DEPOSITION SUMMARY OF XX

JUNE 01, YYYY

Venue	The Circuit Court of St. Louis County, State of Missouri
Plaintiff	Patient name
Defendant	Lutheran Senior Services d/b/a XXXX, et al
Counsel for the Plaintiff	XXXX
Counsel for the Defendant	XXXX
Also Attending	XXXX
Court reporter	XXXX, certified court reporter

Page: Line	Summary	Subject
	Examination by Mr. XXXX	
03:14-09:11	Her name is XXXXX. She lives at 7225 Rudy lane, St. Louis. Her date of birth is 05/04/YYYY and her social security number is XXXX. She is currently employed with XXXX PRN, Missouri Baptist full time. She stated she worked for Lutheran Senior Services as needed and her employer was Missouri Baptist Hospital. She stated her position was patient care tech there. She agreed she was employed by Lutheran Senior Services back in January YYYY. She reported that she first started working in Lutheran Senior Services from April 2012 full time. She was working at Hidden Lake, Florissant and later moved to XXXX but could not recall when. She stated that by January YYYY she was already worked for a year at XXXX. She agreed she had a CNA license which she obtained from North Tech at the Adult education School at June YYYY and still has the license currently. She reported that her CNA license never lapsed from 2011 to YYYY. She stated she was never been suspended or revoked. She stated that besides CNA license she holds CPR certificate in the field of patient care or nursing. She admitted that with respect to being a CNA her first position was with CNA and did not work with any other entity prior. She stated that she had no other positions with respect to patient care from the time she left XXXX till the time she started at Missouri Baptist. She also agreed that other than Lutheran Senior Services and Missouri Baptist she had not worked for any other employer with respect to healthcare.	Her work history and qualification
09:12-10:13	She stated she did not remember XXXXX at all and she would not be able to identify him if he was present in a room with four other gentlemen around the same age. She agreed that before coming there she reviewed Mr. XXXX ADL list also agreed it	Her knowledge about Howard XXXX

	was a list where it has name on it for certain items on January 15th. She reported that she did not review or see anything else. She denied speaking to anybody else other than the attorney about Mr. XXXX care and treatment at XXXX.	
10:14-44:04	She stated that when she started with Lutheran Senior Services she did not have to go through any type of training program and did not review any manuals or policies or procedures. She could not recall signing any charts or letters etc. over there. She reported did not receive any type of education or training class at Lutheran Senior Services or XXXX. She agreed that she had to take education classes to keep her CNA license up to date. She stated that she had multiple classes on how to keep patient safe and how to transfer a patient. She stated she did not have to deal with signs or symptoms of stroke. She stated that she had not had any education or training on assessing patient who may present with signs or symptoms of a stroke. She stated that she did know the signs and symptoms of stroke and according to her understanding it was slurred speech, left-sided weakness, sagging face, face drooping and numb. She was questioned where she had learnt about those symptoms she replied that by taking care of her father-in-law who also had a stroke two to three years ago which was before the YYYY incident. In the sense of a CNA at XXX she stated that if any of her patients presented with the signs and symptoms of stroke then she would notify the nurse. She was asked that if notifying nurse was a policy or written somewhere but she couldn't recall whether it was in writing but stated that she was supposed to notify the nurse. She recalled that back in January YYYY her shift was from 6.45 am to 3.15 pm day shift. She agreed that during the day shift there would be an RN on site. She could not recall who that RN was back at that time. She agreed that there was no medical doctor at site but were available on call. She stated that she worked at rehab unit at XXXX where she would care for an average of eight to ten patients. She stated there were twenty rehab beds at XXXX. She did not know how many RNs would be on site on a given shift at the rehab unit. She stated that she would consider anybody presenting with the signs and symptoms of stroke to be an emergency situation. She stated as a CNA it's an emergency condition because stroke can go bad or good so anything dealing with a stroke is an emergency and she agreed that time is of the essence.	Her work at Lutheran Senior Services and XXXX

She agreed that in Meramec with regards to Mr. XXXX records her name appeared only once in the ADL recordings by the resident. She reported that besides those electronic records she did not make any hand written notes or chart entry. She agreed that everything was done on a computer.
She stated that she did not know if she had cared for Mr. XXXX prior to January 15, YYYY.

She agreed that at 10:57 in the morning on January 10, YYYY she had met Mr. XXXX and noted his ADLs and also on January 15, YYYY at 10:03 am. She agreed that in the rehab unit some of them had physical therapy and some of them had occupational therapy and some had both. She replied that a patient like Mr. XXXX would have his OT and or PT around 9 to 12 or 1 to 4.

She stated that she was not aware if Mr. XXXX had physical therapy on January 15, YYYY.She agreed that she knew Keishe Union and that she also had the same job responsibilities like herself at XXXX on January 15. YYYY. She reported that she did not know if she was still working at XXXX and stated she did not think that Keishe Union worked there when she left XXXX.

She agreed that she worked full time at Missouri Baptist but part time or as needed at XXXX which continued to that day. She stated that since she was back at XXXX she never saw Ms. Union. She denied ever talking to Ms. Union about XXXX. She agreed that on January 15, YYYY Ms. Union worked and her shift had ended on 7:15 am after which was her shift and also there was overlap of time where the CNAs can be updated on what was happening with the patients like a handoff. She stated that there are oral, written documentation received from the CNA who's going off about a specific patient.

She reported that she did not remember anything written about Mr. XXXX regarding any signs or symptoms of a stroke. She stated that she did not document anything in the record with regard to the signs or symptom of a stroke. She stated that she does not document when she sees the patient she further explained that she could have seen the patient by 08.00am but 10.03 am when she would be charted or documented. She stated that as of that day she could not remember who Mr. XXXX was. She stated that on given day she would see about eight to ten patients. She reported that the first thing she does after arriving at 6.45 was to get report from night shift, checking her task list for showers, daily weights, doing her rounds and after that see if the residents were ready for their breakfast as some patients may

take longer than others. She stated that by looking at the records she was not able to tell if Mr. XXXX was already up and out of bed or not and she stated there was no way of knowing it from the record. She agreed that she would first meet all the residents and then will go back and chart everybody at the same time. She stated that how long she used to spend on each resident depended on what their specific needs were. She agreed that she had charted Mr. XXXX records by 10.03 am but she could not exactly recall when she saw him, she stated it would have been before 10 o'clock. She agreed that if Mr. XXXX was her first resident he would have been seen at 7 or 8 o'clock and if the last resident by around 10 o'clock. She answered that she did not remember Mr. XXXX when asked if she had any independent recollection as of that day whether Mr. XXXX had any signs and symptoms of stroke when she examined him on January 15, YYYY.

She was asked if she documented anywhere in her records that Mr. XXXX was presenting with signs and symptoms of stroke for that she replied that she did not know he had signs and symptoms and also that she did not remember.
She stated that if Mr. XXXX had presented with the signs and symptoms of stroke that she knew from her personal and professional experience she would have notified the RN.

She agreed that she had notified in the past to the nurse on duty when she saw a person presented with the signs and symptoms of a stroke, but she could not document it only the nurse could have documented it. She stated that she did not take Mr. XXXX blood pressure on January 15, YYYY morning as it was not her job and was actually job of the CMT. She agreed that she weighed the patients. She did not know if Mr. XXXX attended any physical therapy and occupational therapy on the morning of January 15, YYYY and also she did not recall speaking to any of the family members. She could not recall about any conversation she had from either XXXX or his family members.
She reported that the nurse will know if there was a significant issue reported by the prior CNA like any signs and symptoms of stroke. She agreed that the therapy timing was from 9 to 12 and then from 1 to 4. She stated that it depended on the therapist who handle the residents, if they would go to therapy together or one at a time. She agreed that an individual usually would go the same time to therapy. She stated that there was no documentation that would show Mr. XXXX schedule.

She stated that she would not know the time when to take him to therapy she stated that the therapist comes and gets him around

the same time each day just to keep on a schedule. She agreed that the OT and PT schedules were made through the therapy departments and sometimes she would be notified that they were taking the patients. She also agreed that sometimes she could be down the hall and when she returns back the patient would be gone in those kind of times she or the nurse would call to the therapy just to make sure that the patient had not wandered off.

She again repeated that as she presented that day she could not tell in one way or another if Mr. XXXX presented with any signs and symptoms of stroke. She stated that when she charted the ADL she would not be able to look at the previous entries but the nurse can. She was explained that just before her Ms. Union had charted ADLs, self-performance and support required where she had charted in certain places that extensive assistance was needed and one person assist for bed mobility later the same day when she herself charted she had also put that extensive assistance plus two person assist was needed which meant that she required an extra nurse or an aide to help her with the patient. She agreed that for the same ADLs Mr. XXXX needed more assistance than what was previously provided. She stated that as CNA sometimes patients stand up perfectly fine and the next day she would have problems transferring them which depended on the patients and also varied from day to day. She agreed that if presented with symptoms of stroke she would have notified the nurse.

She agreed that if any of Mr. XXXX performances concerned her with his ADLs and if she felt weren't right her obligation would be just to inform the nurse. She stated if she believed there was a significant problem it would be documented by the nurse and not by herself. She stated after looking at the records that she could not tell just from the self-performance and the support required that if Mr. XXXX was having any significant problem or issue or if it was just the variations from day to day on how he presented.

She stated that she knew Dr. Sodhi who was one of the on call doctors at XXXX. She stated that it was not in her job description to call Dr. Sodhi directly regarding any patient or resident. She stated that if anything concerned her she would notify the nurse and what the nurses do was not known to her.

She replied that she did not recognise whose signature was at the bottom of the page 48. She was asked if she knew RN Ann Nobel she had replied that she knew a RN named Ann but didn't know if she was on duty on January 15, YYYY. She could not recall speaking to RN or nurse Ann about Mr. XXXX.

	She stated she did not know if there was a RN not an LPN in the rehab unit twenty-four hours a day. She stated that she had never completed a MDS sheet and she was not familiar with the document and also did not know who would complete those sheets normally. She stated that she realized that a law suit was being brought by Mr. XXXX against XXXX when she was contacted about a couple of weeks ago in the YYYY year only. She reported that before that time when she was not aware about the lawsuit she was not questioned by anybody about the care or attention which was received by Mr. XXXX. She was asked if there were books or somewhere on line or copies or any documents which talked about the rules, regulations, procedures regarding the patient care and how to document different things they attend to during their day of work. She had replied that may be on line but she did not recall any books or anything sitting around the nurses station. She stated that prior to working at XXXX or while working for Lutheran Senior Services she did not review any types of rules or policies or procedures on line. She stated that she had learned at CNA class that if there was any problem with the resident she was supposed to report to RN as opposed to calling the doctor directly. She stated that she was aware of any documents or materials on line or otherwise that deal with actions or steps to be taken regarding residents if there was a potential medical emergency. She answered that she was aware that she must notify the nurse. She reported that she did not know on line or on the document that must be done and was unaware if there was any.	
44:09-45:04	She stated that she did not know if Mr. XXXX already had therapy before she met him or was it after she met with him and documented in her notes.	Final conclusion questions