MEDICO LEGAL REQUEST LLC
Legal Outsourcing Services

DEPOSITION SUMMARY OF XXXX

October 11, YYYY

Venue: The Circuit Court of the County of St. XXXX, State of XXXX.

Plaintiff: XXXX.

Defendant: XXXX Senior Services d/b/a XXXX Care Center.

Counsel for the Plaintiff: Mr. XXXX.

Counsel for the Defendant: Mr. XXXX

Also Attending: Ms. XXXX (XXXX Senior Services)

Court reporter: XXXX, Certified Court Reporter.

Page: Line	Summary	Subject
	Examination by Mr. XXXX	
3:14-08:14	Her name is XXXX. She works as registered nurse since she passed boards in February of YYYY. She obtained her degree from St. XXXX Community College at XXXX, graduated in December of YYYY, and she got her BSN from UMSL. She stated that she does not have any other degrees in the field of nursing or patient care. She had been licensed continuously since YYYY till the present. She stated that her license had not been suspended or revoked ever. She stated that she was currently employed in St. XXXX Hospital from June of YYYY. She reported that she worked for LSS from November YYYY other than St. XXXX. She stated that she works for LSS continuous since YYYY to the present. She stated that she was working for XXXX Senior Services during January YYYY at REACH West which was XXXX. She reported that there were different communities. She stated they call them communities within. She reported that she works in REACH West community at XXXX. She stated REACH is a rehabilitation type of community. She reported that twenty beds were there in REACH West. She believed that as the RN on duty she was not responsible for all twenty patients and her responsibility would vary based on number of patients who	Her work, and qualification and services provided by her a XXXX Senior Services

	were on the floor. She stated that if it was full census, there would be more than one RN on duty at that time. She stated that she does not include a CNA as a nurse. She reported that by nurse, she meant an RN or LPN. She reported that on a full census, there would be two RNs and/or LPNs staffed during the shift. She stated that if there were two, both of them would be on premises. She agreed that if less than twenty beds were filled, she may not need two nurses. She agreed that during January of YYYY, her shifts were regularly set and she had day shift from 6:45 am to 3:15pm. She stated that her shift would be kind of choppy. She reports that it was like work three days' off one day and if work four days, off two days.	
8:15-13:22	She stated that she had independent recollection of XXXX. She agreed that she would be able to pick him out even if there were five gentlemen in a room. She stated that she specifically remembered that Mr. XXXX had a really short haircut, was friendly, and slender build. She denied any issues or difficulties with him that stood out other than the January 15th when there was a decline in his health. She stated that on January 15th she spoke to his family member for the first time. She could not recall who she spoke to on the phone and she thought that it was either his sister or daughter and the conversation was concerning transfer to a hospital. She stated that she called assuming that person was his relative and she doesn't recall any notation in the records about her contacting any relative of Mr. XXXX. She stated that she reviewed records before she came in today and the records were provided to her by Mr. XXXX or somebody from his office. She stated she doesn't recall seeing anything in that binder regarding her conversations with any family member. She agreed, that it was the only conversation she had with relative or family member of XXXX up until that present date and it was concerning with his transfer to hospital. She recalled her conversation and she had stated that they were going to transfer him to a hospital. She thought that she explained that there was an order from Dr. XXXX to transfer the patient to a hospital to rule out the possibility of a CVA, and she told them she was sending him to St. XXXX and they replied her that they wanted him to go to St. XXXX instead of XXXX are and she replied okay. She agreed that it was the only conversation with the relative of Mr. XXXX that she could recall that day on the phone. She agreed on January 15th, YYYY, she had a conversation with XXXX. She could not recall talking to him	Her recollection of Mr. XXXX and her conversation with his family members

	about to his transfer. She stated that she talked to him about parts of the assessment but couldn't recall what he told her.	
13:23-14:07	She stated that her duty was at 6:45 and she recalled to have met with Mr. XXXX for the first time that day on January 15th, at around 7:30 approximately, and she did his vital signs and assessment.	Her Duty timings
14:08-58:16	She agreed that on Page 211 the last entry was January 15th, YYYY, 8:53am, blood pressure was one eighty over ninety and it had her name under the staff. She also agreed that the 8.53 was her entry time but she could not recall exact time she took his blood pressure. She agreed that after she comes in at 06.45 and with the hand offs and transfer and after finding out what happened the other night at around 7.30 she would start her day meeting the patients and do their vitals. She stated that on that day Mr. XXXX was the first patient she saw and she remembered it. She agreed that on 07.30 she took his vitals and his blood pressure was one eighty over ninety. She believed that that was the number typed correctly. She stated that she had concern about that his number was high as a registered nurse She stated that based on that information she called the physician Dr. XXXX who was off on premises. She could not recall exactly but she stated that she had collected Mr. XXXX vitals and that was a part of the assessment data and also that he was laying on his bed with weakness to one side. She stated that she did not document that in the records because she was doing patient care and after that she did not know. She agreed that the left sided weakness must have been recorded. She recalled not the exact words but Dr. XXXX was in the parking lot and that she would be there soon. She agreed that at some point she spoke with Dr. XXXX about Mr. XXXX. She stated that she made the phone call to Dr. XXXX first and then to the relative of Mr. XXXX she stated that both the phone calls were not in the same time frame. She stated that she spoke to Dr. XXXX for the second time when she was in person at the desk in the REACH west area which was at around 08.00 to 08.30 from her best recollection. She stated that she did patient care after she spoke with Dr. XXXX on the phone, continued it till Dr. XXXX arrived. She could not recall the conversation with Dr. XXXX. She could recall that Dr. XXXX told her that she had placed an order and had left it on the Nurse's desk. She agreed that the nurse's desk was at the REACH west and it was everybody's desk. She explained that flagged meant to take the binder and put the	Sequence of events on 15th January 2015

	paper so that it would be sticking out so that it could catch somebody's attention. She could not recall what XXXX order was. She reported that she read the order to start on it and after that she started with her paper work. She recognized the paper work was the resident transfer sheet, it varies, but for that particular patient it was seven pages. She explained that resident transfer sheet meant that any time they transfer a patient to a hospital they would print that out and send it with them and it just contained overall information she believed, it contained their medications also so that the hospital knows what medication he was taking, but she wasn't sure. She agreed that resident transfer sheet was part of the patient record and copy of that record was given to the ambulance service. She agreed that the top of this document report contained data for the seven days prior to January 15, YYYY, she saw that in small print. She stated that lot of that sheet was not filled out and also his information about his vaccines were not there. She agreed that bottom of page 2 contained vital signs but it was not available for the past seven days and also she could not see anything about his well-being also. She stated that she could not recall if the first thing she did after looking at the flagged order. She stated that pursuant to the order she called the St. XXXX hospital before contacting the XXXX family to set up an appointment for him to have a CT of head. She denied calling ambulance because she had not finished her paper work yet and she was going to check with Dr. XXXX to make sure that she could go ahead and call the ambulance. She stated that she didn't know for sure, she only assumed that when she met Dr. XXXX on the floor by the desk at REACH West she went to examine Mr. XXXX and once again she agreed on her assumption. She stated that she did not see Dr. XXXX in his room. She stated that Mr. XXXX room in relationship to the desk was just around the corner of a halfway and it wasn't that far away. She reported that prior she calling St. XXXX, she had conversation with Dr. XXXX at REACH West, and she had told her what the report was from the night nurse. She stated that there was only one conversation with Dr. XXXX at the desk as in-person. Once again she agreed that there was one phone conversation, then there was one conversation at desk and reported her findings which included the left-sided weakness and the high blood pressure and she couldn't recall any other findings. Once	

	again she agreed that she also reported the night nurse's findings to Dr. XXXX at the desk. She stated that her assessment findings were reported on the phone briefly and once again she agreed to that and that was when Dr. XXXX stated she was on the way. She reported to Dr. XXXX that night nurse's report in the morning stated that Mr. XXXX felt like he was having a stroke at 12:30 at night but that was not documented anywhere in the records that she would know of. She stated that she would not be called as charge nurse or the nursing in charge, she was just registered nurse and she believed that they don't call them charge nurses. She stated that there was a clinical nurse leader above her and before the physician. She agreed that she found out this information from night nurse's findings when she came in around at 6:45 during the handoff. She agreed that her reports usually start a little later and not exactly at 06.45. She stated that she finished the report and that was when she went to see the patient. She agreed that based on the information obtained from the night nurse she acted on it went to see the patient. She agreed that she saw him first and remembered that because of his issues. She agreed that she knew there was a registered nurse on overnight duty in premises and she knew that her name was XXXX, an RN, but she could not recall the last name though. She stated that XXXX had quit her job and now she was again back in LSS. Once again she agreed that XXXX is the person who gave her information during handoff. She was asked if had any conversation with XXXX, and why she did not act on it or did she call Dr. XXXX or anybody when she had known about a stroke or something at night, for this she replied that she had asked why XXXX had not called Dr. XXXX and when asked why XXXX replied that Mr. XXXX had fallen asleep and she checked on him later. She was asked that if she was the night nurse and based on the information that was told about Mr. XXXX and subject to objection she replied that she would have gathered assessment data and then she would have made a determination whether or not to call the doctor.	

	She stated that she did not see XXXX documenting any assessments that she performed on Mr. XXXX. She stated that XXXX didn't tell her anything more so she was unaware whether she did or not woke him up to check on him on any point. She agreed that she remained in that community on REACH West for her entire shift on January 15, 2015, the whole time from about 6:45 am till about 3:15 pm. She stated that she didn't know if therapy was given because she remembered the physical therapist being there in the room with him but she stated that she did not know if he had therapy and also she had no way of knowing it as she could not recall it. She agreed that she recalled Jeni Eigenseher and her being in the room with him but she couldn't recall the time she arrived. She agreed the therapist arrived after her initial assessment and after her call to Dr. XXXX and her arrival at REACH West. She agreed having conversation with Jeni the therapist about Mr. XXXX and they worked together in the room because they were trying to get him up and on the toilet. She reported that they had other conversation about his condition, just that he was weak on his left side but she couldn't recall specifics. She couldn't recall if there was anybody else in the room other than herself, Jeni and Mr. XXXX. She stated that she did not send Jeni out and she did not know if Jeni went out to speak with Dr. XXXX or not. She stated that Dr. XXXX had ordered to set an appointment for CT scan to rule out the CVA and was not specifically to St. XXXX and also agreed that that was the order that was flagged. She agreed that the bottom of the page had her name which was the acknowledgement that she had taken care of doctor's order. She stated on the same page to the right of the RN those initials belonged to Dr. XXXX. She agreed that there was no time on that order. When she was asked that after knowing about what XXXX had told her about Mr. XXXX condition and also after making her own assessment on him for increased blood pressure and left sided weakness did she have any concerns about possible stroke for that she replied that she did not know and because she was a nurse she collected data and reported to the doctor. She was again asked if elevated blood pressure and if any other documented findings on the records be signs and symptoms of stroke from her training and experience she replied the left	

	sided weakness or she apologized and stated one-sided weakness. She was again asked if she made an assessment and believed if somebody was having a medical emergency will she speak to doctor before calling 911 for an ambulance she answered that it depends on what kind of emergency they were talking about. She replied that she was a nurse and that she presented the information to the doctor to give her an order when she was asked to consider Mr. XXXX on January 15 and after knowing the XXXX report from handoffs and based on her own evaluation and vitals findings was that a medical emergency that needed 911.She agreed that she relied upon Dr. XXXX opinion on what was necessary care and treatment. She stated that other than phone and in person conversation she agreed speaking to Dr. XXXX regarding Mr. XXXX before he had left LSS on January 15, 2015. But she did not know the time but stated that the conversation took place at core station between the reach units and she could not recall if the conversation was before the phone call to a family member of Mr. XXXX or after. She stated that in the conversation with Dr. XXXX she reported that she was on the phone when she was on hold, and she asked her that whether she could call the ambulance. She stated that she was on the phone call for pre-authorization for sake of Mr. XXXX but she didn't have any idea whether it was admission to the hospital. She agreed that she attended Mr. XXXX in any ways in between the time she had to order for CT head and second conversation with Dr. XXXX which was in the middle of REACH units. She stated that she had not completed her morning initial assessments of patients as she was going back and forth between trying to find out if she could call the ambulance to pass her medications, doing her other assessments and patient care. She reported that at that she attempted to speak with Dr. XXXX to ask or request an ambulance. She couldn't recall what Dr. XXXX said to her and stated that during conversation she stated that her understanding was that she was on hold, not yet. She could not able to recall the conversation between her and Dr. XXXX and later she moved on and called the ambulance. She stated she could not recall from where she got the quote or unquote to call the ambulance. She agreed that she would have waited for okay from Dr. XXXX. She did not remember about	

	when and what time she called the ambulance. She did not know and she could not recall if she looked over the ambulance records. She agreed according her notes that they were on scene at 12:21pm and the patient was transferred at 12.30. She also recalled that there was a type written note that had stated that. She stated that Dr. XXXX was on phone facilitating transfer or having it pre-authorized. She stated she had no idea if pre-authorization was like Medicare or Medicaid. She agreed that she called up St. XXXX and cancelled that appointment and set that up at St. XXXX. She agreed that she called the Gateway Ambulance and she had called St. XXXX first to see if they can take the patient. She stated she could not recall any other ambulance service before she called Gateway. She denied any other orders from Dr. XXXX regarding Mr. XXXX care during the period of time when Dr. XXXX was first notified of his condition. She denied that no additional medications were given. She stated that she could not recall if she performed any more tests or take his new vitals, but she stated that under normal circumstances she would recheck somebody with high blood pressure and agreed that it was not documented. She agreed that she believed that she was not using the term about the standard of care but the care that she would perform and she would go in and monitor it but it was just not kept documented it was just so that she can keep an eye on it. She denied speaking with any other family member of Mr. XXXX. She stated that the family would know that he would be transferred to St. XXXX from just that one phone conversation. Mr. XXXX was going to be sent out for a CT to rule out a CVA and then she contacted the family she was asked what was the timeline that she spoke to family about and did they know it was an ambulance transport when she called them or was he just going to hospital for the appointment she answered that the appointment was the word in the hospital and it was not an order and it was not written like that. She asked for the clarification of the question again. She stated that she did not remember telling them that and also thought that it was their assumption when asked what her understanding was when doctor wrote Mr. XXXX needs to have a CT to rule out CVA whatever hospital he was going to be was it going to be by an ambulance. She stated that it was not her assumption she knew that he would be transported by	

	ambulance to get that done and she agreed that that was when they wanted him to go to St. XXXX instead of St. XXXX and she stated okay for that. She stated that she did not know exactly how long the time frame was from the time she spoke to the member of Mr. XXXX family to the time he left the facility. She was asked if it was earlier end or the later end of the process that the family was notified and she replied that they were notified earlier as they were the ones that notified her that they wanted him to go to St. XXXX, because her paper work was done early. She stated that she did not have her paper work for St. XXXX completed at that time. She agreed that she spoke briefly to the EMTs that arrived. She couldn't recall the conversation with them exactly she stated that there was his paperwork. She was not sue but stated that there could have been the copy of the order along with the resident transfer sheet. She stated she could not recall the time Mr. XXXX family members got there but reported that they were there right at the time of his transport. She also agreed that they arrived when he was still on the floor. She could not recall if the family members spoke with her or Dr. XXXX. She did not know if Dr. XXXX was still there when the ambulance arrived. She could not recall if she was the only RN on the floor or if there were any other RN or LPN working with her on that day. In the report it was stated that RN reported patient last known well at 12.30 am on 01-15-15 she was asked if it was her speaking to the ambulance and she replied that she could not recall telling them that. She reported that she could not recall other than the one conversation any other conversation with any family member of Mr. XXXX family. She stated that she could not recall seeing the documents like policies/ procedures, regarding the staff or physician notification action besides that day or within a few days. She was not sure if there was any policies or procedures she was supposed to do as an RN while she was working at LSS like if there was any protocol or proper steps she should take when somebody had a change in condition such as Mr. XXXX. She stated that she would provide all the information and follow the order of a physician as a nurse. She agreed that she would use her own cell phone to make calls, but currently she didn't have the same cell phone. Her cell phone number was (314)345-6789.	

	She couldn't recall how she contacted Dr. XXXX if it was an office phone number or her cell phone number. She agreed that she had no way of knowing where Dr. XXXX actually was either on a lot or on her way. She also agreed that it was assumed that Dr. XXXX would have used her cell phone if she was on her way. She stated that she didn't get Dr. XXXX cell phone number from the transfer sheet where Dr. XXXX phone number was mentioned, but she got the phone number from Rolodex on the desk. She said that she was not sure if that was Dr. XXXX cell phone number or office phone number. She reported that she never filled anything in the resident transfer sheet as she would directly take a print out of it through an electronic medical record system, known as Vision presently. She apologized and she could not recall if medical record system was called Vision in 2015, as she had two jobs. She stated that she didn't recall anything about what she spoke with XXXX regarding Mr. XXXX. She agreed that the CNA was Ms. XXXX but she was not under XXXX who was RN at that time. She agreed that Ms. XXXX was on the day shift along with her. She could not recall if Ms. XXXX reported anything about the findings regarding Mr. XXXX condition. She reported that along with Ms. XXXX she would see Mr. XXXX at varied time interval. She denied that she did not have any conversations with anybody at XXXX on January 15, 2015, about Mr. XXXX.	
58:17-60:04	She agreed that if she remembered anything later on, she would let Mr. XXXX know, where he would in turn let Mr. XXXX know so that it would be easy to find out about any other conversations or anything regarding Mr. XXXX. She agreed that she knew XXXX and she also agreed that XXXX had been the CNA and then she was under XXXX and also they were a group. She stated that they would hand off or transfer from one shift to another and while doing so they would have a discussion with the group. She could not recall the conversation with Ms. XXXX about Mr. XXXX.	Final conclusion questions