. Do you think Ms. Foster knew that what she did was wrong?

A. I would hope so.

Q. Okay. She had been trained that, hadn't she?

A. I don't have a clue if she was trained on that or not.

Q. Well, whether she was trained in that or not, she knew that what she did was wrong, didn't she?

A. I would hope so, yes, sir.

Q. Okay. Now, have you ever in your career ever issued a citation for resident abuse to a facility that was appropriately staffed?

MR. KULWICKI: Objection, irrelevant.

A. Yes, sir.

Q. (By Mr. Fifner) So, you've seen in your career facilities that did everything by the book, did everything the way you wanted Manorcare to do it here: have appropriate staffing, have appropriate training, have appropriate literature and have appropriate in-servicing, and you still in your career see instances of resident abuse for which you gave citations, right?

MR. KULWICKI: Objection.

A. Well, yes, sir, because if the staff were -- if they had adequate staffing and if the staff was trained and if they took appropriate action, then the abuse wouldn't have happened in the first place.

Q. I understand.

A. Probably. Probably.

Q. But despite the best efforts of those corporations

to train their employees, to staff their employees, these are human beings we're dealing with. Despite the corporation's efforts to train them, to staff them, to in-service them and to give them literature, instances of resident abuse still happens, doesn't it?

A. Unfortunately, yes, sir, it does still happen.

Q. Because these are human beings that we're dealing with, right?

A. Because these are human beings that are taking care of compromised people.

Q. And it's an incredibly stressful job and incredibly stressful situation, isn't it?

A. Yes, sir, it is.

Q. In fact, you couldn't handle the stress and you were in the corporate level, weren't you?

A. I was a Director of Nurses whenever I decided that I was not going to do long-term care any more.

Q. You were Director of Nurses. You weren't on the floor. You weren't bathing these people, you weren't showering them, were you?

A. Yes, sir, I was.

Q. Not to the extent that NA's are?

A. 1 made a practice to be out on that floor and I spent probably 16 hours a day at the facility, and of the ten hours I was probably out on the floor working side-by-side

with my nurse aides and with the nurses making sure that care was being given the proper way, that stress issues were being dealt with, that diversional therapy was being given. I mean, the whole thing that it takes to be a nurse. And -- and the Director of Nurses, as far as the people that you're responsible for, you have to make sure that they do what they're supposed to be doing. And the only way to do that is be out there beside them and work side-by-side with them.

Q. Okay. And that was so stressful, you left the business?

A. Well, sitting here thinking about it now, I left it because -- not because it was so stressful but because I just didn't want to have another stroke. At that time in my life, stress also involved walking down the street, you know. Any -- any type of major other type of stress was also involved in part of my decision to leave the nursing home industry.

Q. Didn't you already tell me twice today that the major reason why you left the long-term care industry was to reduce stress because you couldn't handle the stress of the long-term care industry?

A. And that was -- yes, sir, that's part of it.

Q. Okay.

A. Part of it. Not exclusively all-inclusive of itself, sir.

Q. Now, you're looking at weights here for Mr. Morton,

are you not?

A. Yes, sir.

Q. And you see and you noted on one date his weight was 129 and he'd lost 11 pounds?

A. Yes, sir.

Q. Did you see where Mr. Morton had edema of his feet and legs?

A. Yes, sir, I did.

Q. Was he given Lasix for that?

A. Yes, he was.

Q. And Lasix would be a diuretic -- get water volume out of his body?

A. Yes, sir.

Q. So, you can't tell me what percentage or portion of that weight loss was due to diuretics being administered, can you?

A. No, sir. However, he was given the weight -- he was given Lasix. It was initially ordered on 4/28/98, 40 milligrams b.i.d. -- I'm sorry -- twice daily, for three days. So, he -- had that been his only weight loss then, that 11 pounds, that would have been something to think about back in -- on 4/28, 29 and 30.

However, as you get on down into July, he begins to have major weight loss from like -- well, June. Like June 24th, he weighed 121.6; June 26th, he weighed 115.6; and

then he continues to fluctuate, and he goes on down to 7/24, he weighs 113.8. So, he continued to have some weight loss until 8/24, he weighed 109.7.

So, in answer to your question, I'm sure that the Lasix did have something to do with that 11 pounds that you may be talking about right there. But as you go on down and see how he continued to lose weight, you know, the Lasix probably did not affect that.

Also here, they were weighing him, sometimes they would have like this leg brace thing on and sometimes they wouldn't. And they didn't always make the notation as to when that was going to be on and when it was going to be off. So, that could have been, you know, a couple of pounds difference there. But, like I said, as you go on down, then by the time that 8/24 gets here, he weighed 109.7.

Q. And he's very shortly -- he's very close to death by day, isn't he?

A. Yes, sir, he was.

Q. And that's not unexpected, to see somebody losing weight while they're in the dying process, is it?

A. No, sir, it's not.

Q. Okay. Now, speaking of medication, did you note whether or not Mr. Morton was taking Ecotrin?

A. Ecotrin? No, sir. I didn't put his meds down here.

Q. What is Ecotrin?

A. Ecotrin. Well, I haven't given it in a long time and I would need to get a medication book and look it up.

Q. Do you know whether that increases the tendency of people to bruise and to bleed?

A. If Ecotrin -- if Ecotrin is what I'm thinking that it is, it's like an anti-coagulant type of medication. It would increase the bruising process, yes, sir.

Q. So, if Mr. Morton were taking Ecotrin before the incident with Nurse Foster, that would increase his tendency to bleed and perhaps cause bruising out of proportion with the incident, would it not?

A. Well, that usually occurs on the -- on the extremities and not on the trunk. You know, usually you're going to see -- if that's going to happen, you're going to have like larger places like on the arms and the legs, or even the ecchymotic areas on the arms and the legs but not necessarily on the trunk of the body.

Q. Not necessarily on the trunk?

A. Yes, sir, not necessarily on the trunk.

Q. Do you have any problems -- you talked about the June Care Plan. You don't have any problems with the June Care Plan, I assume?

A. Just that -- the main problem I have with that is that the interventions were not effective. That evidently it was a, as you put it earlier, a piece of paper.

Q. Well, what interventions weren't effective?

A. Well, sir, had the interventions that they stated been effective, then the man would not have developed pressure sores and contraction -- flexion contractures.

Q. We're talking about the June. June, not the May.

A. April, May, June. June, uh-huh. June is the second Care Plan.

Q. June is the third.

A. Third one?

Q. April is the first, May is the second, June is the third.

A. Okay. June is the third. Whoops. Right. It still -- it wasn't effective. It says here, they're talking about altered cognitive status, nutritional status. It's the same stuff --

Q. Do you have any idea how -- ?

A. -- that they're talking about, sir. I'm sorry.

Q. Do you have any idea how often Nurse Foster interacted with Mr. Morton?

A. No, sir, I do not.

Q. Have any idea what the staffing was on the evening this incident occurred?

A. It seems as though I looked at that. However, that's really irrelative [sic] because the incident happened.

Q. Okay. You were provided with a copy of the incident

report?

A. I have seen the incident report, yes, sir.

Q. Doesn't the incident report note that Jane Morton was notified of this incident?

A. Yes, sir, it does. The incident occurred, what, on the 21st, and she was notified like on the 26th.

Q. Okay. Do you have any idea how many days it took before the incident was brought to the attention of anybody in administration at the facility?

A. No, sir, I don't. However, the -- I believe that standards of -- industry standards stipulate that an incident of that sort is to be reported to the family and to the physician within 12 to 24 hours, and that's certainly longer than 12 or 24 hours.

Q. Well, you don't know when it was reported to the facility, do you?

A. Well, I know according to that piece of paper when it was reported to the family was several days after it occurred. And when it was reported to the physician, it was several days after it occurred. No, I don't know when the facility knew about it. They had to have known about it when they drew the paper up, I would assume.

Q. Okay. So, your concern and your criticism is that it took longer than it should have to notify the family and the physician?

A. Yes, sir.
Q. But per the incident report, they were notified?
A. Per the incident report, they were eventually notified.
Q. And the state was notified, were they not?
A. Yes, sir.
MR. KULWICKI: Objection.
THE WITNESS: Sorry.
MR. KULWICKI: That's okay.
Q. (By Mr. Fifner) Do you know from -- ?
VIDEOGRAPHER: I need to change tapes. Standby. We're off the record at 15:39:42.
(Off record from 15:39:42 to 15:42:06)
VIDEOGRAPHER: This is the oral and video deposition of Shirley Stokley, R.N., Tape Number 2. We're on the record at 15:42:06.
Q. (By Mr. Fifner) Ma'am, you have had an opportunity to review Lynette Foster's deposition?
A. Yes, sir.
Q. And from a review of that deposition, do you know whether or not the state was notified by Manorcare of this incident?
A. Yes, sir.
Q. And the state investigated, did they not?
A. Yes, sir.

Q. And the state --

MR. KULWICKI: Objection.

Q. (By Mr. Fifner) -- ultimately prosecuted, didn't they?

MR. KULWICKI: You can answer.

A. That's what I've heard, yes, sir.

Q. (By Mr. Fifner) Okay. And Manorcare fired her, didn't they?

A. Yes, sir.

Q. And you indicated that as a result of this incident, Manorcare had to do something to make sure that this incident never happened again to Mr. Morton, right?

A. Yes, sir.

Q. And they did do that. They fired Ms. Foster, didn't they?

A. Eventually, yes, sir.

Q. They fired her when they found out, didn't they?

A. I don't know when they fired her.

Q. You don't remember that from her deposition?

A. No, sir. I'm sorry, I don't.

Q. Okay. And while we're speaking about this incident, Mr. Morton never got any medical attention for this, did he?

A. I don't understand your question.

Q. He never got sent to the emergency room, he never got any medical --

A. Oh.

Q. -- treatment, he never incurred any medical bills as a result of this incident, did he?

A. No, sir, he did not.

Q. He got no medical attention whatsoever for this, did he?

A. The physician did not see him related to this incident, no, he did not.

Q. You've indicated in your testimony that as a corporate nurse, you know that there is a high probability of potential for abuse and neglect with an untrained staff, right?

A. Yes, sir.

Q. And you further went on to say even with a trained staff because of the stressful environment, right?

A. Yes, sir.

Q. **You** indicate that the facility has a requirement to adequately staff to care for patients?

A. Yes, sir.

Q. Okay. Enough caregivers to take care of the residents and make sure nothing bad ever happens ever, right?

A. Yes, sir.

Q. Okay. **So,** in your career as a surveyor, there would have been inadequate staffing each and every time you gave a facility a citation, right?

A. No, sir.

Q. Well, -- .

A. Not necessarily.

Q. Well, but they didn't adequately staff to care for the residents and make sure nothing untoward happened to the residents?

A. Not only do you have to have enough staff, you have to have enough staff knowing what they're doing to take care of people.

Q. Okay. So, how many citations do you think you issued while you were a surveyor in your six years?

A. Sir, I have no -- no idea.

Q. Give me a ballpark. Would you give one a day, five a day?

A. I really have not a clue. There were times that I investigated and wrote deficiencies, and there were times that I did and didn't write deficiencies.

Q. But per your analysis, every time you wrote a deficiency, the facility would have been lacking in staffing, training, supervision and education every single time you wrote a citation, wouldn't you?

A. Well, they would certainly be lacking in something or else, you know, the problem would not have occurred to the little residents in the first place.

Q. Well, you now work in a hospital?

A. Yes, sir.

Q. Anything happen to "little patients" while you're in the hospital? Complications occur, don't they?

A. Certainly, complications occur.

Q. Okay. And ulcers develop in hospitals, don't they?

A. Well, let me think. I've been there for eight or nine months and we haven't had any ulcers develop yet.

Q. You're not aware of statistics that suggest that ulcer developments occur far more frequently in hospitals than they do in long-term care settings?

MR. KULWICKI: Objection.

A. Well, they may in other hospitals, but not in our hospital, they don't.

MR. FIFNER: Let's go off the record. I think I'm done.

VIDEOGRAPHER: We're off the record at 15:46:54.

(Off record from 15:46:54 to 15:47:21)

VIDEOGRAPHER: We're back on the record at 15:47:21.

Q. (By Mr. Fifner) You had some discussions on direct examinations about the Laurel Day Program?

A. Yes, sir.

Q. Do you know whether or not Mr. Morton was the type of resident who enjoyed participating in daily activities?

A. Well, whenever he was admitted, there was an admission note -- if I may look real quick.

Q. Please.

A. There was an admission note that said that he, I believe -- let me look here. Just a minute.

Q. Why don't you look at the Kaiser Nursing Home Intake form. Do you doubt that it says he refuses to participate in activities?

A. That's where I was looking at.

Q. Okay.

A. I believe that it was saying that he preferred to be left mainly by himself --

Q. Sure.

A. -- and to do his own -- his own thing.

Q. Sure. And talking about "doing his own thing", when you try and feed a resident, don't you have to have, in part, the cooperation of the resident in order to feed them?

A. Well, yes, sir, and -- mostly.

Q. Okay. And if the resident is unwilling to cooperate in your -- in your attempts to reposition, to turn, to feed, to participate in daily activities, all of that compromises the long-term care facility's ability to provide ultimate optimal care, don't they?

A. If you have explored all your options and still have a deterioration, the answer to your question is yes. If

they've not explored all their options, such as getting the little man up out of bed maybe to sit up in a wheelchair, maybe he would eat better that way, or maybe if a family member came in to feed him, or his wife -- well, of course, that is family member, but -- or maybe a certain aide that he likes better than another one or a nurse that he likes more better than another one. Sometimes they're more cooperative with other people, you know, than strangers. Continuity of care and continuity of making sure that you're doing the same thing over and over for them is extremely important; so, --

Q. And continuity -- ?

A. -- yes and no.

Q. Okay. And continuity is important to these Alzheimer's residents, isn't it?

A, Yes, sir.

Q. Mr. Morton was not oriented to time or place, was he?

A. No. But to person, he was.

Q. Sometimes.

A. Sometimes, yeah.

Q. Okay. And when you take an Alzheimer's resident and put them in an unfamiliar situation, it is not at all surprising to see that Alzheimer's resident not do well initially, isn't it?

A. Initially.

Q. Okay. And that's true. You had to hire nurses, and when you hired nurses, you didn't expect them to come into the building and be gangbusters in the first month, did you?

A. That's correct.

Q. And when you got hired in your capacity, nobody ever told you you were going to have to be gangbusters the first couple of months, were they?

A. No, sir.

Q. No different with an Alzheimer's resident, is it?

A. That's correct.

Q. Thank you.

MR. FIFNER: I have nothing more.

MR. KULWICKI: Dr. Irwin, do you have any questions?

DR. IRWIN: No, I do not. Thank you.

FURTHER EXAMINATION

BY MR. KULWICKI:

Q. I have a few questions on redirect, Mrs. Stokley. First of all, I want to come back to a statement that you made during cross examination regarding exploring all options. Why is it important to explore all options with Alzheimer's patients?

A. Well, because, as the other gentleman stated, sometimes these residents will be cooperative with some things and sometimes they won't be. And so whenever they're

cooperative like with you feeding them now sitting in bed, then -- then all of a sudden they get to where they're not cooperating with that. Well, then you go into, okay, well, why not? Let's see what we can do, and then begin to explore other options to get them to eat or to get them to have the care that they need, along with just making sure that -- that the options, like with sundowners. People behave differently in the mornings than they do in the evenings; so, you do everything you can in the mornings for these little folks because you know in the evening, they're going to be very confused and wandering more, and the whole nine yards. So, you try to get in the care as much as can in the morning. So, things like that.

Q. In your review of these records, and in your professional opinion, did Manorcare Nursing Home explore all of its options in the care of this patient?

A. No, sir, they probably did not.

Q. Now, Mr. Morton had some problems develop that we've talked about here and I'd like to quickly touch on each of those: falls, development of ulcers, deterioration of his weight and combative behaviors. But before I ask about those, are all of these behaviors, are all of these problems when they develop with Alzheimer's patients, are they always related solely to the disease?

A. No, sir, not necessarily so. It's like as -- as the

nutritional status fails, then the electrolyte balance gets off in the system and that adds to confusion, it adds to things like constipation which adds to confusion, and people get a little more combative during those periods of time. I mean, you start going through a whole system breakdown. And so ...

Q. Can care -- ?

MR. FIFNER: Wait. Objection. Move to strike.

Q. (By Mr. Kulwicki) Can poor care cause these problems?

A. Yes, sir. Certainly poor care such as not providing adequate incontinent care, not turning. If -- because industry standard says turn q. two hours, that's minimum standard. That doesn't mean that you can't turn that person every one hour. It doesn't mean you can't put them on a -- on a air loss mattress or a specialty -- specialty flexicare bed to help add the added cushions to prevent the pressures -- pressure points in the first place. Adequate bathing of these people is a big thing. Personal hygiene. Skin -- skin prevention to -- such as putting things like Lantiseptic or Tegaderm or something over the red places when they first develop. Doing passive range of motions with the little residents during the time of their bathing to prevent the contractures. I mean, the list just goes on and on and on.

Q. Now, when you try these interventions with these

patients and implement a full-care plan, and let's talk about Mr. Morton, would you expect his condition to deteriorate as quickly as it did in this case?

MR. FIFNER: Objection.

MR. KULWICKI: Well, you opened the door and you asked specifically about that, whether or not his deterioration was solely disease related and about the timing of it. You absolutely opened the door.

Q. (By Mr. Kulwicki) And you may answer that question.

MR. FIFNER: Objection.

A. I'm sorry. Ask the question again, please.

Q. (By Mr. Kulwicki) The question is: Had an appropriate Care Plan been implemented with Mr. Morton, would you have expected his condition to deteriorate so rapidly?

MR. FIFNER: Objection.

A. Probably not. And part of that is because the -- the additional interventions and exploring other options would have been keeping those muscles moving and keeping them from being stiff and getting more fluids down him and more -- more food and helping to prevent the skin from breaking down. So, probably he would not have deteriorated nearly as quickly.

Q. (By Mr. Kulwicki) Now, you were asked about the Care Plan, and I assume you'll agree that the Care Plan is not -- ?

MR. FIFNER: I'm sorry. Move to strike.

Q. (By Mr. Kulwicki) You would agree with me that the Care Plan is not designed to cure Alzheimer's disease. Fair enough?

A. Oh, yeah. No, sir.

Q. Well, what is the point of having a good Care Plan for these "little patients", as you called them?

A. Well, the point is, it's a blueprint of what you're going to do to give that person the highest quality of care and quality of life that they can have while they are in your care during their in-time, so to speak.

Q. Was that done in this case?

A. Probably not.

Q. Okay. Now, you've been saying "probably", and I'm not sure our jurors will appreciate that or whether we understand why you're saying probably. Are you saying probably because you're not sure of yourself?

A. **No,** sir. I am saying probably because there is a greater than 51 percent chance that -- that that occurred.

Q. Okay. All right. Let me ask you some more specific questions about these various areas of care. **You** were asked about his combativeness and Mr. Fifner argued with you that no harm came from his combativeness. Would his, Mr. Morton's, May 21 assault, or the incident with Ms. Foster that occurred on May 21, would that suggest otherwise?

A. Yes, sir.

Q. And you were asked whether his -- he was not nutritionally compromised because of two lab values that were taken on June -- I'm sorry -- in May of 1998. Would the fact that the June 5 nurses' note indicates that he is emaciated, the fact that he lost ten pounds during the first portion of his admission, and the fact that he developed ulcers suggest otherwise?

A. Yes, sir.

Q. You were asked whether the fall protocols were sufficient because Mr. Morton had not fallen while he was ambulatory. Would the change in condition from being ambulatory, in other words, being able to walk about, to being wheelchair-bound be a change in condition that requires an assessment?

A. Certainly.

Q. And was there an assessment done when that change occurred?

A. No, sir.

Q. And after that change occurred, I believe you've already testified that the response was not adequate, and we talked about the May 1 fall. But would the -- the incident that occurred on May 20 in the nurses, notes where he struck his face on a table while sitting up in the wheelchair at lunchtime, would that suggest further that the Care Plan was not adequate to address this fellow's fall risk?

A. Well, they certainly didn't address the fall risk, and falling is not just from a standing position. It's any type of injury, the leaning, the falling out of the wheelchair, or anything of that sort. I mean, a fall is a fall.

Q. Now, I'm going to turn to another topic here. You were asked about the regulations under Ohio state law, and let me ask you to assume that Ohio state law requires that a patient has a right to a safe and clean living environment. And I want you to further assume that on the date of the incident with Mrs. Foster on May 21st, that she came to the facility and found that Mr. Morton was sitting in urine and defecation. By all appearances, it appeared that he had been sitting that way for some period *of* time, for an extended period of time. Would that appear to be compliant with Ohio's requirement that each patient have a right to a safe and cleaning living environment?

MR. FIFNER: Objection.

A. No, sir.

MR. FIFNER: Not a subject on cross.

A. No, sir.

Q. (By Mr. Kulwicki) And you were also asked about the Ohio regulations and your understanding of the application of the Ohio regulations to this case. Assume that Ohio requires that a patient have a right to be free from physical, verbal,

mental and emotional abuse. Given what you understand to have occurred on May 21, do you believe that that particular Ohio regulation, to a reasonable degree of professional probability, was violated?

MR. FIFNER: Objection. Same objection.

A. Yes, sir.

MR. FIFNER: Not covered on cross.

A. It was violated.

Q. (By Mr. Kulwicki) And I want you to assume that Ohio law further provides that the patient has a right to adequate and appropriate nursing care. Based on your earlier opinions, I assume you feel as though that Ohio law was violated as well?

A. Yes, sir.

MR. FIFNER: Same objection.

Q. (By Mr. Kulwicki) I want you to assume that Ohio law also provides that a patient has the right to the pharmacist of the resident's choice. And I want you to assume that this particular patient, his family chose to use a particular pharmacy, and yet Manorcare directed his pharmacy needs to a pharmacy in which it had a financial interest rather than the pharmacy of the resident's choice. Assuming that to be the law under Ohio, would you agree that that particular Ohio law appears to have been violated?

MR. FIFNER: Objection.

A. If that's what occurred, yes, sir.

Q. (By Mr. Kulwicki) And, finally, I would ask you to assume that Ohio law provides that a resident has a right to have any significant change in his health status reported to his sponsor and that the nursing home shall make a reasonable effort to do so within 12 hours. And I think you've already testified that that's an industry standard and that has been violated?

A. Yes, sir.

MR. FIFNER: Objection

Q. (By Mr. Kulwicki) Now, any of those standards that I've provided to you, are those different in any material way from what you understand to be Texas law or federal law?

A. No, sir, they are no different.

Q. Now, let's turn to this incident on May 21, and you were -- flagged for you was the incident report which indicates that Jane Morton was notified on May 26, 1998. Have you reviewed the deposition transcript of Kelly Ward, a nurse who was employed Manorcare in May of 1998?

A. Yes, sir.

Q. Let me ask you to assume that in that deposition, Kelly Ward testified that, in fact, she did not inform Mrs. Morton about this incident in May of 1998, or ever. And further ask you to assume that that handwriting on this incident report is Kelly Ward's and that, in fact, Mrs. Morton

was never told about the incident in question. Again, would this be in violation, to a reasonable degree of professional probability, of industry standards for notification of a violent incident such as this?

A. Yes, sir.

MR. FIFNER: Objection.

A. It would certainly be.

Q. (By **Mr.** Kulwicki) And, likewise, in your review of the medical records, although Dr. Schwartz is indicated in the incident report as having been notified, do you see any mention whatsoever by Dr. Schwartz's hand wherein he indicates that he was notified by Manorcare about an incident on May 21 wherein Mr. Morton was punched in the chest in the course of receiving a shower?

A. Hang on just **a** second. I'm just making sure.

Q. Okay.

A. **No,** sir. I do not see where the physician was aware.

Q. Now, you were asked about Myra Gold's deposition, and I believe **Mr.** Fifner was having some fun with you because that transcript has not yet been provided to us such that we could provide it to you. However, 1 want you to assume that Myra Gold testified and her notes confirmed that she was never told, as the nurse practitioner responsible for this patient from Kaiser Permanente, that she was never told by any

Manorcare employee about the assault on Mr. Morton, and that Dr. Schwartz, there's no indication in his records that he was told about this assault.

Assuming those facts, do you have an opinion, to a reasonable degree of professional probability, as to whether or not Manorcare complied with industry standards for notifying the patient's physician or medical care provider relative to such an incident?

A. If those facts are correct, then they probably were not within the normal standards.

Q. If those facts are correct, this incident report is a sham, isn't it?

MR. FIFNER: Objection.

DR. IRWIN: Objection.

A. Probably, sir.

Q. (By Mr. Kulwicki) **Now,** let me ask you about the assault. Mr. Fifner suggested to you that there is a chance that an assault could occur even if the patient was adequately staffed, even if the staff was adequately trained, and even if the world was perfect. Does that excuse a nursing home from giving proper and effective training to its staff for care of Alzheimer's patients?

A. No, sir.

Q. Does that excuse a nursing home to provide adequate numbers of staff to care for these challenging patients?

A. No, sir, it does not.

Q. Does that excuse a nursing home telling a patient's family that they're going to provide specialized and high-quality care when they have neither the desire, ability or the training program in place to do *so?*

A. No, sir.

MR. FIFNER: Objection.

Q. (By Mr. Kulwicki) Does that excuse the nursing home from representing to the family that they're going to provide specialized and high-quality Alzheimer's care when they do not have the training program or staff numbers available to do so?

MR. FIFNER: Objection.

A. No, sir. If they say they're going to do it and they're going to take care of those folks and they're going to provide adequate trained staff, then that's what they're supposed to do to take care of those little people.

Q. (By Mr. Kulwicki) Is there any excuse for abusing a patient with Alzheimer's?

A. There is no excuse for ever abusing a patient or a resident.

MR. KULWICKI: That's all I have. Thank you.

FURTHER EXAMINATION

BY MR. FIFNER:

Q. Ma'am, Mr. Morton had end-stage Alzheimer's disease, did he not?

A. Yes, sir.

Q. Okay. And you agreed with me earlier that the manifestations you would expect to see in a resident who has end-stage Alzheimer's disease is a general deterioration in his medical condition, did you not?

A. Yes, sir.

Q. You would expect to see him become more and more malnourished, would you not?

A. You would expect to see his general health decline, not necessarily become more malnutritioned or dehydrated and completely emaciated, and stuff like that. I mean, we see folks that have Alzheimer's that don't go through that process.

Q. But you see plenty that do, don't you?

A. We do see some that do, yes, sir.

Q. Okay. All right. And you're not in any position in this case, because you're not a medical doctor, to differentiate what Mr. Morton's course of his medical disease was versus somebody else's, are you?

A. Sir, I was not trying to -- or attempting to do that.

Q. Okay. Good. Now, I wasn't having fun with you with regard to the deposition of Myra Gold. There (indicating) it is. I do have it. Do you know Ms. Gold has already testified that the reason why they didn't order PT and OT on Mr. Morton

was because the medical doctors didn't think it would him any good?

A. No, sir, I don't -- I don't know that. However -- however, passive range of motion for a resident in deteriorating condition that is bedfast is not ordered by PT or by the physician anyway. That's a nursing intervention.

Q. He was suffering end-stage Alzheimer's dementia, was he not?

A. Yes, sir.

Q. Okay. Now, with regard to this plan of care, the plan of care is a piece of paper, is it not?

A. The plan of care is a blueprint. It is -- it tells what you have assessed that that patient needs help with or what that patient's -- resident's problem is and what you're going to do to help that person maintain or get better, to improve their practical life, day-to-day life. I mean, it is on a piece of paper. Everything in the world is on a piece of paper.

But when you have your care plan meetings, you're in there and you're with the physician and the caregivers and the Director of Nurses, everybody that's in -- everybody -- the food service supervisor, everybody that's involved with that little patient. You're in there and, yeah, you've got it on a piece of paper. Yes, sir, you surely do. But you agree that these are the interventions that we need to do. This is what

we need to do to help this little person get better or maintain where they're at or, if they do start a downhill slide, what we can do to help prevent it from going so fast. So, it's not just a piece of paper. It's a blueprint of the care that you're going to give to those little patients while they're there.

Q. And the first plan of care you were critical of because it didn't have an appropriate fall risk intervention and there were no fall risks during that first plan of care, right?

A. Because they didn't address the potential for. You have to -- you have to -- you have to address the problems before they happen or before they become critical to prevent them from getting worse --

Q. How -- ?

A. -- or getting critical because -- .

Q. How many -- ?

A. I'm sorry.

Q. Sorry.

A. You go ahead. I'm sorry.

Q. How many people fell in the facilities that you were responsible and you were working in in any given month?

A. I don't know the answer to the numbers. I can tell you that it was drastically decreased after I took over the facilities because we developed a paradigm shift into

prevention instead of taking care of it after it happened.

Q. But you can't prevent all falls from occurring, especially in Alzheimer's residents, --

A. You cannot -- .

Q. -- can you?

A. You cannot prevent all falls from occurring.

Q. And prior to May 1st -- we've been over this. Prior to May lst, Mr. Morton had never had an incident where he'd fallen, right?

A. Yes, sir. And we can continue to go over it and I'm still not going to agree with you because they still needed to have the potential for, because this is part of his disease process.

Q. But we had no idea under what circumstances this fall was going to occur; so, we had no idea how and what interventions we could take to prevent it short of tying him down which we're not allowed to do, --

A. That's not -- .

Q. -- correct?

A. No, sir, that's not correct. I'm sorry. I hate to disagree with you so much, but I -- but that's not correct. You know -- .

Q. He was allowed to ambulate throughout the facility, wasn't he?

A. Yes, sir. And you know as a nurse trained in

Alzheimer's residents and trained in long-term care with patients, you know the interventions that have to be implemented to help patients and to prevent them from potential falls. Such as: increased supervision, making sure they don't have on slippery -- slippery shoes, that the grip on the shoes is good, that you remind them to hold onto the handrails. You provide things like merry-walkers for them and -- and just close supervision. I mean, this doesn't have anything to do with tying anyone down. It has to do with a potential problem.

It's like -- it's like you filling up your car with gas before it runs out. You know it's going to run out of gas. You know there's a problem there about to happen. If you don't put gas in it, you're going to be stuck on the side of the road, and in Texas, that's real hot.

So, that's like with this little fellow. You know that he's got the potential for a fall. Whether he actually falls or not is not the point. The point is, is that you've got to have things in place to help -- to prevent him from getting to the point that he falls. And if he does fall, then you say, "Hey, man. We did this, this and this and he didn't fall, and that's good. But he fell, so what was he doing when he did fall? What can we do to ensure that he's not in that type of circumstance again to fall?"

Q. And in this case -- ?

A. And that's what it is.

Q. And in this case, the first thing that happened was he was in a wheelchair, right?

A. Well, yes, sir, he was sitting in a wheelchair.

Q. Okay. And there's nothing you told me earlier in the fall risk assessment to suggest that he was at risk for falling while seated in a wheelchair, right?

A. Sir, a fall is a fall.

Q. Okay. And do you know after the May 20th incident, do you know whether the Treatment Plan or the plan of care was updated?

A. I think it was.

Q. Yeah. They gave him a lap buddy, didn't they?

A. Yeah. It was updated and they gave him a lap buddy, uh-huh.

Q. Okay. So, they did do an intervention after the second incident, didn't they?

A. Yeah. They finally put a lap buddy on, yes, sir.

Q. And I wasn't suggesting, ma'am, that the world is purple. But the point I was making, and I think that you agreed with me is that, in your career, you have seen countless instances where the facility has done everything right. They have trained the workers, they have staffed the facilities, they have in-serviced the facilities, they have given literature, they have given guidance to the workers, and

you have still seen instances where workers, because they're human beings working in a very stressful environment, still have a moment of indiscretion and abuse a resident. And you have seen that in your career, have you not?

A. Yes, sir. I have.

Q. Yes. Thank you.

MR. KULWICKI: Are you done?

MR. FIFNER: Yes.

FURTHER EXAMINATION

BY MR. KULWICKI:

Q. Does stress play any role in management of nourishment, hydration, wound care, ambulation, management of incontinence?

A. No, sir.

Q. Thank you.

MR. KULWICKI: Dr. Irwin?

DR. IRWIN: Yes.

MR. KULWICKI: Anything?

DR. IRWIN: Nothing, thank you.

MR. KULWICKI: Okay. We're done.

VIDEOGRAPHER: That concludes -- .

DR. IRWIN: Thank you very much. Thank you, Nurse Stokley.

THE WITNESS: Thank you, sir.

DR. IRWIN: I'll talk with everybody later.

Bye.

VIDEOGRAPHER: That concludes the oral and video deposition of Shirley Stokley, R.N., at 16:16:59.

(Deposition concludes at 16:16:59)

PEGGY PEACOCK
CSR No. 1786
P. O. Box 9944
Longview, Texas 75608
(903) 297-6729

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

ROBERT MORTON, ADM., OF THE ESTATE OF EUGENE MORTON, et al.	)	
Plaintiffs,	)	CASE NO.: 37075
v.	)	JUDGE CAROLYN FRIEDLAND
MANORCARE HEALTH SERVICES, INC., et al.	)	
Defendants.	)	

REPORTER'S CERTIFICATION

ORAL AND VIDEOTAPED DEPOSITION OF SHIRLEY STOKLEY, R.N.

JULY 22, 2000

I, PEGGY PEACOCK, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, Shirley Stokley, R.N., was duly sworn by me and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the deposition transcript was mailed on July 24, 2000 to the attorney for the Plaintiffs for safekeeping and use at trial;

That the amount of time used by each party at the deposition is as follows:

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Mr. David A. Kulwicki - 1 hour, 25 minutes

Mr. Douglas K. Fifner - 1 hour, 6 minutes

Dr. John R. Irwin - 0 minutes

That $1,218.00 is the charge for the original deposition transcript and any copies of exhibits, charged to Mr. David A. Kulwicki, attorney of record for the Plaintiffs;

That pursuant to information given to me at the time said testimony was taken, the following includes all parties of record:

Mr. David A. Kulwicki - Attorney for Plaintiffs

Mr. Douglas K. Fifner - Attorney for Defendant, Manorcare Health Services, Inc.

Dr. John R. Irvin - Attorney for Defendant, Lynette Foster

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Sworn to by me this 24th day of July, 2000.

PEGGY PEACOCK
CSR No. 1786
Expiration Date: 12/31/01
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