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COMMON PLEAS DIVISION

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April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (OUT OF COUNTY) WITH JURY DEMAND

PAGES FILED: 41

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

LAUREN CARTER By and through her Legal Guardian, Gregory Carter c/o Michael Hill Trial Law 815 Superior Ave., Ste. 623 Cleveland, Ohio 44113 and GREGORY CARTER Individually, c/o Michael Hill Trial Law 815 Superior Ave., Ste. 623 Cleveland, Ohio 44113 Plaintiffs, vs. TAKODA TRAILS AKA MILLER HOLDINGS TAKODA, INC. 350 Kolb Dr Fairfield, Ohio 45014 Also Serve c/o Registered Agent: L & M Statutory Agent, LLC 100 N. Main Street Suite 350 Chagrin Falls, Ohio 44022 and EMPOWERING PEOPLE, INC. DBA CLW DBA CREATIVE LEARNING WORKSHOP DBA TAKODA TRAILS 1268 North River Rd. NE Warren, Ohio 44483 Also Serve c/o Registered Agent: Matthew J Parker 2460 Elm Road, Ste 500 Warren, Ohio 44483	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND** Previously filed Case No.: A2204280

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and

FOUNDATIONS HEALTH, LLC
c/o Registered Agent:
Ohio Agent Solutions, Inc.
25000 Country Club Blvd., Suite 255
North Olmsted OH 44070

and

FOUNDATIONS HEALTH SOLUTIONS, LLC
c/o Registered Agent:
Ohio Agent Solutions, Inc.
25000 Country Club Blvd., Suite 255
North Olmsted OH 44070

and

EMPOWERING PEOPLE WORKSHOP, INC., DBA CLW DBA CREATIVE LEARNING WORKSHOP
c/o Registered Agent:
Matthew J Parker
2460 Elm Road, Ste 500
Warren, Ohio 44483

and

EMPOWERING PEOPLE MANAGEMENT, INC.
c/o Registered Agent:
L & M Statutory Agent, LLC
100 N. Main Street Suite 350
Chagrin Falls, Ohio 44022

and

FAIRFIELD VILLAGE REALTY, LLC
c/o Registered Agent:
Christopher L. Keller
5710 Wooster Pike Ste 122,
Cincinnati, Ohio 45227

and

DESATIN CURTIS

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360 Carver Place Hamilton, Ohio 45011	)
Defendants.	)

Plaintiffs Lauren Carter, by and through her next friend and legal guardian, Gregory Carter, and Gregory Carter, individually, for their refiled Complaint against the above-named Defendant(s), state and aver upon information and belief:

INTRODUCTION

1. This action involves Takoda Trails, an intermediate care facility for developmentally disabled adults with multiple disability diagnoses or intense behavioral needs, an Empowering People, Inc. company, and Empowering People's daytime adult care center Creative Learning Workshop's repeated disregard for the health and well-being of Lauren Carter, a 37-year-old, developmentally disabled woman who suffers from cerebral palsy, cortical blindness (she is legally blind), and reduced mental capacity.

2. Lauren is legally incompetent and has been under a legal guardianship since reaching adulthood. Her father, Gregory Carter, has been appointed as her legal guardian. See Case No. PG08-03-0042, Probate Court of Butler County.

3. Any applicable statutes of limitation for Lauren's causes of action have been tolled by operation of O.R.C. §2305.16 due to her legal incompetence.

4. Despite her limitations, Lauren can walk on her own. Lauren utilizes a wheelchair for instances in which she requires vehicular or other long-distance transportation.

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5. Lauren is not capable of safely eating and swallowing food on her own. She requires feeding via a gastrostomy tube (G-tube). The purpose of the G-tube is to prevent the possibility of any food entering Lauren's esophagus which could result in choking.

6. Due to her disabilities, Lauren requires around-the-clock care. Lauren's family entrusted her care to Takoda Trails, an intermediate care facility for people with similar disabilities. Lauren was admitted to Takoda Trails in December of 2002 and has remained a resident since that time.

7. While under Takoda Trails' and CLW's care and supervision, their staff has regularly subjected Lauren to recurrent incidents of neglect and abuse, including cutting her throat, abandoning her in a hot van for hours (twice), sleeping while on duty supposedly supervising her, broken bones, burns, and physical and emotional abuse.

8. Empowering People was aware of significant, dangerous, and even deadly incidents causing harm and injury to residents by staff neglect, abuse, or assault, as well as unexplained injuries, but chose to understaff the facility, not put in supervisory equipment like cameras, hire underqualified staff, fail to adequately train or supervise their staff, and permit, ratify, and cover up employee misconduct, leaving incredibly vulnerable and defenseless residents, who cannot self-report abuse, in the hands of a single, underqualified staff member on night shifts, totally unsupervised, without cameras or another way to identify, report, or prevent abuse and neglect of residents, all while advertising to families of potential residents that they "have both the ability and experience to serve this population with EXCELLENCE."

9. There is a pattern of concerning incidents without adequate response from Empowering People, Takoda Trails, and CLW to prevent future incidents.

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10. On October 18, 2003, Lauren received eighteen (18) stitches to her hand after allegedly getting it caught in a door at Takoda Trails. Her family and legal guardian was never notified of this incident. According to witness reports, Takoda Trails is uncertain as to where and how this injury happened.

11. On May 8, 2006, staff at Fairfield High School where Lauren attended became concerned about a burn on Lauren's arm. The school believed that Lauren had been burnt by a hairdryer due to a grill-shaped pattern in the burn. Takoda Trails' staff was notably uncooperative with the investigation.

12. On February 28, 2008, Kimberly Charles, a Medical Records Specialist at Takoda Trails, witnessed an aide at Takoda Trails forcibly push Lauren, who is legally blind, into her wheelchair.

13. On January 6, 2010, Lauren was forcibly restrained in her wheelchair by CLW staff. Notably, Lauren is able to walk and only utilizes a wheelchair for long-distance transportation to ensure her safety. Such restraint is abuse.

14. On July 21, 2011, a hot summer day, Lauren was left on a transport bus by CLW staff for approximately two hours. When she was finally found, she was in distress, drenched in sweat, and had an elevated body temperature.

15. On October 2, 2014, the Takoda Trails staff who were assigned to provide Lauren with 24-hour care were found asleep on duty. Multiple residents—all of whom suffer significant disabilities as a prerequisite for admittance—were without care during that period.

16. On November 18, 2014, Lauren sustained a broken clavicle. The family was not notified of this incident. The origins and circumstances of the injury remain unknown.

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17. On August 25, 2019, Lauren was hospitalized due to food backing up into her esophagus and out through the surgical site of her G-tube. When proper care is provided, neither of these things should be possible.

18. On the overnight shift on November 30, 2021, Takoda Trails once again left Lauren and the 9 other residents alone with a lone caretaker, DeSatin Curtis. When the night shift began, Lauren was in her pajamas, and unharmed. When the day shift began, DeSatin Curtis was reportedly acting strangely, went to her car for a period of time, and changed clothes. Lauren was discovered with a serious laceration (cut) to the throat that required 12 stitches to close. DeSatin Curtis denied knowledge of how this occurred, changed her story, and failed to cooperate with investigations. Police investigation of her building at Takoda Trails could not identify any non-human source for the laceration. Lauren's pajamas, which she was last seen wearing by other staff, had been washed. Detectives also determined that blood had been cleaned from the hallway outside of Lauren's room. Curtis was noted to provide differing versions of events. Curtis was not fired for her involvement with Lauren's injury, but only after failing to cooperate with the investigation.

19. The Defendants knew DeSatin Curtis had a history of violent conduct. In 2018, she was charged with disorderly conduct in Hamilton County Municipal Court Case No. C/18/CRB/33409. The description of the violation states that Curtis "recklessly engaged in turbulent behavior to wit; fighting witnessed by several apartment residents."

20. A month prior to Lauren's throat being cut, Curtis was identified as the principal person of interest in a substantiated Major Unusual Incident (MUI) against a different resident at Takoda Trails, but the Defendants still allowed her to be the lone supervisor over their vulnerable, defenseless, and high-needs residents, without so much

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as a working surveillance camera in the building to document how she treated the residents.

21. On July 18, 2022, once again CLW staff left Lauren on a hot transport bus. The person who left her on the bus was the Administrator of the CLW facility—the person responsible for training others for conducting safety head-counts to prevent a repeat of the incident from 2021. This time, Lauren was left on the hot bus for a period of approximately five hours.

22. Plaintiffs bring this action for compensation for the harms and losses sustained as the result of the negligence, recklessness, conscious disregard, reckless disregard, conduct by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that their conduct is likely to cause, at the time those services or that treatment or care were rendered, an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct, and other wrongful conduct described herein or discovered during litigation.

23. Plaintiffs seek punitive damages in an amount necessary to punish the above-named Defendants and deter the Defendants from engaging in similar conduct in the future, attorneys' fees, and the costs of this litigation.

24. Plaintiffs request a trial by jury.

DEFENDANTS

25. Takoda Trails aka Fairfield Center aka Miller Holdings Takoda, Inc. is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Takoda Trails aka Fairfield Center aka Miller Holdings Takoda, Inc.

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26. Foundations Health Solutions, LLC, is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Tukoda Trails aka Fairfield Center aka Miller Holdings Tukoda, Inc.

27. CLW aka Creative Learning Workshop aka Empowering People Workshop, Inc. is an Ohio corporation that holds itself out to the public as a provider of residential and intermediate care and programming for persons with disabilities, through its agents, operatives and / or employees and does business as CLW aka Creative Learning Workshop aka Empowering People Workshop, Inc. CLW is also used by Empowering People, Inc.

28. Empowering People Management, Inc. is an Ohio corporation that holds itself out to the public as a provider of residential and intermediate care, through its agents, operatives and / or employees and does business as Empowering People Management, Inc.

29. Fairfield Village Realty, LLC is an Ohio limited liability corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and does business as Fairfield Village Realty, LLC.

30. Empowering People, Inc., is an Ohio for-profit corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees, and operates and controls the other Defendant entities, excepting Foundations Health, LLC, which exercises ultimate control over Empowering People, Inc.

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31. Foundations Health, LLC, is an Ohio corporation that holds itself out to the public as a provider residential and intermediate care, through its agents, operatives and / or employees and operates and controls the other Defendant entities.

DIRECT AND VICARIOUS CORPORATE LIABILITY

32. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., Fairfield Village Realty, LLC, Takoda Trails, and CLW ("Corporate Defendants") employ, manage, and direct the care and service providers who were responsible for Lauren Carter's care, treatment, and safety at Takoda Trails and CLW and / or are responsible for creating unsafe conditions at Takoda Trails and CLW through their control of the Takoda Trails and CLW management that directly led to Lauren Carter's injuries.

33. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., and Fairfield Village Realty, LLC direct and control operations at Takoda Trails and CLW and are therefore directly liable for the harms caused by such mismanagement without regard to piercing the corporate veil.

34. Foundations Health, LLC, controls the other corporations in a way that is so complete that the corporations have no separate mind, will, or existence of their own, is exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity; and injury or unjust loss resulted to the plaintiff from such control and wrong, meaning they should be held directly liable for such harms and losses.

35. Foundations Health, LLC, Foundations Health Solutions, LLC, Empowering People, Inc., Empowering People Management Inc., and Fairfield Village

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Realty, LLC collectively own, manage, control, and/or are responsible for the care delivered to residents of Takoda Trails and CLW directly or through their domination and control of any putative entity license holder.

36. Some or all of the Corporate Defendants employ the care providers who were responsible for ensuring Lauren Carter's care and safety at Takoda Trails and CLW.

37. Lauren Carter and her family looked to Corporate Defendants for care based upon their representations.

38. Corporate Defendants are vicariously liable for the negligent actions of their employees and agents (respondent superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including residential care providers.

JURISDICTION AND VENUE

39. This Court has Jurisdiction over Defendant(s) because, among other things, all Defendant(s) do, and all times relevant did, purposefully avail themselves of the laws of the State of Ohio, and/or committed tortious acts within the State of Ohio.

40. Venue is proper in Hamilton County, Ohio under Civil Rule 3(B) because, among other reasons: (a) one or more Defendants reside, domicile, or carry on their principal place of business in that county; and (b) part of the claim for relief arose in that county.

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COMMON FACTS

Who is Lauren Carter?



Photo of Lauren Carter.

41. Lauren Carter is a 35-year-old woman with cerebral palsy and cortical blindness.

42. Lauren smiles.

43. Lauren enjoys going on walks.

44. Lauren enjoys listening to country music.

45. Lauren was admitted to Takoda Trails in December 2019 for long-term residential care.

Defendants' Negligence and Recklessness with Lauren Carter

46. Corporate Defendants accepted Lauren Carter as a resident/attendee for long-term care for issues related to cerebral palsy.

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47. Corporate Defendants agreed to accept Lauren Carter into their facility and provide care to her in exchange for monetary payment.

48. Takoda Trails and CLW knew Lauren Carter's care needs when they accepted her into their care.

49. Lauren Carter endured mental and physical pain suffering as a direct and proximate result of Corporate Defendants' failure to provide adequate care due to understaffing the facility.

50. Takoda Trails promised Lauren Carter and her family person-centered services and 24/7 nursing support:



Empowering People's promises to Lauren's family.

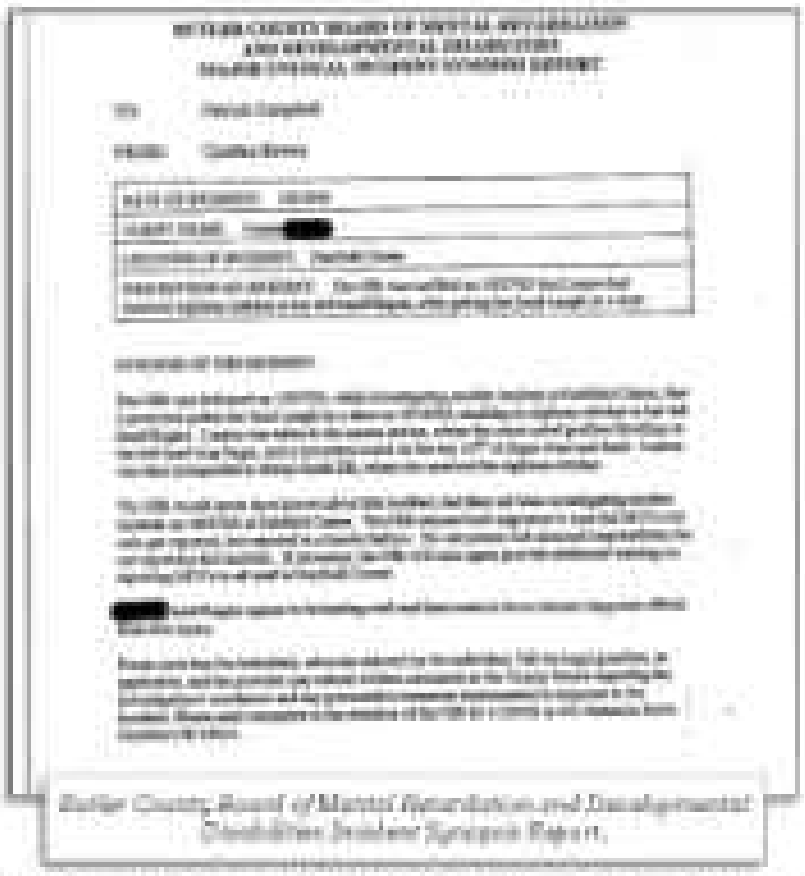
October 18, 2003 – Laceration to Lauren's Hand, Requiring Eighteen (18) Stitches

51. On October 18, 2003, Lauren received eighteen (18) stitches to her hand after allegedly getting it caught in a door. Her family was never notified of this incident.

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According to witness reports, the facility is uncertain as to where and how this injury actually happened. The injury bled so profusely that Lauren was transferred to the hospital where she received 18 stitches.

52. On October 27, 2005, the Butler County Board of Mental Retardation and Developmental Disabilities inadvertently heard about Lauren's injury while at the Takoda



Butler County Board of Mental Retardation and Developmental Disabilities Incident Synopsis Report.

Trails investigating a separate case for another reason. An investigation determined that the facility failed to report the MUI in a timely manner. (See **Exhibit 01**).

March 23, 2006 – Bite Marks on Lauren's Shoulder

53. On March 23, 2006, Fairfield High School nurse, Nina Ross, reported that Lauren came to school with a bite mark on her left shoulder. (See **Exhibit 02**).

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April 3, 2006 – Burn on Lauren's Arm

54. On April 3, 2006, Fairfield High School nurse, Nina Ross, reported that Lauren came to school with a burn on her arm. (See **Exhibit 02**)

55. Lauren's teacher, Tony Huff at Fairfield High School, also believed the injury to Lauren's arm to be a burn. He also reached out to Takoda Trails regarding his concerns with this burn and potential abuse.

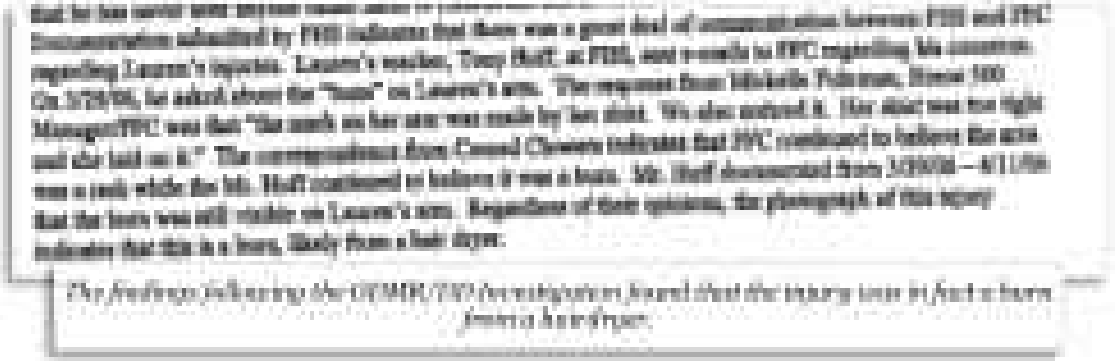
May 8, 2006 - Abrasions on Lauren's Back

56. On May 8, 2006, Fairfield High School nurse Nina Ross reported that Lauren came to school with two (2) fresh abrasions on her back (See **Exhibit 02**).



Cathy Hopkins Statements on the ODMR/JJI Incident Report

57. Fairfield High School nurse Nina Ross attempted to discuss these injuries and her concerns with Takoda Trails. However, staff quickly became defensive. These incidents were filed as an MUI for alleged physical abuse (See **Exhibit 02**).

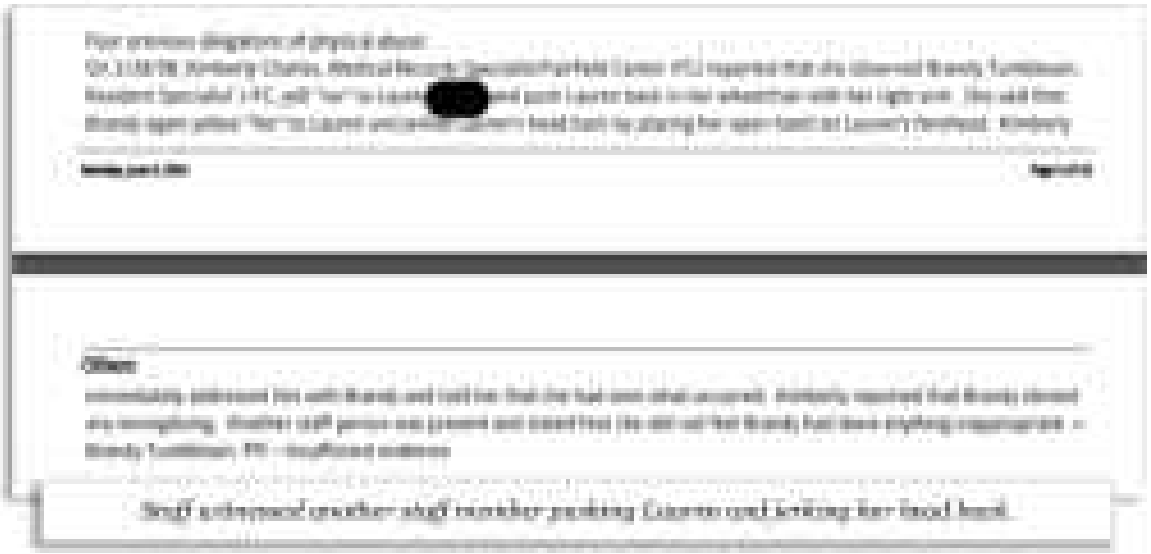


The findings following the ODMR/JJI investigation found that the injury was in fact a burn from a hairdryer.

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February 28, 2008 - Witnessed Physical Abuse

58. On February 28, 2008, Kimberly Charles, a Medical Records Specialist at Takoda Trails reported that she observed Resident Specialist Brandy Tumbleson yell at Lauren twice, push her back into her wheelchair, and jerk Lauren's head back (See **Exhibit 03**).



Staff witnessed another staff member pushing Lauren and jerking her head back.

January 7, 2010 - Lauren's involuntary restraint

59. On January 7, 2010, Tanya Vance from Takoda Trails reported to Patrick Campbell, the investigating agent, that she had discovered that CLW workshop staff were using seatbelts to keep Lauren in her wheelchair. This was not approved in Lauren's care plan or by her family (See **Exhibit 04**).

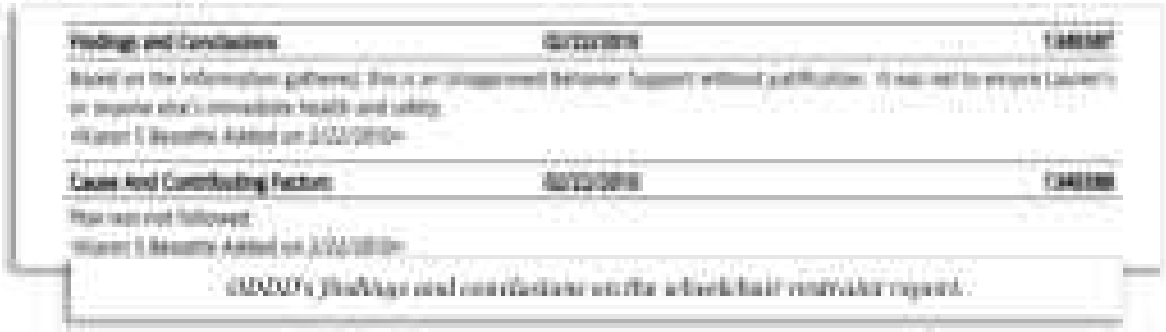


Tanya Vance's initial report to Ohio Department of Developmental Disabilities.

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60. As noted previously, Lauren is ambulatory. Use of a wheelchair in this manner is an unlawful restraint on Lauren's liberty.

61. The Ohio Department of Developmental Disabilities opened up an investigation regarding this report. The findings were substantiated on February 22, 2010 (See **Exhibit 04**).



Findings and Conclusions	02/22/2010	1460587
Based on the information gathered, this is an unapproved behavior support without justification. It was not to ensure Lauren's or anyone else's immediate health and safety. <Event 1 Recently Added on 2/22/2010>		
Cause And Contributing Factors	**02/22/2010**	**1460588**
Plan was not followed. <Event 1 Recently Added on 2/22/2010>		

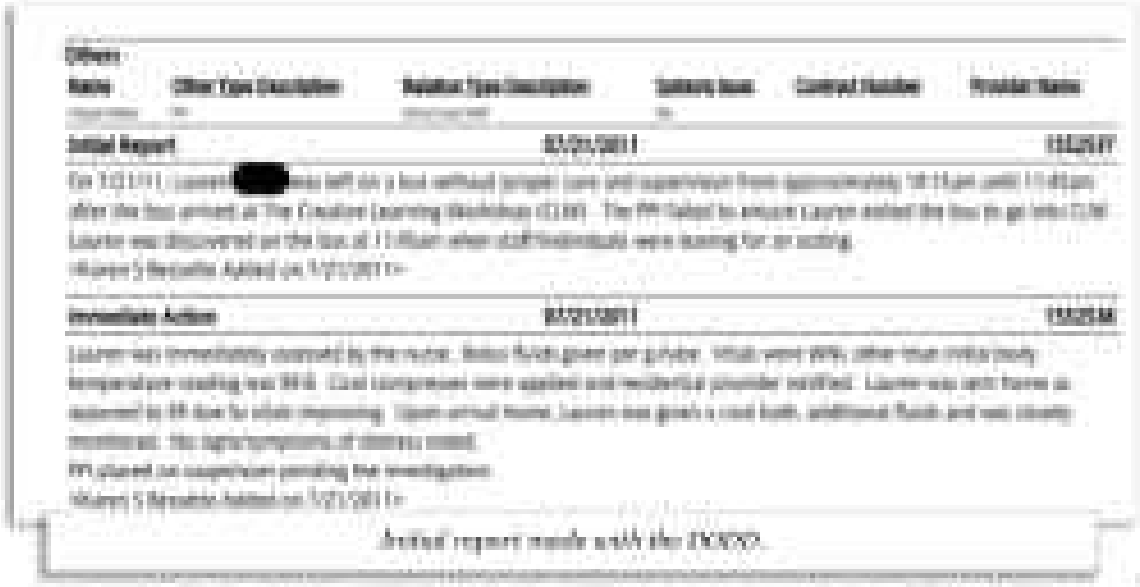
(DODD's findings and conclusions on the wheelchair restraint report.

July 21, 2011 – First Bus Incident

62. On July 21, 2011, a hot summer day, while in the care of CLW, Lauren was left on a transport bus by CLW employee Cheryl Collins for about two (2) hours. Lauren was unable to escape. When she was finally found, she was in distress and had an elevated body temperature.

63. Following Lauren being left on the transport bus, an incident report with the DODD was created that same day. Their investigation was substantiated (See **Exhibit 05**).

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Others

Name	Other Type Description	Relation Type Description	Address Num	Contract Number	Provider Name

Initial Report — 12/21/2011 — 115257

On 12/21/11 Lauren [redacted] was left on a bus without proper care and supervision from approximately 08:15am until 11:40am after the bus arrived at The Creative Learning Workshop (CLW). The PP failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:40am when staff/individuals were looking for an outing.

<Nurse's Records Added on 1/21/2011>

Immediate Action — 12/21/2011 — 115258

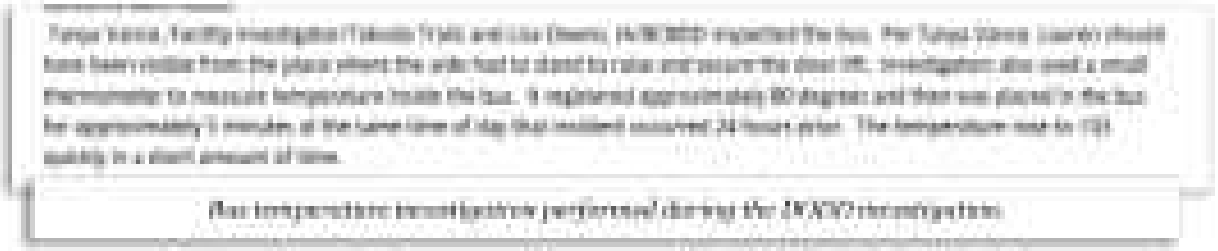
Lauren was immediately assessed by the nurse. Rectal fluids given per g-tube. Vitals were WNL other than initial body temperature reading was 99.6. Cool compresses were applied and residential provider notified. Lauren was sent home as assessed by PP due to vitals improving. Upon arrival home, Lauren was given a cool bath, additional fluids and was closely monitored. No signs/symptoms of distress noted.

PP placed on suspension pending the investigation.

<Nurse's Records Added on 1/21/2011>

Initial report made with the DODD.

64. During this investigation, investigators used a small thermometer to measure the temperature inside the bus. Their thermometer test day mimicked the weather on the day that Lauren was left on the bus. Outside of the bus, the thermometer registered eighty (80) degrees Fahrenheit. After only five (5) minutes of the thermometer being left on the bus, the temperature quickly rose to one-hundred-and-three (103) degrees Fahrenheit (See **Exhibit 05**).



Tanya Vance, Facility Investigator Takeda Yoki and Lisa Owens, RN/BSW inspected the bus. Per Tanya Vance, Lauren should have been visible from the place where she had to stand to raise and secure the door lift. Investigators also used a small thermometer to measure temperature inside the bus. It registered approximately 80 degrees and then was placed in the bus for approximately 5 minutes at the same time of day that incident occurred 24 hours prior. The temperature rose to 103 quickly in a short amount of time.

Bus temperature investigation performed during the DODD investigation.

November 18, 2014 – Diagnosed with Broken Clavicle

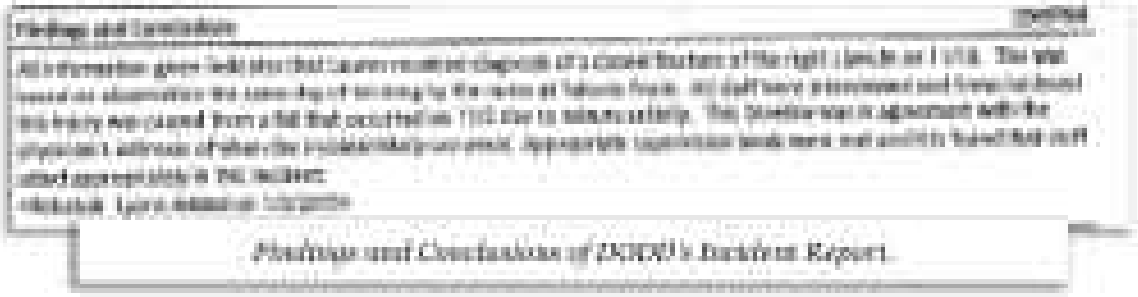
65. On November 18, 2014, Lauren was diagnosed with a broken clavicle. The Ohio Department of Developmental Disabilities completed an incident report and investigation.

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66. Sandy Osterberger, LPN, was preparing to administer Lauren her medication when she noticed yellow bruising measuring approximately 4 inches x 6 inches. She also noted a 1 cm x 1 cm raised area to the right of Lauren's scapula.

67. Lauren was scheduled to see an orthopedic surgeon that afternoon, Dr. Gangle, where she was diagnosed with a broken clavicle.

68. Staff blamed Lauren's broken clavicle on a fall on November 2, 2014, over two weeks prior to the discovery of her injury (See **Exhibit 06**).



Findings and Conclusions of DODD's Incident Report.

August 25, 2019 - Hospitalization for Bowel Obstruction

69. On August 25, 2019, staff at Takoda Trails noted skin discoloration to all four of Lauren's extremities and coffee ground enemas. Lauren was sent to the Mercy Fairfield ER for further evaluation.

70. Emergency medical services personnel noted that Lauren had coffee ground enemas leaking from her g-tube and that she had been vomiting the same type of fluid. She also had bruising all over her body. (See **Exhibit 07**).



Narrative Writeup from the Paramedics report.

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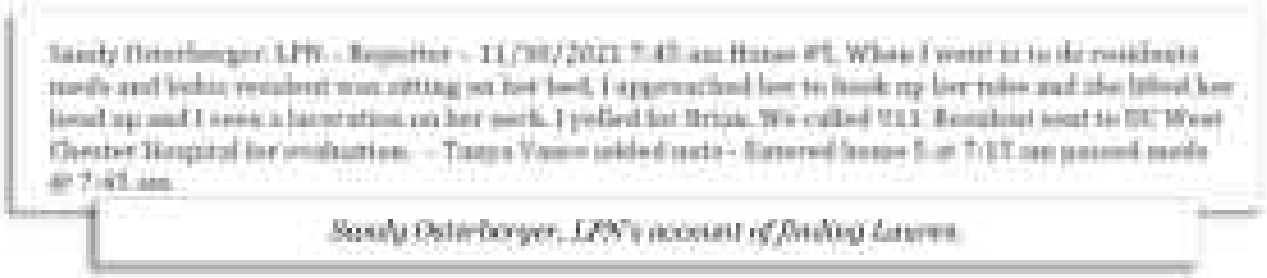
71. Emergency Room physicians determined that Lauren had a bowel obstruction. They initially believed the obstruction would require surgery. However, luckily, Lauren's bowels started working properly again without surgery. She was discharged from the hospital on August 29, 2019 (See **Exhibit 08**).



Findings and conclusions on the MCI Report

November 30, 2021 – Lauren's Throat Slashing

72. On November 30, 2021, Sandy Osterberger, LPN found Lauren in her room, with her throat slashed. (See **Exhibit 03**).



Sandy Osterberger, LPN's account of finding Lauren

73. It was reported to Holly Metz, SSA on-call BCBDD that a laceration was discovered on Lauren's neck at 7:45 a.m. from the side to the middle of her neck (See **Exhibit 03**).

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Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

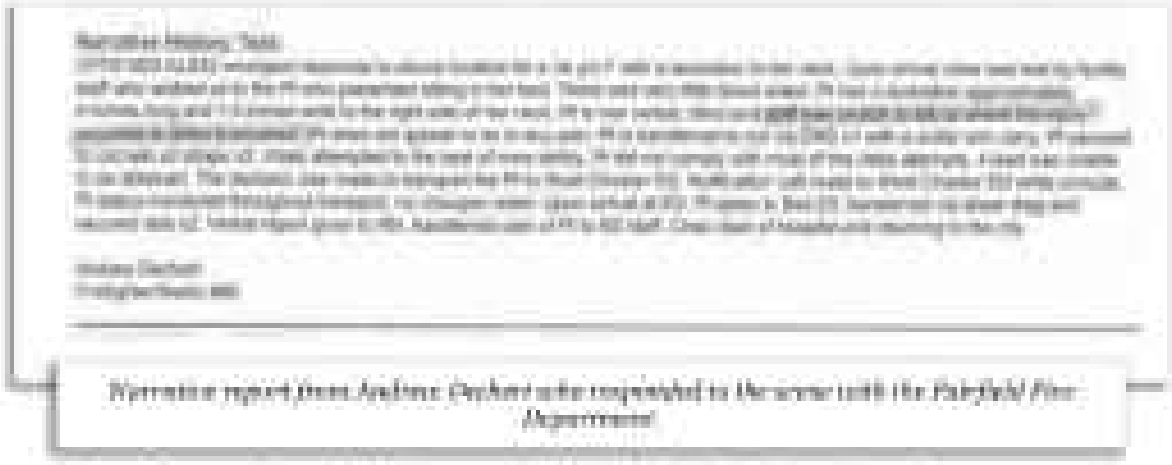
Initial Report 12/01/2021 3137112

On 11/30/2021, it was reported to Police Medic 10A Dis-Cat/BCBSO that a laceration was discovered to Laure[redacted] neck at 7:45am. Layton was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause undetermined.

Airport medic to 10A10:

74. Emergency medical services were called.

75. Andrew Dechart, firefighter/medic with the Fairfield Fire Department noted in his report that there was very little blood at the scene. He also noted that the laceration to Lauren's throat was approximately 4 inches long and 1.5 inches wide located to the right of her neck (See **Exhibit 09**)



Narrative report from Andrew Dechart who responded to the scene with the Fairfield Fire Department

76. Lauren's neck injury required twelve (12) sutures to close.

77. Emergency Room personnel informed Lauren's father, Gregory Carter, that they did not believe this was an accident.

78. The following images depict this wound and may be disturbing to some viewers.

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Lauren with her throat slashed

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Closer image of Lauren's slit throat.



Lauren's throat after the 12 sutures.

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79. The Fairfield Police Department investigated this incident. They "had great concern for this injury. Lauren is blind and could not have done this to herself."

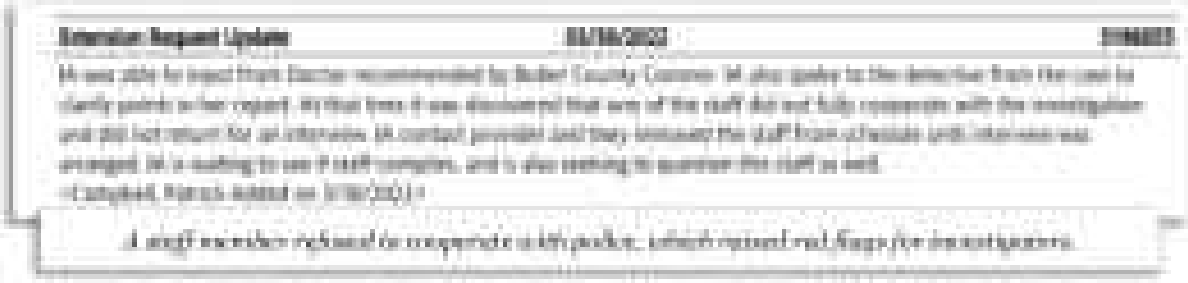
80. Sgt. Pete Lagemann, the Supervisor of Investigations with the Fairfield Police Department stated that there was blood in the hallway that had been cleaned up. He also stated that Lauren's clothes had been changed and she had then been placed back in bed (See **Exhibit 03**).



Sgt. Pete Lagemann's interview report to DODD

81. Defendant DeSatin Curtis, the sole staff member on duty during the events surrounding Lauren's throat being slashed, became uncooperative with police and did not show up for her second interview.

82. Sgt. Pete Lagemann's police report stated that he believed that DeSatin Curtis was aware of Lauren's neck injury and failed to seek medical attention or call the on-call nurse (See **Exhibit 03**).



A staff member refused to cooperate with police, which raised red flags for investigators.

83. Police believe Defendant Curtis knew about Lauren's throat slashing, cleaned up the blood, and changed Lauren's clothes.

84. According to medical professionals that the Fairfield Police Department spoke to, the injury would have had to have happened on Defendant Curtis's shift, several

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hours before medical attention was sought for Lauren. This is corroborated by the fact that the blood on Lauren's neck had dried by the time the cut was reported.

85. The Fairfield Police Department spoke to Michelle Truett, QA RN with BCRDD. They provided her photos of Lauren's neck incised wound for review. Ms. Truett believed there would have been more bleeding than what the images showed.

86. The Fairfield Police Department spoke with Kathy Tallon, QA RN with BCRDD. They showed her photos of Lauren's injuries for review. According to documentation, Kathy was unsure as to how such an injury could occur "accidently," but that the object used to make the cut would have had to have been sharp to cause a clean cut (See Exhibit 03).



Opinions of Michelle Truett, QA RN with BCRDD and Kathy Tallon QA RN with BCRDD as listed in DODD's Incident Report.

87. The Fairfield Police Department spoke with Dr. Gary L. Utz, a pathologist in Cincinnati, Ohio. Dr. Utz has been a practicing doctor for more than twenty (20) years, and he received his degree from the University of Cincinnati College of Medicine.

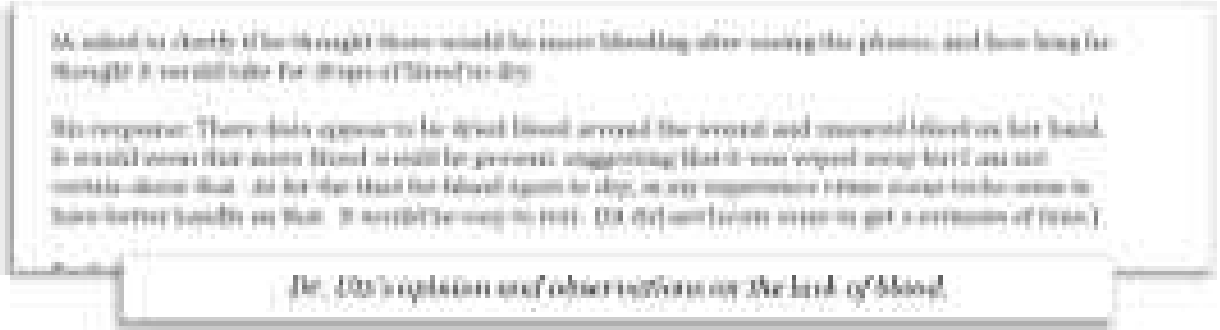
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88. Dr. Utz believed the incision came from a sharp object. He also believed that the injuries were more than a few hours old (See **Exhibit 03**).



Dr. Gary Utz statements as documented in DCDD's incident report.

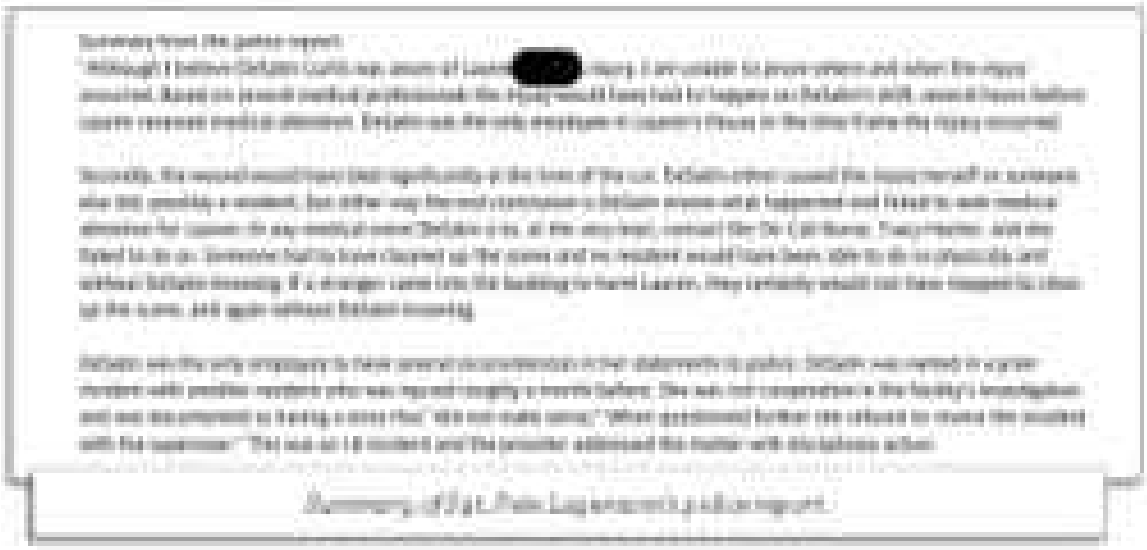
89. Dr. Utz thought there would be more bleeding. He noted dried blood around the wound and smeared blood on Lauren's hand. The lack of blood suggested that blood had been wiped away. (See **Exhibit 03**).



Dr. Utz's opinion and observations on the lack of blood.

90. Defendant DeSatin Curtis was named in a prior incident with another injured resident just a month prior to Lauren's neck injury (See **Exhibit 03**). However, she was not released from employment.

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Summary of Police Log entry in police report

91. Defendant Curtis was eventually terminated from Takoda Trails due to her failure to cooperate with the police investigation.

July 18, 2022 – Second Bus Incident

92. On July 18, 2022, Lauren was transported to CLW by CLW Administrator, Josh Morris, in CLW's transport bus. Morris, the Administrator and person responsible for training staff on performing head counts for bus safety after the First Bus Incident, left Lauren on the bus for a period of five hours.

93. CLW staff lied and said the windows of the bus were down the entire five hours. Camera footage proved this statement to be a lie.

94. This incident was reported to the Butler County Board of Developmental Disabilities. They did an investigation and found the report to be substantiated (See Exhibit 13).

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Based on the information obtained, it is the findings of this investigator that the allegation of neglect is substantiated due to the following:

Supervision levels were not met, and Lauren was left alone on the bus for 5 hours. [not in need 5 hours as originally reported]
Lauren has no safety skills and needs to be in view of staff in the community and at CLW.
Lauren has a history of behaviors and the PA of outlined behaviors with supervision not in place, this placed Lauren at risk for serious injury, physical or severe events or she attempt to exhaust from the bus finding left in a vehicle, even although exercised, as noted This condition places Lauren at risk for harmful injury. The above and attachment were issued. [not open as originally reported]

Butler County Board of Developmental Disabilities' findings in the investigation

CORPORATE CONTROL

95. Corporate Defendants hold themselves out to the public as providers of residential and intermediate care services.

96. Corporate Defendants' for-profit model means their primary goal is to maximize profit, measured by revenues minus expenses.

97. For intermediate care facilities and residential care facilities generally, the largest individual revenue source is residents (filling beds), and the largest individual expense is the cost of employing staff to provide care to those residents. This creates a financial incentive to take on more residents with greater care needs than the staff can properly care for, a violation of federal regulations regarding staffing levels.

98. Corporate Defendants manage, control, and / or employ the staff at Takoda Trails and CLW.

99. Corporate Defendants exercise actual control over the Takoda Trail's and CLW's management and operations to maximize profits, including control over facility-level, including:

a. Policies and procedures: including regarding resident supervision and care;

b. Finances, including obtaining credit and loans, guaranteeing loans (both at the corporate and individual facility level), maintaining funds and banking, obtaining, owning, and leasing facility land and buildings, and capital expenditures.

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c. Budgeting, including controlling the amount of funds available for staffing facilities;

d. Personnel management, including hiring and firing, or having authority to hire and fire, the supervisory and management personnel in each facility;

e. Supervision of management, care providers, and staff in each facility, including compliance with federal and state regulations;

f. Employment, such as setting pay scales, shifts, and time and vacation policies;

g. Systems for training, monitoring, and supervising staff;

h. Medical record systems and management;

i. Financial control systems, including budgeting and payment processing;

j. Marketing, including setting the image and expectations residents and their family should expect at the facility, and even the name of the facility;

k. Reporting procedures, including reporting to government organizations as to individual resident care and facility-wide issues.

100. As the result of this control, Corporate Defendants make decisions that affect the day-to-day care of residents of the Takoda Trails and CLW, such as the resources available for providing staff and care to residents like Lauren Carter, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

101. Corporate Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that the facilities were sufficiently staffed to meet the individual needs of its residents, including Lauren Carter.

102. Corporate Defendants engaged in a systemic practice to understaff the facilities to maximize profits at the expense of its residents' care.

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103. This lack of sufficient staff directly resulted in Lauren Carter not receiving basic and necessary services to prevent, among other things, neglect and abuse leading to her injuries.

104. Corporate Defendants also exercise operational and managerial control, and apply this profits-over-safety model throughout Ohio. Defendant Empowering People, Inc., alone, operates at the following facilities in the State of Ohio according to their website:

a. Manor Home - Geneva, OH

b. Takoda Trails - Fairfield, OH

c. Vienna Meadows - South Vienna, OH

d. Consumer Choice Inc. - Lisbon, OH

e. Sunrise Homes - Lisbon, OH

f. Affinity Place - Mount Healthy, OH

g. Hunsford - Cincinnati, OH

h. John Gray - Cincinnati, OH

i. Munon Ave. Home - Cincinnati, OH

j. Northbend - Cincinnati, OH

k. Woodbine - Cincinnati, OH

l. Broadfield Care Center - Madison, OH

m. Stewart Lodge - Madison, OH

n. Foundations - New Paris, OH

o. Alliance Group Homes - Alliance, OH

p. Carnegie - Massillon, OH

q. Deborah - Canton, OH

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r. Stranner Home - Canal Fulton, OH

s. Sturbridge Home – Alliance, OH

t. Dunbar – EPI Summit – Tallmadge, OH

u. Ellsworth – EPI Summit -Stow, OH

v. Frank – EPI Summit – Barberton, OH

w. Lakeview – EPI Summit – Stow, OH

x. North Thomas – EPI Summit – Tallmadge, OH

y. Pontius – EPI Summit – Uniontown, OH

z. Ritchie – EPI Summit – Stow, OH

aa. Springfield – EPI Summit – Akron, OH

bb. Winchester – EPI Summit – Fairlawn, OH

cc. Empowering People Inc. – Warren, OH

dd. Brookside Care Center – Mason, OH

ee. Cedar Creek – Elyria, OH

Misleading Advertising

105. To persuade the families of patients to become customers, Corporate Defendants make promises to the families of such potential residents that they will provide a level of care that they know they are incapable of providing.

106. The intent and outcome of this misleading practice is to cause residents, their families, and external care providers to believe the facility is much better staffed to provide the promised care than what is actually the practice of the Corporate Defendants with regard to staffing the facility.

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107. The intent and outcome of this misleading practice is to drastically limit the budget and overhead needed to run a safe facility in order to maximize profits and syphon resources at the expense of patient safety.

Systemic Understaffing and Lauren Carter's Care

108. Corporate Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Takoda Trails and CLW were sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Lauren Carter during the period she was a resident at Takoda Trails and attendee at CLW.

109. Corporate Defendants engaged in a systemic practice to understaff Takoda Trails and CLW to maximize profits at the expense of its residents' care.

110. This lack of sufficient staff directly resulted in Lauren Carter not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect and abuse leading to her injuries at Takoda Trails and CLW during the period she was a resident and attendee.

FIRST CAUSE OF ACTION
(NEGLIGENCE / RECKLESSNESS)

111. Plaintiff(s) Incorporate all other paragraphs of this Complaint as if fully rewritten herein.

112. Lauren Carter depended on Corporate Defendants, and their respective staff, including Defendant DeSatin Curtis, residential care.

113. Defendants had a duty to provide proper care and treatment to Lauren Carter and to avoid causing her injury.

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114. Defendants, including their staff, failed to provide proper care and treatment to Lauren Carter, which they knew or should have known she required, and their negligence was the direct and proximate cause of the injuries that Lauren Carter suffered.

115. Defendants' failure to provide proper care included, but is not limited to:

a. Choosing to put inadequate prevention and response interventions in place to prevent injuries;

b. Choosing to provide inadequate resident observation, supervision, and monitoring;

c. Choosing to provide improper training to staff members regarding resident monitoring, assessment, response, and treatment;

d. Choosing to provide too few, and / or underqualified staff members for resident needs at each facility to protect and provide adequate care to residents like Lauren Carter;

e. Choosing to not provide accurate, adequate, or timely information to Lauren Carter's family;

f. Choosing to provide inadequate supervision to prevent accidents and injuries;

g. Choosing to violate orders relating to care of Lauren Carter;

h. Choosing to violate state and federal regulations governing care and staffing levels in facilities by which residents like Lauren Carter are a member of the class of persons intended to be protected from injuries like those she suffered;

i. Failing to ensure the rights and safety of its residents, including Lauren Carter, as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Lauren Carter while she was a resident/attendee; and

k. Such other acts or omissions described in this Complaint or discovered in litigation.

116. These actions constituted a conscious disregard for Lauren Carter's rights and safety with a great probability of causing substantial harm from this misconduct, by

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which—through heedless indifference to the consequences—Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct was likely to cause, at the time those services or care were rendered, constituting an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct. Defendants were aware of the great probability of harm that could result from their willful, wanton, and/or reckless misconduct.

117. Defendants' disregard for the rights and safety of residents like Lauren Carter created circumstances under which it became substantially certain that serious injuries would result, entitling Plaintiff to awards for compensatory and punitive damages.

118. Defendants are directly liable for their own willful, wanton, and/or reckless misconduct.

119. Corporate Defendants are also vicariously liable for their employees' and agents' willful, wanton, and/or reckless misconduct.

120. Defendants and their staff provided care to Lauren Carter that fell below the standard of care expected of residential care facilities, under the same or similar circumstances.

121. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., and Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

122. As a direct and proximate result of the negligent and/or willful, wanton and/or reckless actions of the Defendants described above, Lauren Carter sustained

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permanent injury and loss including, but not limited to, conscious pain and suffering, and permanent bodily disfigurement.

123. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), for conscious pain and suffering, permanent bodily disfigurement, loss of enjoyment, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

SECOND CAUSE OF ACTION
RESIDENTS' RIGHTS CLAIM

124. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

125. Defendants, directly or through their employees or agents, violated Lauren Carter's rights as a resident of Defendants' facilities, as enumerated in R.C. 3721.13, including, but not limited to:

a. The right to a safe and clean living environment;

b. The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

c. Upon admission and thereafter, the right to adequate and appropriate care and services that comprise necessary and appropriate care consistent with the program for which the resident contracted;

d. The right to be free from physical or chemical restraints or prolonged isolation; and

e. The right to have any significant change in the resident's health status reported to the resident's sponsor.

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126. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Lauren Carter endured conscious pain and suffering, emotional distress, permanent bodily disfigurement, and other injuries.

127. WHEREFORE, Plaintiff demands judgment against Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

THIRD CAUSE OF ACTION
NEGLIGENT HIRING, SUPERVISION, AND RETENTION

128. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

129. Corporate Defendants were in an employer-employee relationship with Defendant DeSatin Curtis, Cheryl Collins, *Josh Morris*, and other staff who caused harm to Lauren Carter.

130. Corporate Defendants' employees were incompetent to provide care and services to Lauren Carter.

131. Corporate Defendants had actual or constructive knowledge of their employees' incompetence, including Defendant DeSatin Curtis.

132. Corporate Defendants' employees' acts or omissions caused injury to Lauren Carter.

133. Corporate Defendants' negligence in hiring, retaining, or supervising their employees is the proximate cause of Lauren Carter's injuries.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit,

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attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

FOURTH CAUSE OF ACTION
CIVIL CONSPIRACY

134. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

135. Defendants had an express agreement, mutual understanding, or tacit agreement to, and/or their agents maliciously combined efforts to:

a. defraud residents and their families by delivering wholly inadequate care, contrary to their promises;

b. systemically understaff their facilities in violation of federal regulations, and for the purposes of their own profit, at the expense of resident health and safety;

c. under-capitalize the facilities and syphon money to themselves and related entities for the purposes of their own profit at the expense of resident health and safety;

d. not provide the level of care, by understaffing the facility, paid for by taxpayer dollars; and

e. as otherwise may be described in the Complaint or learned through discovery.

136. This understanding constitutes a malicious combination to injure residents/attendees of the Takoda Trails and CLW, including Lauren Carter.

137. In pursuance of this common plan or design to commit tortious acts, Defendants actively took part in it, or furthered it by cooperation or request, or lent aid or encouragement to the wrongdoers, or ratified and adopted the wrongdoers' acts done for their benefit.

138. The conspiracy caused injury to Lauren Carter.

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139. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

FIFTH CAUSE OF ACTION
FRAUD

140. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

141. Corporate Defendants concealed facts concerning their staffing levels, gaps, and the amount of care they were actually capable of providing at Takoda Trails and CLW.

142. Not only did Corporate Defendants conceal this information, but they also publicly and privately represented that they provide exceptional services in an effort to induce the family of Lauren Carter and other potential customers to place their loved ones in their care and custody.

143. These inducements were made falsely, with knowledge of their falsity, or with such utter disregard and recklessness as to whether they were true or false that knowledge may be inferred with the intent of misleading Lauren Carter's family and other potential customers into placing their loved ones in the care and custody of Defendants.

144. Lauren Carter's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

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145. The result of these inducements and concealments was that Lauren Carter's family, and the family of numerous other residents, allowed their loved one to be placed in Corporate Defendants' facilities.

146. As a direct and proximate result of Defendants' actions, representations, and concealments, Lauren Carter suffered conscious pain and suffering, permanent bodily disfigurement, and other injuries as otherwise described in this Complaint.

147. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

SIXTH CAUSE OF ACTION
NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

148. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

149. Plaintiff Lauren Carter reasonably appreciated the peril which took place when she was injured while in the care of Defendants.

150. Plaintiff Lauren Carter suffered emotional distress as a result of her peril at the hands of Defendants.

151. Plaintiff Gregory Carter was a bystander to the omissions of care suffered by his daughter, Lauren Carter.

152. Plaintiff Greg Carter reasonably appreciated the peril which took place when Lauren Carter was injured while in the care of Defendants.

153. Plaintiff Greg Carter suffered emotional distress because of his awareness of Lauren Carter's peril at the hands of Defendants.

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154. WHEREFORE, Plaintiffs demand judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

SEVENTH CAUSE OF ACTION
ASSAULT AND BATTERY

155. Plaintiff(s) incorporate all other paragraphs of this Complaint as if fully rewritten herein.

156. Defendants and their employees willfully threatened or attempted to harm or touch Plaintiff Lauren Carter offensively, which threat or attempt reasonably placed Plaintiff Lauren Carter in fear of such contact, and did make such contact.

157. Defendants and their employees knew with substantial certainty that their act or acts would bring about harmful or offensive contact.

158. Defendants and their employees willfully acted to harm or touch Plaintiff Lauren Carter offensively.

159. Defendants and their employees' acts to harm or touch Plaintiff Lauren Carter offensively resulted in harm or offensive contact with Plaintiff Lauren Carter.

160. Plaintiff Lauren Carter suffered injuries as a result of Defendants' and their employees' acts.

161. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

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A TRIAL BY JURY IS HEREBY DEMANDED

Respectfully Submitted,

/s/ Matthew A. Mooney

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Counsel for Plaintiff

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Addendum: Redacted font from all caps of patient name to proper format. Changed during station check. (E. Dyppel 10-5-2021

Addendum: Changed Incident Location Type to Res. Custodial Facility. (Stallman 10/21/21

Unable to Sign:
Unable to Sign Reason: Verbally unable (must describe in comments)
Authorized Representative: No authorized representative is available or willing
Authorized Representative Signature: No
Secondary Documentation: Patient Medical Record
Secondary Documentation Signature: No
Comment:
Pt is NPO/E only verbal and blind

Auth Signature: No **Primary Sig:** No **Unable to Sign:** Yes **Refused to Sign:** No

Signature Image(s):
Authorization Signature

Privacy Notice Signature

Receiving RN / MD Signature - Jun Ho - 11/26/2021 08:20



Technician 2 Signature - Miller, Ryan - 11/26/2021 08:36



Termination Signature - Dechert, Andrew - 11/26/2021 09:13



Recommended Service Level: BLS (A0429) / Dispatch Service Level: ALS
Run Type: Emergency
Calculated Mileage: 16.43
Medically Necessary: Yes (S)

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PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 17

EXHIBIT

01

Ohio Department of Mental Retardation and Developmental Disabilities
Division of Information Systems
ODMR/DD INCIDENT REPORT (ITS)

Incident Type: [illegible]	Classification: MUI	Facility: [illegible]				
SSN: [redacted]	DOB: [redacted]	Client Sex: [redacted]	Client Name: [redacted] LAUDIO			Ethnicity: [redacted]
Address: 330 KYLE DRIVE		City: FAIRFIELD		State: OH	Zip Code: 45014	
Date Med Due: 11/1/2003	Incident Date: 10/31/2003	Incident Time: 3:00 PM	Discovery Date: 10/31/2003	Discovery Time: 6:00 PM	Report Date: 10/31/2003	
Incident Category: Injury - Accident - 1 - 0 - 0						
Incident Location: Non-County Operated Program - Residence - 57048 - 0						
Incident Status:						
Provider Agency - Oct 18 2003 Legal Guardian - Oct 18 2003 Family - Oct 18 2003 SSA - Oct 27 2003	Closed: Notified: Incident Review Status: Open With Information Submitted Guardian	Accepted: Unauthorized	Autopsy: Last Change By: Cynthia S Brown			

Incident: 2003-056-0277 | Page 1 of 2 | Printed: 11/01/2003 12:27:36 PM

[redacted] LAUDIO [redacted]
MUI Date/Time: 11/01/03 11:30:36 AM

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Statement:

The OIR was notified on 10/7/03 that Lauren had received 18 stitches to her left hand/fingers, after getting her hand caught in a door on 10/1/03. The OIR is attempting to find out why we were not notified on this. The OIR "accidently" found out about this incident while investigating another one at Fairfield Center. Parties Completed is continuing to ask why an Incident Report was not filed, or if one was, who they sent it to. Joan said I never received anything and Brenda is out for several weeks. Lauren's stitches were a result of her getting her hand caught in a door (details are forthcoming, once Patrick locates the Incident Report). Nurse's notes, however, state that Lauren had profuse bleeding on left hand ring finger, and a laceration noted on top 1/3rd of finger front and back. Also, notes that Lauren was transported to Mercy Hospital ER. The OIR will update the files upon receipt of additional information regarding Lauren's efforts. <Cynthia S Brown Added on 10/28/2003>

Statement:

According to Patrick Campbell, Fairfield Center, no one at Fairfield Center is taking the responsibility for not filing this in a timely fashion. The OIR is setting up, yet another training on the importance of reporting and reporting in a timely fashion. [redacted] and injury appears to be healing and has suffered no ill effects resulting from the injury. The OIR is requesting that this case be closed. <Cynthia S Brown Added on 11/21/2003>

Immediate Actions:

Lauren was taken to the nurse's station, then transported to Mercy South Hospital. <Cynthia S Brown Added on 10/28/2003>

Prevention Plan:

[redacted] will be closely monitored regarding her movements, hopefully alleviating any further problems. Fairfield Center will [illegible] yet another training regarding reporting and reporting on a timely fashion! <Cynthia S Brown Added on 11/21/2003>

SUMMARY COMPLETED BY INVESTIGATIVE AGENT
FOR
THEIR INVESTIGATION FILE

A) Allegation

On 10/27/03, this IA was informed, inadvertently, by a witness in another incident at Fairfield Center, that Lauren [redacted] had accidently caught her left hand in a door, resulting in her receiving a total of eighteen stitches to her left hand/fingers.

Statement/Interview/Documentation Review

Interviews

Patrick Campbell/Program Support Manager
Betty Black/LPN/Fairfield Center
Rachel Buczek/Staff/Fairfield Center

Documents Reviewed

MUI Report 2003-009-0277
Nursing Notes
Witness Interview/Rachel Buczek/Staff

C) Findings of Investigation

This IA initiated the investigation on 10/27/03, after being notified by a witness, Rachel Buczek, in another incident at Fairfield Center, that Lauren had caught her hand in a door on 10/18/03, requiring eighteen stitches to her left hand/fingers. This IA has been unable to determine who was responsible for getting the Incident Report to us, however, this IA has stressed to Patrick Campbell how important it is to report and to report in a timely fashion. There was documentation, however, in the nursing notes as to Lauren's injuries and transportation to the hospital for treatment.

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Lauren's injury appears to be healing well, and there seems to be no known long-term effects from this injury.

D) Concluding

It is the conclusion of this IA, that Lauren received eighteen stitches in her left hand/fingers due to getting her hand caught in a door at Fairfield Center.

The case disposition is based upon the following findings:

1. This IA's interviews with those individuals listed above.
2. Incident Report.
3. Nursing notes regarding Lauren's injury.

Investigative Agent

11/29/23
Date

Cynthia Brown

From: ITD.Support@admin.state.ak.us
Subject: Case Closed - Incident 2020-000-0277

Automated Notification of Case Closure: 2020-000-0277
Client: Client Number [redacted] Lauren
Incident Date: 10/18/2020
Current Date: 11/24/2020 9:18:17 AM
Closed Date: 11/24/2020
Updated By: Amy E Kapernikas

11-24-20
Notified Patient & Grace Adams

E-FILED 04/20/2020 3:54 PM | CONFIRMATION NUMBER: [illegible] | CONSUMER PROTECTION

BUTLER COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
MAJOR UNUSUAL INCIDENT SYNOPSIS REPORT

TO: Patrick Campbell

FROM: Cynthia Brown

DATE OF INCIDENT: 10/18/03
CLIENT NAME: Lauren [redacted]
LOCATION OF INCIDENT: Fairfield Center
DESCRIPTION OF INCIDENT: The OIR was notified on 10/27/03 that Lauren had received eighteen stitches to her left hand/fingers, after getting her hand caught in a door.

SYNOPSIS OF THE INCIDENT:

The OIR was informed on 10/27/03, while investigating another incident at Fairfield Center, that Lauren had gotten her hand caught in a door on 10/18/03, resulting in eighteen stitches to her left hand/fingers. Lauren was taken to the nurses station, where the nurse noted profuse bleeding on the left hand ring finger, and a laceration sized on the top 1/8th of finger front and back. Lauren was then transported to Mercy South ER, where she received the eighteen stitches.

The OIR would never have known about this incident, but they out here investigating another incident on 10/27/03 at Fairfield Center. The OIR stressed how important it was that MUI's not only get reported, but reported in a timely fashion. No one person had assumed responsibility for not reporting this incident. If necessary, the OIR will once again provide additional training on reporting MUI's to all staff of Fairfield Center.

[redacted] hand/fingers appear to be healing well and there seem to be no known long-term effects from this injury.

Please note that the individual, advocate selected by the individual, OR the legal guardian, as applicable, and the provider may submit written comments to the County Board regarding the investigation's conclusion and any preventative measures implemented in response to the incident. Please send comments to the attention of the OIR by 11/03/03 at 441 Patterson Drive Fairfield OH 45014.

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SIGNED: Cynthia L Bridle DATE: 11/12/03
INVESTIGATIVE AGENT

Cc: Sharon Frederick
File

WDM

Ohio Department of Mental Retardation and Developmental Disabilities
Division of Information Systems
ODMR/DD INCIDENT REPORT (ITS)

Incident Date: 10/26/2003	Occurrence: 9:01	Facility: [redacted]					
Age: [redacted]	SSN: [redacted]	Gender: [redacted]	Ethnicity: [redacted]			Race: LAUREN	Sex: F
Address: [redacted]		City: [redacted]		State: OH	Zip Code: 43614		
Local Use Data: 12/1/2001	Initial Report Date: 10/26/2003	Initial Report Time: 9:01 PM	Occurrence Date: 10/25/2003	Occurrence Time: 8:00 PM	Closed Date: 10/28/2003		
Incident Category: Injury - Accident - 1 - 2 - 0							
Incident Location: Non-County Operated Program - Residence - [redacted] - 0							
Provider Agency - Oct 18 2003 Legal Guardian - Oct 18 2003 Family - Oct 18 2003 SSA - Oct 27 2003	Current Status: Verified Initial Review Status Open with Information Pending Closed Date		Accepted Multidisciplinary		Assigned Last Changed By Cynthia S Barnes		

Statement:

The OIR was notified on 10/27/03 that Lauren had received 18 stitches to her left hand/fingers, after getting her hand caught in a door on 10/18/03. The OIR is attempting to find out why we were not notified on this. The OIR "accidently" found out about the incident while investigating another case at Fairfield Center. Patrick Campbell is checking to see why an Incident Report was not filed, or if one was, who they sent it to. Jean and I never received anything and Ronnie is out for several weeks. Lauren's stitches were a result of her getting her hand caught in a door (details are forthcoming, once Patrick locates the Incident Report). Nurse's notes, however, state that Lauren had profuse bleeding on left hand ring finger, and a laceration noted on top 1/3rd of finger front and back. Also, notes that Lauren was transported to Mercy Hospital ER. The OIR will update the State upon receipt of additional information regarding Lauren's status. <Cynthia S Brown Added on 10/28/2003>

Immediate Action:

Lauren was taken to the nurse's station, then transported to Mercy South Hospital. <Cynthia S Brown Added on 10/28/2003>

To: Joan O'Hair

From: Patrick Campbell [pcampbell@magcorp.com]
Sent: Tuesday, October 28, 2003 8:00 AM
To: Joan O'Hair
Subject: Lauren [redacted]

Hello

Checked into Lauren's finger and..... 10 stitches....

10-18-03 Has produse bleeding on left hand ring finger.
laceration noted on top 1/3rd of finger front and back.
Staff report resident caught her finger in the door.

Nursing notes all parties notified on 10-18-03... I have not found the incident report yet.

OMRP made Lauren 1:1 visual range until door can be altered.

I'm feeling nursing roms

Patrick

Fairfield Center

FACSIMILE TRANSMITTAL SHEET

TO: Jeffrey

FROM: Patrick

COMPANY:

DATE:

FAX NUMBER:

TOTAL NO. OF PAGES:

RE: Lauren

☐ URGENT ☑ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ CONFIDENTIAL

NOTES/COMMENTS:

18 - 21 Tables

FAIRFIELD CENTER, INC.
350 KOLB DRIVE, FAIRFIELD, OHIO 45014
PHONE (513) 874-0433, FAX (513) 874-0288

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NURSE'S NOTES

Name [redacted] Doctor Room No.

10/28/03	Staff collect urine - Pt has patient identification band - Index finger Staff reports pt caught his finger in the door [illegible] noted on the tip of finger on both sides (Lateral) Bandage applied & clean. Clock to transport to MSER for possible splinting. All parties notified — [illegible]
10-28-03	Pt [illegible] Dressing dressing from [illegible] intact to L hand 4th digit [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
10/28/03	Patient dressing intact to tip finger (L) hand has slightly one 1/2 of distal end — [illegible]
10/28/03	Patient [illegible] Ordered [illegible] per [illegible] Pain reduced. Med [illegible] [illegible] [illegible] [illegible] patient [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

NURSE'S NOTES

Name [redacted] Number Surgical Room No. Exam

10/23/15 1015	T: 98 Oxygenation and Saturation dry/sterile neg fingers (L) hand Fingers of adhesive tape put in place as usual to distal nail — C. Allen LPN
10/26/15 1430	T: 98.5 Oxygenation and Saturation dry/sterile to neg fingers (L) hand — Collins LPN

0277

INDIVIDUAL INFORMATION FORM (IIF) Reviewed By: _____

Site(3): 38 School Dist(4): 0803 Review Date(8): 030903

Student(6): [redacted] Name(7): [redacted] SSN(9): [redacted]

Medicaid Number(9): [redacted] Gender(10): F Date of Birth(11): [redacted] Date of Death(12):

Race(13): 3
1 Indian/Alaskan
2 Asian/Pacific
3 White
4 Black 6 Other
5 Hispanic 9 Unknown

Religion(14): 0
1 Protestant
2 Catholic
3 Jewish
4 Other
5 Unknown

Current Liv Arr(15): 4
1 Liv in Home/Own or Lease 4 Licensed Fac
2 Liv with Family 8 Nursing Fac
3 Foster Care Placement 9 Other

Residential Fac #(16): 0810037 Licensed Fac Name(17): [redacted]

Address(18): 306 8058 DR City(19): [redacted]

Zip Code: State(20): OH Zip(21): 45014 Residence County(22): BUTL Termination Date(24):

Initial Enrollment Date(25): 060606

Program Enrollment Date(26): 010898

County Board Program(27):
01 Early Intervention
02 Homebound
03 School
04 Supported Education
08 Children's Enrichment
10 Adult Assessment
11 Adult Base Services
12 Adult Non-vocational
13 Sheltered Workshop
14 Workshop/Comm Training
15 Comm Trng/Empl < 10 hrs
16 Comm Employment 10+ hrs
17 Retirement
18 Self-directed Supports
X Blank Current CB Program

Other School Prog(28): 00

Family Resources(29): N

Service Coordination(30): 2

Designated Svc Coord(31): 31

Other Service Provider(32):

Health Service Provider(33):

Supported Living Services(34): N

Dev Delay 0-5 Yrs(36):
0 No dev delay
1 Dev delay
2 More than one delay

At Risk 0-5 Yrs(37):
0 No identifiable risk
1 Environmental/Biological
2 Established risk

MR Level 6 yrs and up(38): 3
0 None
1 Mild
2 Moderate
3 Severe
4 Profound

Substantial Functional Limitations (DD02/DD03) 6 yrs+

Self Care(39): 7
Receptive/Expresse Lang(40): 7
Mobility(41): 7
Self Direction(42): 7
Capacity Indep Liv(43): 7
Learning(44): 7
Econ Self Sufficiency(45): (Age 16 and up)

Age of Onset of Disability if age of onset 18-21(46):

Behavior(47): 3
1 Current Plan
2 No Current Plan

Vision(48): 0
0 Under evaluation
1 No vision problem
2 Vision after correction
3 Visually Impaired
4 Legally Blind

Hearing(49): 1
0 Under evaluation
1 No hearing loss
2 Fluent after correction
3 Hearing Impaired
4 Complete Loss

Communication(50): 3
0 Fluent with speech
1 Fluent with other modes
2 No Fluent communication

Ambulation(51): 1
0 Walks independently
1 Walks w/device/assist
2 Uses wheelchair

Chronic Med Cond(52): 1

Prim Skin Cond(53): 000

Second Skin Cond(54): 001

[redacted] Applied Code(55): 1
0 Normal Full-3 Limited

[redacted] Applied Code(56): 0
0 None 3 ADD
[redacted] 4 Other
9 Oth Fam Member

(Town Code: 08 Work Code: [redacted]

Cynthia Brown

From: Patrick Campbell [pcampbell@mgpcorp.com]
Sent: Monday, November 10, 2003 2:20 PM
To: Cynthia Brown
Subject: Re: [redacted] Lauren [redacted]

----- Original Message -----
From: Cynthia Brown
To: Patrick Campbell
Sent: Monday, November 10, 2003 1:04 PM
Subject: [redacted] Lauren [redacted]

Hey Patrick.....

I need info on the above regarding:

- [redacted]: Did [redacted] receive any disciplinary action for leaving [redacted] alone on 10/11/03? If so, is there anything in writing? [redacted] was 1/1 on that date, however, according to witnesses had been left alone several times during his shift. Please update. Thanks! [redacted] was disciplined, Written warning for not following plan.

- [redacted] What is the status of [redacted] injury (9 staples) from 10/26/03? Any evidence that he had a seizure? Please update. Thanks! Injury is healed.

- [redacted] What is the status of Lauren's injury (eighteen stitches) from 10/16/03? Has there been any talk of therapy/rehabilitation for Lauren's hand? Please update. Currently she does not need therapy due to the injury but she is receiving therapy to keep hand out of mouth/eye. Stitches removed healed without complications is doing well.

- [redacted] What is the status of [redacted] injury (five stitches) from 10/20/03? Please update. Thanks! Fell from wheelchair, most likely from actions as seizure activity has increased. Nursing is referring to a new neurologist. Injury is healed.

- [redacted] What is the status of [redacted] injury (six stitches) from 11/5/03? Has [redacted] medications for his seizures been changed? Please update. Thanks! No they have not, [redacted] has seizure 1-2x a year his seizures are controlled very well under current plan.

**I'm trying to play catch-up since I will be out of town from 11/12/03 to 11/19/03. Sorry to bombard you, but...

THANKS!!!

Cyndi

[redacted]

[redacted]

(c) LOCATION CODE
A. Hospital
B. ER OFFICE
C. Residential Fac/Home
D. Place of Employ/Day Prog/School
E. Inpatient of Clinic
F. Other

(d) CONTACT CODE
A. Face to Face
B. Phone Call/Individual/Phone
C. Made Reminder Other
D. Made Reminder Other/Phone
E. Witness

(e) SERVICE CODE
A. Psych Assessment
B. Crisis Intervention
C. Collateral/Referral
D. T.C.M.
E. Service Monitoring
G. Service Coordinating

(f) UNIT MEAS CODE
A. Hourly/15-minute
B. Unsupervised
C. Monitoring
D. Supervised Activities
E. T.C.M. Monthly
F. Outside Commission
G. Other
H. Team Meeting

SERVICE DURING: 10/01/22 - 10/31/22

SIGNATURE STAFF GIVEN: [redacted]

NAME: [redacted] (LAST NAME 6 + INIT)

PROVIDER #: [redacted]

DOB: [redacted]

SIGNATURE: Rosalyn O'Neill DATE: 10/31/22

DATE	BEGAN	END	C	E	F	A	UNITS	DESCRIPTION/COMMENTS	SIGNATURE
10/28/2022	11:00:00	11:15:00	H	G	A	9	0	Rec. fax from Dan Vaughn of PC re: Lauren's back. This incident was discovered by the RTC while doing an investigation on PC on 10/27/22. Lauren (pt. is stating to her mom) have isolated reports. Mom info was given to Cyndi Brown to file w/state.	GJO

[redacted]

[redacted]

[redacted] COUNTY BOARD OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
CASE MANAGEMENT SERVICES

1) Location code:
A. Hospital
B. In Office
C. Residential Facility
D. Place of Employment
Program/School
E. Transport of Client
F. Other

2) Contact Code
G. With Individual
H. With Individual/Phone
I. With Essential Other
J. With Essential Other/Phone
K. Collateral

3) Service Code
L. Needs Assessment
M. Crisis Intervention
N. Information/Referral
O. I.P.P.
P. Service Monitoring
Q. Service Coordinating

4) Case Notes Code
R. Quality/Timeliness
S. Consequences
T. Monitoring
U. Comprehensive Evaluation
V. I.P.P. Follow-up
W. Crisis Assistance
X. Other
Y. Team Meeting

[redacted] [redacted] [redacted]

[redacted] [redacted] [redacted]

[redacted] [redacted] Cynthia L Sather MSW, LSW, CPM

DATE	START	END	1	2	3	4	NOTES	SIGNATURE/INITIALS	INITIALS
10/27/20	10:00:00	11:00:00	M	A	O	N	I filed lawyer's injury with the Ryan Trustee but person has been sought to see a doc. regarding eighteen attorney.		

PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 79

Ohio Department of Mental Retardation and Developmental Disabilities

Division of Information Systems

EXHIBIT

02

ODMR/DD INCIDENT REPORT (TFS)

IncidentNum 2006-MR-0214	CreateDate 10/TL	CliniNum 999[illegible]	CliniName [redacted]	Gender F
SSN [redacted]	DOB [redacted]	PrefixNum 0	PrefixDesc ADMISSION SERVICES/FAIRFIELD	
Address1 [illegible]		City FAIRFIELD	State OH	ZipCode 45014
FirstDocDate 6/20/2006	AwareDate 6/8/2006	IncidentDate	DiscoveryDate 5/8/2006	DiscoveryTime
CreateDate 5/9/2006				

Incident Owners

Alleged Abuse Physical Unknown 0 0

Incident Location

Non-County Operated Program Residence 0.0646 0

Notifications

Children Services Bureau - May 8 2006
Provider Agency - May 8 2006
Legal Guardian - May 8 2006
Family - May 8 2006

ODA - May 8 2006

Current: Living Arrangement: ICF/MR
Modified: Accepted Accepted

Rec Closure 6/20/2006 2:04:52PM

Incident Service Status
Open With Information Submitted

CloseDate	Classification	Investigation By
	Insufficient evidence	Investigative Agent Last Changed By Kumpe, R Fabian

Name	SSN	DOB	Address

Employment Relation:

Text:

[redacted] 6/20/2006 11:31:27 AM

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BEATRIX#1:
On 1/8/08 Miss Rose, nurse at Fairfield HS, reported to Caller Regina that she had concerns about Lauren. She reported Lauren came to school on 1/2/08 with a Mat mark on her left shoulder. On 1/7/08 a bump was noted on her head and on 1/8/08 two (2) fresh abrasions were noticed on Lauren's back. Miss Rose indicated she has attempted to discuss this with Fairfield County and they become defensive. DFC is unknown at this time.
<Sandy L. Donaldson Added on 1/8/2008>

BEATRIX#2:
a. Allegation
On 1/8/08 Miss Rose, nurse at Fairfield High School, reported that Lauren [redacted] came to school on 1/2/08 with a blue mark on her left shoulder, on 1/7/08 a bump was noted on her arm and on 1/8/08 two (2) fresh abrasions were noted on Lauren's back. This was filed as an MDI for Alleged Physical Abuse.

b. Summary Interviews/Documentation Review

Interviews
Patrick Campbell, Program Support Manager/Fairfield Center (FFC)
Nick Filippini, Caseworker, Butler County Children's Services (CSS)
Daniel Clowers, QMRP/FFC
[redacted] Julius (interviewed by Nick Filippini)
Fred Mawuyo, Resident Specialist I (RSI)/FFC
Alicia Hobbs, RSI I/FFC
Kelli Akwele, RSI/FFC
Shandy Tomlinson, RSI/FFC
**Lauren was not interviewed due to her limited communication skills

Documents Reviewed
ITH Report for MD20100-008-0214
BCBSRSDD Incident Report dated 1/8/08
FFC Incident Reports dated 1/15/08, 1/2/08, 1/8/08
BCBSRSDD UI Quarterly Tracking Report – 1st quarter 2008
FFC Nurse's Notes 1/1/08 - 1/8/08
FFC Resident At-A-Glance/Room assignment
FFC Active Treatment Schedule
Behavioral Active Treatment Plan dated 1/26/08
FFC Health Functional Assessment dated 10/12/07
Fairfield High School (FHS) Daily Health Issues for Fairfield Center
School Correspondence
Interview Notes
Witness Statements
Room 100 Staff Assignment Sheets for 1/1/08 – 1/2/08
Photographs of injuries (taken by ITH school nurse **Please note that photographs are not labeled or dated.)

C. Findings of Investigation
On 1/8/08, Lauren's injuries as noted above were reported to the Butler County Children's Services Board. A caseworker, Nick Filippini, was assigned and this investigation was completed by CSB and MRDD.
On 1/8/08, this IA and Nick met at FFC to begin the investigation. This IA and Nick met with Patrick Campbell, Program Support Manager/FFC. After advising Patrick of Lauren's injuries that had been reported, he located incident reports and Nurse's Notes. It was noted on 1/2/08 that Lauren had a mark on her arm. This is the same date that the school reported she had a bump on her arm.
This IA, Patrick and Nick observed Lauren in her home and after locating the current injuries on her body, photographs were taken. Lauren was resistant to this IA locating the injuries and was provided several items by Lauren in the process. This IA, Patrick and Nick agreed that the injuries were best described as "abrasions" and were approximately 1-2 ½ inches in length. One of the abrasions appeared to have a "tapered" edge. Both areas were red in color. No other injuries or marks were observed on Lauren on this occasion. This IA, Patrick and Nick noted that Lauren was very active and moved about the home quickly, often bumping into objects. (Lauren has a diagnosis of cortical blindness.)
We observed accessibility in Lauren's home that could have caused her current injuries. We determined that it was possible that Lauren had scraped against the corner of another resident's bed, a table, or the handle of the

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room. The shower chair that Lauren was also observed. Layren has been known to "squirm" in the shower chair on a previous occasion, causing redness to her skin. The shower chair is small and could have possibly caused the abrasions.

This IA, Patrick and Nick spoke with Counsel Clowers, QMRP, regarding his knowledge of any of the above mentioned injuries. Counsel stated that he was aware of Lauren having a rash on 4/2016 and stated that he corresponded with Lauren's teacher at school about it. He stated that the teacher stated it was a burn, but he said a nurse at FPC observed the area and she more determined it was a rash. Counsel stated that when the rash was treated, it went away. Counsel was not aware that Lauren had a "blue" on her shoulder on a previous occasion.

This IA, Patrick and Nick reviewed the log book in Lauren's home. It was noted that Lauren went for a visit with her parents on 3/2016. There were no concerns reported from this visit. Nick stated that he would speak with [redacted] Lauren's father, to determine if anything unusual occurred during this visit. We agreed that FPC staff will be interviewed to determine if they have any knowledge of how Lauren may have sustained these injuries, but agreed that we may not be able to make a determination.

On 3/23/16, this IA spoke with Patrick. He stated that the hair dryer used in Lauren's home clearly resembled the mark on Lauren's arm (as indicated in a photograph taken by FPC.) He stated that he has removed that hair dryer and replaced it with one with a recessed grid. He also placed a "different" on the hair dryer to prevent anyone being able to touch the grid. Patrick stated that he would determine who was working on and around 3/18/16 (when the injury was noted) and schedule interviews with staff.

On 3/31/16, this IA spoke with Nick. He stated that he had spoken with Lauren's father who reported that he picked Lauren up from FPC on 3/18/16 for church. He stated that when he arrived, she was not appropriately dressed for church, so he assisted with changing her. He stated that he did not remove Lauren's body suit, so he did not observe her current injuries. He also stated that he had changed her Attend later that day, but again, did not remove her body suit. He reported that there were no incidents that may have caused these injuries.

On 3/16/16, this IA and Patrick interviewed staff at FPC who worked on or around 3/18/16 w Lauren's house. Nicole declined to participate in the interviews. Brandy Tomlinson, RSE, was interviewed. She stated that she has seen bruises on Lauren in the past, but no areas that might be reported from her bumping into things (doors, chairs, etc.) Brandy stated that she had not observed the abrasions on Lauren's back or the mark on her arm that appeared to be a burn. Upon further questioning, she stated she has seen Lauren have red marks on her shoulders from where her body suits have rubbed her skin. Brandy stated that she is aware that Lauren does not like to have her hair dried with the hair dryer. She stated that Lauren will often put her arms up and tuck her head to avoid the hair dryer. Brandy denied ever seeing a staff person cause harm to Lauren and denied that she has ever done anything to cause harm to Lauren.

Alicia Stokes, RSE, was interviewed. Alicia stated that she was aware of Lauren not liking to have the blow dryer used to dry her hair. She stated that she typically uses the dryer sometimes on medium and dries Lauren's hair while she is in the shower chair. She stated that she was not aware of anyone causing harm to Lauren and denied causing harm to Lauren.

Kelli Akowitz, RSE, was interviewed. He stated that Lauren often does not want to sit still while being bathed (either in the shower chair or in the bathtub.) He stated that while he uses the blow dryer to dry Lauren's hair, she often "puts her hands in the way" to avoid the heat from the hair dryer. He stated that it takes a very long time to dry her hair because she won't stand still and that he is rarely able to get her hair fully dry. He stated that he had never seen anyone cause harm to Lauren and denied doing so himself.

Shemeyia Pool, RSE, was interviewed. She stated that when he uses the hair dryer to dry Lauren's hair, he always uses the "medium" setting. He stated that Lauren will often not keep her head still and uses her hand to push the hair dryer away. He stated that he did not recall seeing a bruise or mark on Lauren's arm in March. He stated that he has never seen anyone cause harm to Lauren nor has he caused harm to Lauren.

Documentation submitted by FPH indicates that there was a great deal of communication between FPH and FPC regarding Lauren's injuries. Lauren's mother, Tony Huff, or FPH, sent e-mails to FPC regarding the concern.

On 3/29/16, he asked about the "burn" on Lauren's arm. The response from Michelle Pulleman, Home FPH Manager/FPC was that "the mark on her arm was made by her chair. We also noticed it. She must was too tight and she left on it." The correspondence from Counsel Clowers indicates that FPC counsel do believe the area was a rash while the Ms. Huff continued to believe it was a burn. Mr. Huff documented from 3/29/16 -- 4/1/16 that the bruise was still visible on Lauren's arm. Regardless of their opinions, the photograph of the injury indicates that this is a burn, likely from a hair dryer.

D. Conclusions

Based on the information gathered, this IA has determined that the allegation of physical abuse is substantiated.

The case disposition is based upon the following findings:

1. There is no evidence that physical force was used to result in Lauren's injuries

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3. It is possible that Lauren received the abrasions on her back from scraping against an object.
3. It is possible that Lauren received the burn on her arm while putting her arms up to avoid the hair dryer.
4. CSB also agreed that allegations of physical abuse are unsubstantiated.
5. Witnesses appear to be credible.

<Karen S Palmer Added on 6/30/2006>

IMMEDIATE ACTION:
Nick Filippini, CSB SW, and Karen Palmer, IA assigned to this HLI, went to Foothill Center to evaluate Lauren. Lauren has two (2) abrasions that do not require medical treatment. Lauren is non-verbal and cannot identify who PPI or indicate what happened. CSB could not justify removal at this time. Lauren is on visual checks every 15 minutes and this was not increased by the provider.
<Sandy L Donathen Added on 5/9/2006>

PREVENTION PLAN:
1. HPC staff are completing body checks on Lauren on each shift.
2. A hair dryer safety instruction was completed with HPC staff.
3. The hair dryer in Lauren's home was replaced with one with a recessed grid and a different was placed on it for safety.

<Karen S Palmer Added on 6/30/2006>

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Investigation Report

Summary Completed By Investigative Agent For Their Investigative File

Lauren [redacted]
MUI#2006-009-0314

A. Allegation
On 3/5/06 Nina Ross, nurse at Fairfield High School, reported that Lauren [redacted] came to school on 3/23/06 with a blue mark on her left shoulder, on 4/3/06 a burn was noted on her arm; and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. This was filed as an MUI for Alleged Physical Abuse.

B. Statement/Interview/Documentation Review

Interviews
Patrick Campbell, Program Support Manager/Fairfield Center (PSC)
Nick Flippini, Caseworker, Butler County Children's Services (CSB)
Conrad Clowers, QMRP/FFC
[redacted] father (interviewed by Nick Flippini)
Fred Akanwiju, Resident Specialist I (RSI)/FFC
Alicia Stokes, RSI I/FFC
Kofi Akwete, RSI/FFC
Brandy Tomlinson, RSI/FFC
**Lauren was not interviewed due to her limited communication skills

Documents Reviewed
ITS Report for MUI#2006-009-0314
BCDMRDD Incident Report dated 5/8/06
FFC Incident Reports dated 3/23/06; 5/3/06; 5/8/06
BCDMRDD UI Quarterly Tracking Report – 1st quarter 2006
FFC Nurse's Notes 2/3/06 – 5/4/06
FFC Resident At-A-Glance/Recommendations
FFC Active Treatment Schedule
Behavioral Active Treatment Plan dated 1/26/06
FFC Health Functional Assessment dated 10/12/05
Fairfield High School (FHS) Daily Health Issues for Fairfield Center
E-Mail Correspondence

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Interview Notes
Witness Statements
Home 500 Staff Assignment Sheets for 3/26/06 – 3/28/06
Photographs of injuries (taken by FHS school nurse **Please note that photographs are not labeled or dated.)

C. Findings of Investigation:

On 5/8/06, Lauren's injuries as stated above were reported to the Butler County Children's Services Board. A caseworker, Nick Filippini, was assigned and this investigation was completed by CSB and MRDD.

On 5/8/06, this IA and Nick met at FFC to begin the investigation. This IA and Nick met with Patrick Campbell, Program Support Manager/FFC. After advising Patrick of Lauren's injuries that had been reported, he located incident reports and Nurse's Notes. It was noted on 4/3/06 that Lauren had a rash on her arm. This is the same date that the school reported she had a burn on her arm.

This IA, Patrick and Nick observed Lauren in her home and after locating the current injuries on her back, photographs were taken. Lauren was resistant to this IA locating the injuries and was pinched several times by Lauren in the process. This IA, Patrick and Nick agreed that the injuries were best described as "abrasions" and were approximately 2-2 ½ inches in length. One of the abrasions appeared to have a "squared" edge. Both areas were red in color. No other injuries or marks were observed on Lauren on this occasion. This IA, Patrick and Nick noted that Lauren was very active and moved about the home quickly, often bumping into objects. (Lauren has a diagnosis of cortical blindness.)

We observed areas/objects in Lauren's home that could have caused her current injuries. We determined that it was possible that Lauren had scraped against the corner of another resident's bed, a table, or the handle of the stove. The shower chair that Lauren uses was also observed. Lauren has been known to "squirm" in the shower chair on a previous occasion, causing redness to her skin. The shower chair is sturdy and could have possibly caused the abrasions.

This IA, Patrick and Nick spoke with Conrad Chewns, QMRP, regarding his knowledge of any of the above mentioned injuries. Conrad stated that he was aware of Lauren having a rash on 4/3/06 and stated that he corresponded with Lauren's teacher at school about it. He stated that the teacher stated it was a burn, but he and a nurse at FFC observed the area and the nurse determined it was a rash. Conrad stated that when the rash was treated, it went away. Conrad was not aware that Lauren had a "bite" on her shoulder on a previous occasion.

This IA, Patrick and Nick reviewed the log book in Lauren's home. It was noted that Lauren went for a visit with her parents on 5/7/06. There were no concerns reported from this visit. Nick stated that he would speak with [redacted] Lauren's father, to determine if anything unusual occurred during this visit. We agreed that FFC staff will be interviewed to determine if they have any knowledge of how Lauren may have received these injuries, but agreed that we may not be able to make a determination.

On 5/12/06, this IA spoke with Patrick. He stated that the hair dryer used in Lauren's home closely resembles the mark on Lauren's arm (as indicated in a photograph taken by FHS.) He stated that he has removed that hair dryer and replaced it with one with a

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recessed grid. He also placed a "Lillian" on the hair dryer to prevent anyone being able to touch the grid. Patrick stated that he would determine who was working on and around 3/28/06 (when the injury was noted) and schedule interviews with staff.
On 5/15/06, this IA spoke with Nick. He stated that he had spoken with Lauren's father who reported that he picked Lauren up from FFC on 5/7/06 for church. He stated that when he arrived, she was not appropriately dressed for church, so he assisted with changing her. He stated that he did not remove Lauren's body suit, so he did not observe her current injuries. He also stated that he had changed her Attend later that day, but again, did not remove her body suit. He reported that there were no incidents that may have caused these injuries.
On 5/18/06, this IA and Patrick interviewed staff at FFC who worked on or around 3/28.06 in Lauren's home. Nick declined to participate in the interviews. Brandy Tumbleson, RSI, was interviewed. She stated that she has seen bruises on Lauren in the past, but no areas that might be expected from her bumping into things (arms, shins, etc.) Brandy stated that she had not observed the abrasions on Lauren's back or the mark on her arm that appeared to be a burn. Upon further questioning, she stated she has seen Lauren have red marks on her shoulders from where her body suits have rubbed her skin. Brandy stated that she is aware that Lauren does not like to have her hair dried with the hair dryer. She stated that Lauren will often put her arms up and tuck her head to avoid the hair dryer. Brandy denied ever seeing a staff person cause harm to Lauren and denied that she has ever done anything to cause harm to Lauren.
Alicia Nolen, RSI, was interviewed. Alicia stated that she was aware of Lauren not liking to have the blow dryer used to dry her hair. She stated that she typically sets the dryer temperature on medium and dries Lauren's hair while she is in the shower chair. She stated that she was not aware of anyone causing harm to Lauren and denied causing harm to Lauren.
Kelli Alewyn, RSI, was interviewed. He stated that Lauren often does not want to sit still while being bathed (either in the shower chair or in the bathtub.) He stated that while he uses the blow dryer to dry Lauren's hair, she often "gets her hands in the way" to avoid the heat from the hair dryer. He stated that it takes a very long time to dry her hair because she won't stand still and that he is rarely able to get her hair fully dry. He stated that he had never seen anyone cause harm to Lauren and denied doing so himself.
Shawntia Pratt, RSI, was interviewed. He stated that when he uses the hair dryer to dry Lauren's hair, he always uses the "medium" setting. He stated that Lauren will often not keep her head still and uses her hand to push the hair dyer away. He stated that he did not recall seeing a burn or rash on Lauren's arm in March. He stated that he has never seen anyone cause harm to Lauren nor has he caused harm to Lauren.
Documentation submitted by FSS indicates that there was a great deal of communication between FSS and FFC regarding Lauren's injuries. Lauren's teacher, Tony Huff, at FSS, sent e-mails to FFC regarding his concerns. On 3/29/06, he asked about the "burn" on Lauren's arm. The response from Michelle Peterson, Home 500 Manager/FFC was that "the mark on her arm was made by her shirt. We also noticed it. Her shirt was too tight and she laid on it." The correspondence from Central Closets indicates that FFC continued to believe the area was a rash while the Mr. Huff continued to believe it was a burn. Mr. Huff documented from 3/29/06 – 4/7/06 that the burn was still visible on

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Lauren's arm. Regardless of their opinions, the photograph of this injury indicates that this is a burn, likely from a hair dryer.

D. Conclusions

According to the OAC 5123:2-17-02 "physical abuse means the use of physical force that can be reasonably expected to result in physical harm."
Based on the information gathered, this IA has determined that the allegation of physical abuse is unsubstantiated.

The case disposition is based upon the following findings:

1. There is no evidence that physical force was used to result in Lauren's injuries.
2. It is possible that Lauren received the abrasions on her back from scraping against an object.
3. It is possible that Lauren received the burn on her arm while putting her arms up to avoid the hair dryer.
4. CSB also agreed that allegations of physical abuse are unsubstantiated.
5. Witnesses appear to be credible.

E. Prevention Plan

1. FPC staff are completing body checks on Lauren on each shift.
2. A hair dryer safety interview was completed with FPC staff.
3. The hair dryer in Lauren's home was replaced with one with a recessed grid and a diffuser was glued on it for safety.

Karen Gilliam
Investigative Agent

4-15-20
Date

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Karen Feltner

From: Randy Donaldson
Sent: Tuesday, July 11, 2006 8:32 AM
To: Karen Feltner; Jolanda Hamlin; Cathy Hughes; Patricia Campbell
Subject: FW: Case Closed - Incident 2006-009-0014

This alleged physical abuse MIC has been closed by the state.

Randy Donaldson

-----Original Message-----
From: ITS.SupportBoard@[redacted].state.oh.us [mailto:ITS.SupportBoard@[redacted].state.oh.us]
Sent: Monday, July 10, 2006 5:49 PM
Subject: Case Closed - Incident 2006-009-0014

Automated Notification of Case Closure: 2006-009-0014
Client: Client Number: 0000000 - [redacted] Tanner
Incident Date: 06/16/2006
Current Date: 7/10/2006 5:44:54 PM
Closed Date: 7/10/2006
Updated By: Natalie A Emerson

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BUTLER COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES INCIDENT SUMMARY REPORT

TO: Patrick Campbell, Program Support Manager/Fairfield Center (FFC)

FROM: Karen Palmer, Investigative Agent (IA)

DATE OF INCIDENT: 3/8/06
INDIVIDUAL'S NAME: Lauren [redacted]
LOCATION OF INCIDENT: Residence – Fairfield Center
DISCRIPTION OF INCIDENT: Alleged Abuse - Physical

This report is written as a requirement of the Ohio Department of Mental Retardation and Developmental Disabilities to follow up to an incident that was reported. The Butler County Board of Mental Retardation and Developmental Disabilities is required, through the Ohio Administrative Code, to complete an administrative review of incidents that involve individuals who have been hospitalized, injured to a degree that affects their health and safety, or experience other situations that are negative or harmful to the individual. This report is not all inclusive of the information that was gathered, but is intended to give you a brief summary of the incident, the outcome of the administrative review, and plans that are intended to deter future incidents. If you have questions about this process please do not hesitate to contact me at 867-5674 and I will do my best to assist you.

A. STATEMENT:
On 3/8/06 The Office of Incident Review (OIR) received a report that Lauren [redacted] came to school on 3/23/06 with a bite mark on her left shoulder, on 4/3/06 a burn was noted on her arm and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. This was filed as an MUI for Alleged Physical Abuse.

B. SUMMARY OF REVIEW:
Staff at FFC were interviewed regarding these injuries. All staff interviewed indicated that they had not seen anyone cause harm to Lauren nor had they caused harm to her themselves. Staff indicated that Lauren does not like to have her hair dried with the hair dryer and often puts up her arms to block it. (The photograph of the burn is in the pattern of a grid on a hair dryer.) Lauren's home environment was observed for objects that could have possibly caused any of these injuries. It was determined that it was possible that Lauren had scraped against the corner of another resident's bed, a table, or the handle of the stove, causing the abrasions on her back. The shower chair that Lauren uses was also observed. Lauren has been known to "squirm" in the shower chair on a previous occasion, causing redness to her skin. The shower chair is metal and could have possibly caused the abrasions. The area on her shoulder could have possibly been caused by her

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clothing being too tight. This was observed on one occasion by one of the FPC staff interviewed.
According to FPC documentation, there are no known incidents that could have resulted in these injuries.

C. FINDINGS AND CONCLUSION:
According to the OAC 5123:2-17-02 "physical abuse means the use of physical force that can be reasonably expected to result in physical harm."
Based on the information gathered, this IA has determined that the allegation of physical abuse is unsubstantiated.

The case disposition is based upon the following findings:

1. There is no evidence that physical force was used to result in Lauren's injuries.
2. It is possible that Lauren received the abrasions on her back from scraping against an object.
3. It is possible that Lauren received the burn on her arm while putting her arms up to avoid the hair dryer.
4. CSD also agreed that allegations of physical abuse are unsubstantiated.
5. Witnesses appear to be credible.

D. PREVENTION PLAN:

1. FPC staff are completing body checks on Lauren on each shift.
2. A hair dryer safety inservice was completed with FPC staff.
3. The hair dryer in Lauren's home was replaced with one with a recessed grid and a diffuser was glued on it for safety.

Please note that the individual, advocate selected by the individual, or the legal guardian, as applicable, and the provider may submit written comments and/or dispute the findings of the County Board regarding the Administrative Review's conclusion and any preventative measures implemented in response to the incident. Any dispute of the findings in this report will be forwarded to the Ohio Department of Mental Retardation and Developmental Disabilities for review. Please send any comments to the attention of Karen Whalen, Director of Quality Assurance and Medicaid Services, by 6/28/06, 441 Patterson, Fairfield, Ohio 45014

This Administrative Review will not be officially closed by the Ohio Department of Mental Retardation and Developmental Disabilities any sooner than the date listed above.

SIGNED: Karen DeMoss DATE: 6/13/06
INVESTIGATIVE AGENT

cc: [redacted] Father
Cheryl Faraday, Administrator/FPC
Jimmie Harden, QE for ICFs/DCR/MR/DD

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Karen Whalen, Q-ANS Stimulus/SCHMIDDO
MVI File

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Ohio Department of Mental Retardation and Developmental Disabilities
Division of Information Systems

ODMRDD INCIDENT REPORT (IIS)

Incident Date: 5/5/2006	Time:	Facility: [redacted]					
Name: [redacted]	DOB: [redacted]	Gender: [redacted]	Last Name: [redacted]	SSN: [redacted]		Status:	
Address: [redacted]		City: FAIRFIELD		State: OH		ZIP Code: [redacted]	
Incident Occurred: [redacted]		Incident Code:		Reported Date: 5/5/2006		Received Date:	
Incident Type:							
Category:							
Alleged Abuse: Physical - Unknown - 9 / 0							
Incident:							
Location:							
Non-County Operated Program - Residence - 3 / 300 / 3							
Notifications:							

Children Services Bureau - May 8 2006 Provider Agency - May 8 2006 Legal Guardian - May 8 2006 Family - May 8 2006 DDA - May 8 2006	Current: Void/Rejected Incident Review Status: Open with Information Pending Closed Date:	Assigned: Unclassified	Reviewer: Last Change By: Sandy L. Donathan

Incident: 2006-05-0214 | Page 1 of 2 | Printed: 5/8/2006 8:10:03 AM

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Statement:
On 5/8/06 Nina Ross, victim at Fairfield JDS, reported to Cathy Hagins that she had concerns about Lauren. She reported Lauren came to school on 3/23/06 with a title mark on her left shoulder. On 4/3/06 a knot was noted on her torso and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. Ms. Ross indicated she has attempted to discuss this with Fairfield Center and they become defensive. PPI is unknown at this time. <Sandy L Donelkas Added on 5/8/2006>

Immediate Action:
Nina Riggins, CSB SW, and Karen Fellers, IA assigned to this WCS, went to Fairfield Center to evaluate Lauren. Lauren has two (2) abrasions that do not require medical assistance. Lauren is non-verbal and cannot identify a PPI or indicate what happened. CSB could not justify removal at this time. Lauren is on Geodon which is a Class A medication and this was not witnessed by the providers. <Sandy L Donelkas Added on 5/8/2006>

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Sandy Donathan

From: Sandy Donathan
Sent: Tuesday, May 06, 2008 8:18 AM
To: Cathy Hagins; Jimmie Hecht; kdowens@magnus.com; Patrick Campbell
Subject: Lauren [redacted] 008-009-0214

A MUI for alleged physical abuse has been filed on Lauren's behalf. Karen Feltner has been assigned to the investigation.

Sandy L. Donathan
Incident Review Specialist
Butler County MRDD
441 Patterson Drive
Fairfield, OH 45014
513-867-5882
sandyd@butlermrdd.org

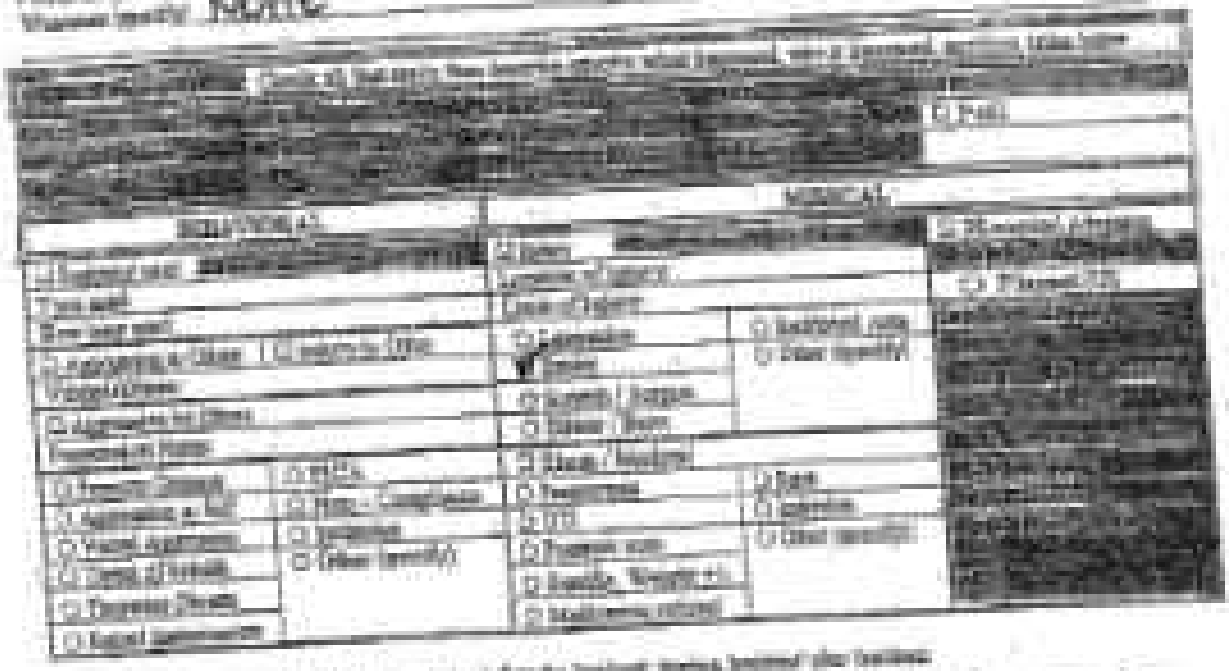
5/6/2008

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Time 5:00 Time Report: ____ AM/PM
Date 5-1-26 Time Issued: ____ AM/PM

Victim's Name: Lauren [redacted]
Location of Incident: Workout Co.
Event assigned to individual at time of notice:
Witnesses nearby: None

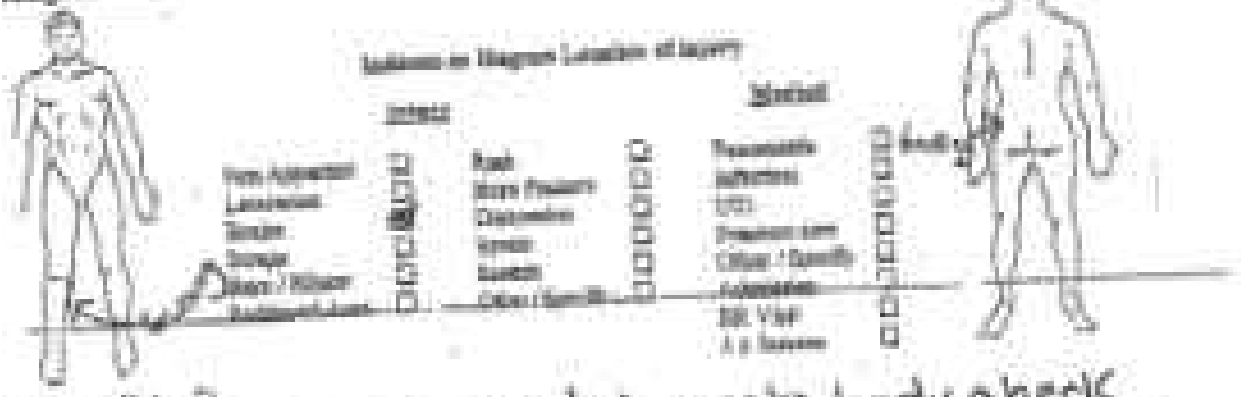


Description of Incident: What was happening before the incident during incident? After incident?
Employee arrived late for work (worked) or reported the incident happening was:
Lauren arrived late for work & reported she had been approached by a male customer who asked for us to check her blood sugar and stated she was a diabetic. She declined & he left. Lauren reported he was wearing a hair dryer around his neck.

Name of Police Assigned Supervisor: J. Campbell Time Notified: 2:30pm
Report completed by: Jennifer Cano Date: 5-8-26

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Guidelines for Nursing follow-up and reporting



Did Congenital lead check ok on Carter hand two days late due to excess left lower back and buttocks. Baby also had two bruises on right upper arm. Possibly 1 day old also had two bruises on right side of head checked by 2 nurses and deny no abuse. Head checked by 2 nurses and deny no abuse. Head checked by 2 nurses and deny no abuse.

Incident reports

Please ensure that all appropriate information is filled out. Please print.

Individual's Name: [redacted] Room: [illegible] Time Began: [illegible]
Location of Incident: [illegible] Date: [illegible] Time Ended: [illegible]
Person subject to restrictive or time of incident: [illegible]
Witnesses (specify): [illegible]

[illegible]	Check all that apply. Then describe briefly what happened, who is involved, and any other facts.
☐ Injuries Prior Known	☐ Medical Attention ☐ Medication Refused ☐ Medication ☐ Hospitalization
☐ Property Abuse	☐ Complaint Received ☐ Medication Refused ☐ Other
☐ Verbal Abuse	☐ Medical Neglect ☐ Emergency Services ☐ Police

PHYSICAL CONTACT		WEAPON(S)			
☐ Restraint used ☐ Assistance to person(s)		☐ None ☐ Restraint (Other than Hands)		☐ Physical Altercation ☐ Witnessed (staff) ☐ Witnessed (PT)	
Type used:		Location of Injury:			
How long used:		Cause of Injury:			
☐ Aggression to Others ☐ Agency to Other		☐ Lacerations	☐ Bite	☐ Emergency Services ☐ EMS Visit	
Victim(s) Name:		☐ Bruise	☐ Abrasion/Scratches	☐ Hospitalization	
☐ Aggression to Others		☐ Swelling	☐ Other (specify)	☐ Police Involvement	
Perpetrator Name:		☐ Bumps		☐ Refusal	
☐ Property Damage	☐ Fire	☐ Other / Medical		☐ Other (specify)	
☐ Aggression to Self	☐ Hits Compliance	☐ Fingernails	☐ Infection	☐ Declining	
☐ Verbal Aggression	☐ Spitting	☐ ER	☐ Other (specify)	☐ Refusing	
☐ Threat of Suicide	☐ Other (specify)	☐ Passage over		☐ Other (specify)	
☐ Disrobing Others		☐ Meds			
☐ Sexual Inappropriate					

Description of Incident: What was happening before the incident/ during incident/ after incident.
Describing person/ area you or person involved/ or property or number/ time happening/ what.

[illegible]

Reasons to report to nursing immediately & here to the report to the state nursing station within 1 hour

Name of Nurse contacted (required): [illegible] Time notified: [illegible]
Report completed by (signature/Title): [illegible] Date: [illegible]

Date Received: [illegible]

[illegible]

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Notification

Guidelines for Nursing follow-up and reporting

Nursing assessment



Indicate on Diagram Location of Injury



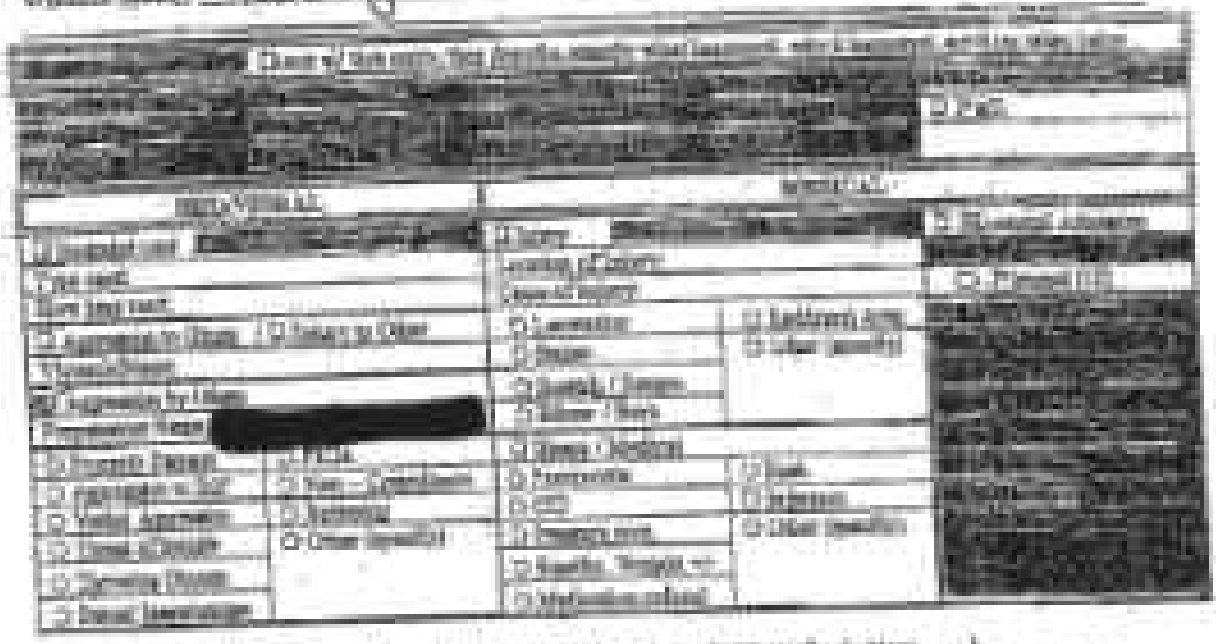
Physician notified: ☐

Immediate Action / Medical Intervention:

Nurse's Signature: _____ Date: _____

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[redacted]



Description of Incident: What was happening before the incident occurred? Who was involved? What happened? Where did it occur? Were there any witnesses? Was the victim transported for medical treatment? Was property damaged? Was anyone arrested? Any other relevant information.

Victim known to suspect. She has been texting [redacted] and [redacted] to see her self-harm. She has been texting [redacted] and [redacted] to see her self-harm. She has been texting [redacted] and [redacted] to see her self-harm

Date / Time: 5/2/2 9:26

Name: [redacted]

Guidelines for Nursing follow-up and reporting

	Alleging - Unable (on) / over
	Medical Emergency - Unstable, IV right arm
	Unplanned Hospital admission
	Injury - Observe / Reassess the injuries every 60 minutes (as per a physician or nurse practitioner) are given, significant injury, or worse occurs
	Subjective: worsen - call or consult 911 or plan
	Prolonged duration - monitoring or pain - Report worsen pain
	Nurse - to treat / to (guide / advocate) effective pain (activity) as per assessment or Plan.
	Other - for (e.g. severe nose etc) or not responsive
	Temporary concern - use of nurses (for e.g. to stay)
	Long - monitor - for (e.g. chronic) other conditions
	Change in status, Condition worsen (e.g. weakness) or collapse

Injury accompanied

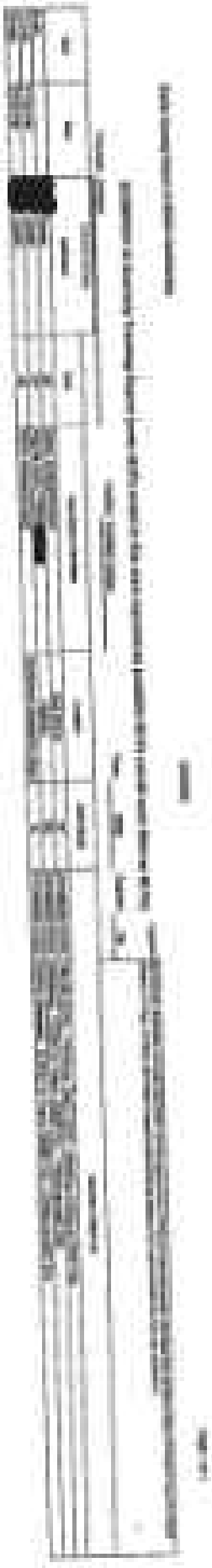
Indicate on Diagram Location of Injury

Injuries				Medical	
Pain Assessed	☑	Burn	☐	Hypertension	☐
Laceration	☐	Bone Fracture	☐	Infection	☐
Bruise	☐	Dislocation	☐	UTI	☐
Scrape	☐	Sprain	☐	Pressure sore	☐
Pain / Stress	☐	Swollen	☐	Other / Specify	☐
Restricted Area	☐	Other / Specify	☐	Assistance	☐
				ER Visit	☐
				Hospitalization	☐

other comment ☐

Medical Action / Medical Intervention: ☑ emergency dental

Signature: [signature] Date: 5/2/24



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Name [redacted] Ward Med-Surg Room No. 330

4/5/16 7:00pm Pt. is A+O x 4 but confused at times. Oriented to unit. Call light within reach. Bed in low position. Will continue to monitor.

5/2/16 2:00pm Monthly summary: April
Resident pulled out mic-tube on several occasions. Replaced & difficulty had once d/t on several occasions. Oral drainage resolved. G-tube site continues to improve. [illegible]

5/2/16 5:00pm Pt has bilateral DVT's which will be intact. Q shift dressing changes. Resident has a ½ inch scratch on the left side on cheek. Area cleaned & area left open to air. [illegible]

5/2/16 7:00pm At 12:30 the blood tumor called Dentina had had a Vitamin drink may during lunch. Allowed. Has allergies. During Allowed. Has pectin. Has history of [illegible] Dentina was to be [illegible] Dentina was brought + [illegible] Contacted guardian, [illegible] Dentina Dawson DDS. [illegible]

5/3/16 1pm Scraped site per pt's dtr. Area for Clear nasal drainage. Rub [illegible] 5 minutes. [illegible]

5/5/16 10pm Q shift Oral drainage. [illegible] Cotton swab [illegible] [illegible] [illegible]

Name [redacted]

3/16/16 Tp Precedent given Sent Judge's pow order dft moral drawings Details will continue to monitor. D. Jennings

3/16/16 Sp Ft further moral drawings noted Details obtained bodies and media Brief will continue to monitor. Jennings

3/16/16 Inf DYS reported escape on Parsley Rd Dep Deputies DJS & Unidentified Police Officers Chased area Ft Hood troops Major Dan Mitchell Hagerty Interagency Liaison Message Shawnee

3/16/16 If Violent Man [illegible] a Shawnee Stage Agency which is [illegible] Shawnee Stage Agency Small Dodge Truck Approximately All parties Notified Jennings

4-1-16 Info Rec'd [illegible] Sent Spoken Pow Brief [illegible] Pow order: 1-83 Ft Carlo [illegible] Jennings

4-1-16 Ft Dr [illegible] Jennings

4/16/16 Ft Clear Fire Scene Fire Marshal [illegible] with Department Recorded Area of 30 min and it was all gone. Jennings

Police Brief Almost Like Dragon Wants And Act Jennings

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Lauren [redacted]

Fairfield Center, Inc

Resident at a Glance/ Recommendations

Name: Lauren [redacted]

Date: 10/10

Functional level: Profound Retardation

Bladder: NPO. 6 tube voiding by mouth

Toileting: (Partial Progress)Sits on the toilet with PP's

Dressing: (Partial Progress)Program to pull down shirt. Can do it

Oral care:

Handwashing: (Partial Progress)

Allergies: mold

Mobility

Ambulation: Independent. Has unsteady gait, monitor closely. Does utilize wheelchair for transportation

Communication: communicates through vocalization and gestures. Responds to name by looking toward

Behavior Concerns: Lauren will hit, pinch, pull hair, throw objects, bite and hit wheelchair with fist. Spends much time in sensory room.

Monitoring: Due to Lauren's poor vision she is 15 minute check monitoring when outside the sensory room. Staff member should make sure Lauren is not going in other residents rooms destroying things.

Approach: Be consistency with Lauren. Lauren has been know to test limits. For example, If Lauren hits someone tell Lauren, "We do not hit other people Lauren." After you have redirected her to three yet respectful voices.

Safety Concerns: Lauren needs 24 hour supervision. Lauren needs total assistance exiting the building during fire drills

Likes: Music, 1 to 1 activities, sensory room activities. Always tell Lauren what you are doing with her before you do it.

Note: schedule may be interrupted for special events, activities, and outings i.e family visits

Active Treatment Schedule
Monday-Friday

Name: Lauren [redacted] 10/07

Suggested Leisure Activities: Sensory room activities, music

6:30-6am	Awaken personal hygiene, and dressing. May participate in low-demand motor or sensory activities. Take feeding.
6:00-6:15am	Toileting
6:15-6:45am	Load bus for Fairfield High School
6:45am- 1:45pm (during School year)	Fairfield High School
9am-3 pm	(During Summer) Fairfield Center Day Program or therapy program
3:45 pm-6:30pm	toileting, handwashing, sensory activities, motor activities. Feeding time through tube by nursing dept
6:30pm-6:45pm	Dinner. Lauren is NPO and receives only tube fed food
6:45pm-6:50pm	Toileting, handwashing
6:50pm-7:30pm	Concentration leisure, sensory activities, group activities, group music
7:30-9 pm	Hygiene, Shower

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Dietary / Mealtime Instructions

Name: Lauren [redacted] Home: 500 Updated: 10-12-05

Diet Consistency: NPO

Diet: Bolus Feeding

Supplements	Meals			Snacks			
	B	L	D	AM	PM	AWS	HS

Likes:
Preferences:
Allergies:
Workshop: Fairfield City Schools

Adaptive Equipment

Special Mealtime Instructions

Lauren receives her nutrition through a Mic-tube.

FILE:\\Appsrv-1\a Common\Forms / Common Forms / Dietary / Dietary Mealtime Instructions.rtf

NAME: Lau [redacted]

BEHAVIORAL ACTIVE TREATMENT PLAN

BEHAVIOR	DESCRIPTION	ACTIVE TREATMENT STRATEGIES	DOCUMENTATION
Aggression to others and self Uncooperative Behavior	may hit, push or pinch others may kick or poke herself refusing request for ADLs and hygiene either pushing away becoming aggressive or throwing items. Lauren often throws most everything that is presented to her	**Daily Interaction** Throughout the day, provide frequent interaction with Lauren. Take a few minutes to sit with Lauren, making interaction friendly and playful to get her in a relaxed mood. **Sensory Processing:** -OT/PT to work with Lauren to increase acceptance of tactile stimulation & proprioceptive input. -Offer Lauren rocking chair, gliding swing, rolling on PT ball or PT ball being rolled on Lauren, Rocking deep pressure bag, etc. to help her calm. -Also follow OT recommendations for calming techniques (before massage and cold towel compress to arms and hands) follow instructions from OT. -Play music that Lauren likes in areas which she dislikes (bathroom, etc.) to help create a more positive environment. -Follow OT recommendations for a sensory diet to avail down through out the day **Communication** -Acknowledge Lauren's attempts at communication attempts & provide reinforcement. -Encourage communication of basic wants and needs daily. -Encourage turn taking skills.	OT Progress Notes
Agitation for no apparent reason		**INTERVENTION:** - Assess Lauren's needs and assist as necessary. - Use daily interaction techniques to get Lauren to relax. - If Lauren continues to be upset, leave Lauren alone for 5 min. - Reapproach Lauren and offer her opportunity to go to a quiet area. - A wheelchair seatbelt featured may be used. - If reapproach fails, leave Lauren alone. **Daily Interaction During Hygiene** - Always employ daily interaction techniques, making sure requests are not made as demands. – Offer choices when Lauren is bathing: bath or shower.	

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NAME: Lee, [redacted]

BEHAVIORAL ACTIVE TREATMENT PLAN

BEHAVIOR	DESCRIPTION	ACTIVE TREATMENT STRATEGIES	DOCUMENTATION
Agitation/aggression (as a result of having made requests of Lauren: ex. hygiene)		**INTERVENTION:** If agitation occurs after request or if Lauren is already agitated and the request was made for hygiene or safety: - Attempt to get Lauren to calm. - If agitation persists, leave Lauren alone for 5 minutes. - Reapproach Lauren. Offer her a wash/towel. - Once in area physically assist Lauren as needed to complete tasks while blocking injury to herself or others.	Behavior Frequency Sheet
Self-Injurious Behavior	may hit or pinch herself	**INTERVENTION** 1. VP, PF to stop. 2. HOH to guide hand away from object hitting. 3. Block attempts may use PT ball to block continued SIB. If continues, try to determine what is upsetting Lauren (i.e. medical, environmental) and assist as possible. Offer soft object to hit (i.e. pillow, pad PT ball).	Behavior Frequency Sheet
Sitting on floor		-Offer Lauren bowling or furniture & provide reinforcement for cooperation./verbal praise and/or a small drink of juice or milk.	

FILE:D:\PROGRAMS\PM / CONFIGURATION\SHARE / A 2000\PT / COMMON FILES / A PM / ICN

HEALTH

1 FUNCTIONAL ASSESSMENT

Date: October 12, 2005

Resident's Name: Lauren [redacted]

Summary **Lauren is a 18 year old female with profound mental retardation whose diagnosis include cerebral palsy, stable seizure disorder, H/O Multiple Otitis media, S/P PE tubes, cortical blindness, S/P gastrostomy w/claws. She has had a good health year this year with no major medical problems or hospitalizations or trips to the ER. She was put on antibiotics twice this year. Once in January for conjunctivitis and in March for upper respiratory infection. She also has had skin issues. In March she had a ruptured blister to her great toe and an open area to her left elbow both of which have healed. In April she was noted to have cellulitis to her G-Tube site. She has had two different treatments to this area. This area is healing but very slowly. Dr. Sehgal is monitoring this area very closely.**

Physical Exam **Seen by Dr. Sehgal eight times this past year once for her yearly physical. For conjunctivitis, 3 times for cellulitis to her g-tube and 3 times for upper respiratory infection. All immunizations are up to date last PPD done on 9-30-05 and was negative for TB. Last Phenobarb level, CBC, CMP, and hepatic function panel drawn in August were with in normal limits.**

Vision Last exam done by Dr. Exley 2-23-05. Cataract was noted surgery is not indicated at this time.

Neuro She is now being seen by Dr. Zulikoff. She was seen on 7-12-05. Her seizure activity was under good control up until just recently Dr. Zulikoff will see her during the October clinic. Her Phenobarb levels have been with in normal limits.

Audio Last seen by Hearing and Speech Center of Cincinnati on 2-19-03. This was the second attempt to get hearing evaluation done and she refused headphones further testing was noted recommended as staff states that hearing loss is not a particular concern for her. Recommends hearing screen every three years.

Mammo/GYN Lauren is not of age yet to have a mammogram, and last year her father did not wish for her to have a PAP and pelvic this will be addressed with him again on the IP date.

Dental **Last seen by Dr. Fraza on 6-9-05 was noted to have fair to good oral hygiene.**

Allergies **Salfa, Reglan, Surgical Tape**

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Current Meds
Claritin 10mg QD
Miralax 17gm qd
Nasonex Spray QD
Phenolsorb 60mg BID
Senokot One QD
Acetaminophen 160mg PRN
Bisacodyl Supp 10mg PRN constipation
Motrin Susp PRN
Phenergan supp 12.5mg PRN
Head and Shoulders shampoo QHS
Phisoderm and triple antibiotic ointment to g-tube site bid
Pseudo-Ephedrine liquid 30mg/5cc prn nasal drainage
Peleveras ointment prn irritation to peri-area
Bisacodyl Supp. 10mg every 3 days

Completed by: xxxx
Signature: _____ Title: _____ Date: _____

STRENGTH
Ambulatory
Good Health
Enjoys company of caregivers
Tolerates tube feeding well

Needs
To become less touch defensive
To become more social
To be more cooperative with medical treatments and exams

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ENROLLMENT INFORMATION FORM (IIF)

Reviewed By: _____

Site(3): 05 Schools Site(4): 0402 Review Date(8): 100109

Firstname(6): [redacted] State(7): [redacted] 100509 SSN(9): [redacted]

Medicaid Number(9): 1010040401899 Gender(10): F Date of Birth(11): [redacted] Date of Death(12):

Race(13): 3
1 Indian/Alaskan
2 Asian/Pacific
3 White
4 Black 6 Other
5 Hispanic 7 Unknown

Religion(14): 5
1 Protestant
2 Catholic
3 Jewish
4 Other
5 Unknown

Current Liv Arr(15): 4
1 Lic in Home/Own or Lessee 4 Licensed Fac
2 Liv with Family 5 Nursing Fac
3 Foster Care Placement 6 Other

Residential Fac #(16): 0010027 Licensed Fac Name(17): Patterson Centers

Address(18): 100 Main St City(19): Dalerville

State(20): OH Zip(21): 44016 Residence County(22): Mill Termination Date(24):

Initial Enrollment Date(25): 090996

Program Enrollment Date(26): 010509

County Board Program(27):
01 Early Intervention
02 Preschool
03 School
04 Supported Education
05 Children's Environment
10 Adult Assessment
11 Adult Home Services
12 Adult Non-vocational
13 Sheltered Workshop
14 Workshop/Comp Training
15 Comp Emp/Supp - 19 hrs
16 Comp Employment 19+ hrs
17 Retirement
18 Self-directed Supports
0 Blank Current CB Program

Other School Days(28): 00

Family Resources(29): N

Service Coordination(30): 6

Unsigned Srv Count(31): 05

Other Service Provider(32):

Health Service Provider(33):

Supported Living Services(34): N

Dev Delay 0-2 Yrs(36):
0 No dev delay
1 Dev delay
2 More than one delay

At Risk 0-5 Yrs(37):
0 No identifiable risk
1 Environmental/Biological
2 Established risk

MR Level 6 yrs and Up(38): 3
0 None
1 Mild
2 Moderate
3 Severe
4 Profound

Substantial Functional Limitations (SFDL/CSBDD) 6 yrs+

Self Care(39): 3
Receptive/Expressive Lang(40): 3
Mobility(41): 3
Self Direction(42): 3
Capacity Indep Liv(43): 3
Learning(44): 3
Econ Self Sufficiency(45): (Age 16 and up)

Age of Onset of Disability if age of onset 18-21(46):

ICD-9 Code: 319.4

Education(47): 3
1 Current Stud
2 No Current Stud

Vision(48): 6
0 Under evaluation
1 No vision problem
2 Fixed after correction
3 Visually impaired
4 Legally blind

Hearing(49): 1
0 Under evaluation
1 No hearing loss
2 Fixed after correction
3 Hearing impaired
4 Complete loss

Communication(50): 3
0 Fluent with speech
1 Fluent with other modes
2 No Basic communication

Ambulation(51): 1
0 Walks independently
1 Walks w/devices/assist
2 Uses wheelchair

Chronic Med Cond(52): 1

Prim Beh Cond(53): 000

Second Beh Cond(54): 001

Court Appted Guard(55): 1
0 None 1 Full 2 Limited

Court Appted Guard(56): 1
0 Mom 3 Aunt
1 Parent 4 Other
2 Sib Fam Member

Team Code: Host Code: 00 Service Coordinator:

DATE: 3/23/16

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

Name	Bowel Movement	Comments
CARTER, LAUREN	Didn't really poo. Feeding normal	Daycare came in w/ a bruise mark on left shoulder area. Came in w/ diaper not on correctly, which made her diaper extremely soiled. Other than that day had no issues.
[redacted]		Would not eat breakfast.
[redacted]		
[redacted]		OK day!

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Tuesday, March 25, 2008 8:41:01 AM

Message

From: Tony Huff

Subject: Issues

To: Toni Arquette <tarquett
Conrad Clowers

Toni I have a couple of issues that I wanted to bring to your attention. Last week I email Laurene que to ask for more drainage pants he then forward my email on to Nursing. I still have not recieved any pants. Also we notice a mark on her right arm that looks like a burn, that I wanted to make you aware of. We have noticed that in the last week or so she has been overly aggressive biting, scratching, and hitting. I didn't know if you guys had been noticing the same types of behaviors or not. She is out of her chair atleast 70% of the day now, the only time she is in the chair is for transportation and while she is in the other class room. Thanks for your time.

Thank you.

Tony Huff
MH Teacher
Fairfield Senior High School
Ins. 2408 ext. 408

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DATE: 3/28/06

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

Name	Bowel Movement	Comments
[redacted] LAUREN		Very aggressive - Bit (Asst. Teacher - Has a Mark on (L) arm that seems to be a burn - (took to Clinic) nurse look @ it.
[redacted]		No breakfast: refused
[redacted]		
[redacted]		When getting off bus - sat down in the mud. Clothes sent in (1) pr pants to bg (1) pr pants home

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Wednesday, March 29, 2006 9:51:47 AM

Message

From: mfullerman@mail.magcorp.com;
Michelle Fullerman <mfullerman@mail.magcorp.com>

Subject:

To: Tony Hoff

Tony:

We have noticed on several occasions that when Lauren is getting ready to have her menstrual cycle that she becomes more aggressive. The mark on her arm was made by her shirt as she rubbed it her shirt was to right and she laid on it. Any time you are not getting answers you can send me an email and I will respond right away. Sorry for any inconvience. Michelle Fullerman Home Manager Home 606

This message has been scanned for Viruses and cleaned by MailMarshal at SWDGA.

Thursday, March 26, 2009 8:22:33 AM

Message

From: § mdulaman@mail.megcorp.com;
§ Michelle Pulaman <mdulaman@mail.megcorp.com>

Subject: Re: Lauren [redacted]

To: § Tony Huff

Tunk,
I will be getting with our nursing staff to add him to the foot doctors clinic. In the mean time I will try to thin them sometime this weekend myself.

Thanks,
Michelle------ Original Message ------
From: "Tony Huff" <huff_t@excitech-llc.123.sh.us>
Date: Thu, 26 Mar 2009 09:09:27 -0400

[redacted]

This message has been scanned for viruses and cleaned by MailMarshal at PHYDOA.

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4/3/06

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

Bowel Movement	Comments
[redacted] LAUREN	Lauren came in w/ a bruise like Mark on (L) upper thigh near groing area. Nurse checked area said it has probably been there for awhile
[redacted]	Had a pretty good breakfast
[redacted]	
[redacted]	Sleeping!

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Tuesday, April 04, 2006 1:05:00 PM

Message

From: Terry Huff

Subject: Lauren [redacted]

To: Toni Arquette <[redacted]>
Michelle Fuhrman

I was talking to Lauren's Dad to day about her being overly aggressive and that I was concerned about the fact that she has a burn on her Left Arm. Then I realized that I told you guys the wrong arm its the left one and the burn mark is still there from a week ago. Sorry for the miss understanding. But regardless I just wanted you to check into what may have burned her. We also noticed yesterday that She has a Dime shaped sore in her pelvic area that is blistered up pretty badly.

Thank you.

Terry Huff
MH Teacher
Fairfield Senior High School
Ext. 2405 ext. 408

DATE: 7/15/26

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

Name	Issue Reported	Comments
[redacted] LAUREN		Lauren came in w/ a "mark" on left top shoulder went to clinic to have it looked at
		Mark on (L) arm still there ate no breakfast
		~~HH~~ Bloody noses
[redacted]		
[redacted]	Diarrhea (2)	Kept taking OTC pepto Chirst!

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Printed for Tony Huff
Title: Re: Lauren [redacted] (DSD)

Wednesday, April 05, 2006 8:16:01 AM

Message

From: § refuhrman@mail.mapcorp.com
§ Michelle Fuhrman <refuhrman@mail.mapcorp.com>

Subject: Re: Lauren [redacted]

To: § Tony Huff

Tony,
The nurses and I looked at it and we think she may be allergic to the plastic please on the stand id wire it was
rubbing on her leg. We will keep and eye on this and keep antibiotic cream on it.
Michelle ------Original Message ----------
From: "Tony Huff" <huff_tony@bp.city.12.oh.us>
Date: Tue, 04 Apr 2006 13:05:55 -0400

[redacted]

This message has been scanned for Viruses and cleaned by MailSentinel at SWDCA.

Wednesday, April 05, 2017 9:36:00 AM
Message

From: Tony Huff

Subject: Lauren [redacted]

To: Toni Arquello <toniquell
Michelle Fuhrman

What about the bare on her left arm, this is really my main concern?

Thank you.

Tony Huff
MH Teacher
Fairfield Senior High School
Ext. 2408 ext. 408

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 1023394 / A 2502307 / COMMON PLEAS DIVISION / HON

Printed by: Tony Huff
Title: Lauren [redacted] #288

Wednesday, April 05, 2006 12:30:31 PM
Message

From: Tony Huff
Subject: Lauren [redacted]
To: Michelle Fuhrman

mishelle i just got off the phone with some one from nursing they suggested that i circle the burn mark, i also when ahead and circle the other areas that we had discussed plus marsels. a new mark that the nurse here said i should alert you to on her shoulder. please send this on to your nursing staff. if anyone has any questions please feel free to call my cell phone 513-934-6878 its long distance from Fairfield.

Thank you.

Tony Huff
9th Teacher
Fairfield Senior High School
Rm. 2408 ext. 409

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 102334 / A 2502307 / COMMON PLEAS DIVISION / KOSN

Printed by: Tony Huff
Title: Lauren [redacted] PCSO

Wednesday, April 06, 2016 12:46:14 PM
Message

From: Conrad Oswick <policemo@magnor3.com>
Subject: Lauren [redacted]
To: Tony Huff

Attachments: Attach0.html

Tony,

just left you a message and here's an email. Did a check of Lauren along with the name Judy yesterday. Whatever was on her arm did look like a burn. The mark on her arm was consistent with some type of allergic reaction. Judy put an ointment on the mark, it faded rapidly, and an incident report was filed out. I have no problem if you'd like to e-mail or call my supervisor or Toni with any info on Lauren. I'd appreciate it if you'd initially send Lauren concerns to me so I can address them. Thanks, Conrad

This message has been scanned for Viruses and cleared by MailMarshal at SWDCA.

DATE: 11/4/06

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

Inst.	Bowel Movement	Comments
[redacted] LAUREN		ink pen marks (that we where told to put on) never washed off. Very aggressive behavior (hitting, scratching & trying to pull over chairs) Back in CS room still there refused to eat breakfast
[redacted]		
[redacted]		Taking her clothes off alot today!

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Friday, April 07, 2006 9:30:38 AM
Message

From: Anne McKinney <annmckinney@magnolia.com>
Subject: Lauren [redacted]
To: Tariq Huff

Attachments: Attached.html

Mr. Huff

Lauren was involved in a MVC on 4/4/06 at 5:30 pm and was transported by Rolla Rescue (driver was cited). Thanks for your concern. Please let me know if you need further assistance.

Anne McKinney, for Lauren

This message has been scanned for viruses and blocked by MagicMail at [illegible]

Friday, April 07, 2006 12:21:32 PM

Message

From: Tony Huff

Subject: Lauren [redacted]

To: Toni Arguello <targuell
Anne Mckinney
Conrad Chavers

I received a message from Conrad and Anne saying that Lauren was checked and that the mark was not a burn.Conrads also said that you had put cream on it and that it had went away. As of today the mark is still there along with the pen marks that I circled it with on Monday. I'm not trying to accuse anyone of anything, I just want to make sure that what every she got to to or a hold of, that it doesn't happen again. Our nurse is not here today but I will pass on the info you gave me and she can take it from there.

Thank you.

Tony Huff
MH Teacher
Fairfield Senior High School
Ext. 2606 ext. 400

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 1023354 / A 2502307 / COMMON PLEAS DIVISION / I CON

Friday, April 07, 2006 12:36:08 PM
Message

From: Conrad Clowers <[redacted]>
Subject: Re: Lauren [redacted]
To: Tony Huff

Tony,

It appears that this tomchieh situation on Lauren continues to snowball. It's almost as if we're talking about two different Lauren [redacted]'s. I'm personally not a doctor but what I've witnessed on Lauren is no way appears to be or is consistent with a burn. It does appear to be consistent with some type of an allergic reaction. I stand by what I and our nursing dept witnessed and I'm sure you do the same. I think the time has come where we should meet with you and your nurse so we can discuss these issues. Can you please give me some dates and times of availability? Thanks, Conrad
----- Original Message -----
From: "Tony Huff" <huff...@fairfield.oh.k12.us>
To: "Toni Arquette" <[redacted]>; "Anne McKinney" <[redacted]>; "[redacted]"
Sent: Friday, April 07, 2006 12:01 PM
Subject: Lauren [redacted]

[redacted]

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DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

me	Bowel Movement	Comments
[redacted] LAUREN		Mark Stall on (C) arm
[redacted]		refused to eat breakfast?
[redacted]		
[redacted]		sleeping / talking pants o

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 102334 / A 2502307 / COMMON PLEAS DIVISION / I02N

DATE: 4/11/06

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

me	Bowel Movement	Comments
[redacted] LAUREN		Mark Still on (L) arm
[redacted]		Refused breakfast
[redacted]		
[redacted]		Sleeping !
[redacted]		

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DATE 2/11/06

DAILY HEALTH ISSUES FOR FAIRFIELD CENTER

ID#	Bowel Movement	Comments
[redacted] LAUREN		Lauren came in w/ marks on lower part & back area (left) Had Advil nurse looks @ area.
[redacted]		Refused breakfast today
[redacted]		
[redacted]		

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WITNESS STATEMENT

Witness Name: Idoreyn Fred
Witness Position:
Witness Date of Hire:
Witness Date of Birth:
Witness Address:

DESCRIPTION OF INCIDENT

Date of Incident: _____ **Time of Incident:** _____

Location of Incident: _____

Summary: _____

When working with [redacted] especially during Shower's I always sit her in the Shower Chair to day her hair for Safety because She turns her head to different directions and I have Seen anybody or me doing hard to [redacted] Door.

Signature of Witness: Fred Idoreyn **Date:** 5/13/25

Location Witness Statement was obtained: _____

Signature of others present when Witness Statement was obtained:

_____ **Date:** _____

_____ **Date:** _____

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WITNESS STATEMENTS

Witness Name: Alicia
Witness Position: ESI
Witness Date of Hire: 8-24-13, 1553
Witness Date of Birth: 2-19-80
Witness Address:

DESCRIPTION OF INCIDENT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Summary: I remember when [redacted] had M lines on her right breast and they switched up to Erik sometime this year and since I started here Erik accused the building Almost lawsuit had the same marks on her as and [redacted] This is when Eric Frasier was still working at Fairfield Center it was a late day and Eric came in at 7:00 a.m.

Signature of Witness: [signature] Date: 3/28/16

Location Witness Statement was obtained: _____

Signature of others present when Witness Statement was obtained:

_____ Date: _____

_____ Date: _____

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WITNESS STATEMENTS

Witness Name: Brandy Tumbleson
Witness Position: CO1
Witness Date of Hire: 10/14/02
Witness Date of Birth: 5/28/73
Witness Address: 528 Hannah Ave Loveland OH 45140

DESCRIPTION OF INCIDENT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Summary: id personally never seen anyone
beat Dawson. Only thing id have seen
Dawson do is lunge when being on
her skin and pinch or poke when
she had a tobacco. And maybe when
she bite her hands but she always
broke the skin. I have never
seen or have id ever beat Dawson

_____

_____

Signature of Witness: Brandy Tumbleson Date: 5/16/24

Location Witness Statement was obtained: Staff Training Room

Signatures of others present when Witness Statement was obtained:

_____ Date: _____

_____ Date: _____

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WITNESS STATEMENTS

Witness Name: Kofi J. Akwete
Witness Position: R31
Witness Date of Hire:
Witness Date of Birth:
Witness Address:

DESCRIPTION OF INCIDENT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Summary: Lauren [redacted] is more challenging
as the Shower Time, all the other clients
She wouldn't allow you to really give her
a shower. She wouldn't allow you to
even shampoo her hair. All I do is to go around
her & the best that I can. I was washing her hair & it
was then that she had urinated. She left an accident (B m)
that so when Cha turn down or go to wash her anal cleaning
It's also very tough to clean her hair. So I
her hands over [illegible] before I rinse the rest shampoo off
the other day.

Signature of Witness: K. J. Akwete Date: 5/18/16

Location Witness Statement was obtained: STAFF TRAINING RM

Signature of others present when Witness Statement was obtained:

_____ Date: _____

_____ Date: _____

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WITNESS STATEMENT

Witness Name: S Robinson

Witness Position: RSI

Witness Date of Hire: Sept 02

DESCRIPTION OF INCIDENT

Date of Incident: Not Known Time of Incident: Not Known

Location of Incident:

Statement: I was not here at work. I was back to work on monday night 5-8-06 11:00pm and was pull to 2nd.

Shanna Runnels - Robinson

WITNESS STATEMENT

Witness Name: Stella Bonsu

Witness Position: RSI

Witness Date of Birth: Dec 04

DESCRIPTION OF INCIDENT

Date of Incident: Unknown — Time of Incident (Approximate): _____

Location of Incident: _____

Summary:

I was here Saturday night on the 4 way
Stop and Lauren slept all night and when she
was awake I changed her and then we left
early around 8 or 9 since she had to be at
work by 10 and I was paid to 4:00. So that is all that
I know.

Stella Bonsu

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WITNESS STATEMENT

Witness Name: Betty Woods

Witness Position: _____

Witness Date of Birth: _____

DESCRIPTION OF INCIDENT

Date of Incident: 5/8/23 Time of Incident: _____

Location of Incident: _____

Statement:

I was here at Zion and had the investigation group called me in to verify an incident that I should help them. Take Lucas's dress off and take pictures so he broke the bed on her back.

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WITNESS STATEMENT

Witness Name: Rafael [illegible]

Witness Position: [illegible]

Witness Date of Birth: _____

DESCRIPTION OF INCIDENT

Date of Incident: 5/6/26 Time of Incident: _____

Location of Incident: _____

Summary:

When I was [illegible] a [illegible]
I did see [illegible] [illegible] to the window

WITNESS STATEMENT

Witness Name: Lieutenant A. Thomas

Witness Position: ASU/E-3

Witness Date of Hire: 7/2021

DESCRIPTION OF INCIDENT

Date of Incident: 6th 23rd 22 Time of Incident: Unknown

Location of Incident: Lockbox

Summary:

I did not see any marks on Lawson the 6th or 7th.

I did not work the 5th.

Lieutenant A. Thomas

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 192334 / A 2502307 / COMMON PLEAS DIVISION / KOSN

WITNESS STATEMENT

Witness Name: Alicia Stokes

Witness Position: RSI

Witness Date of Hire:

DESCRIPTION OF INCIDENT

Date of Incident:

Time of Incident:

Location of Incident:

Statement:

I did not Have Lauren on the 6, 7th or 8th of MAY I did not Notice Anything on Her

WITNESS STATEMENT

Witness Name: Brandy Tomlinson

Witness Position: ES

Witness Date of Birth: 10/10/82

DESCRIPTION OF INCIDENT

Date of Incident: 6/13/25 Time of Incident: ?

Location of Incident:

Statement:

I got her up for school on monday the 9th. She had bruises on her chin and they were old. She had a mark on her back shoulder that did look red old they were yellow and faint.

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WITNESS STATEMENT

Witness Name: Edwin Ford

Witness Position: ESI

Witness Date of Hire:

DESCRIPTION OF INCIDENT

Date of Incident: 05/07/16 Time of Incident:

Location of Incident:

Summary:

I showed Donovan [redacted] Spalding on Sunday before I left home at 9:45pm I did not see any scratch or bruises

Fred Edwin Ford

E-FILED 04/22/2020 3:54 PM / CONFIRMATION 1033394 / A 2002307 / COMMON PLEAS DIVISION / KOSN

River[redacted] Staff Assignment Sheet

Date: 31 Aug 06

Shift Leader: Brenda
Duties: Homeless Manual Checklist, Census, Walkie Talkie, Doors unlocked at dawn

1st Shift Staff Assigned	Residents	Lifts	Machines George	Job Duties #	Staff Assignments Name	Time	Activities
Group 1	Marguerite B	Invoicare – only					
Staff	Lauren [redacted] Tara M-F	3rd shift		5/6			
	Sue F						
Brenda	Tom R						
Group 2	Jack K						
Staff	Judy H						
	Edith L		1-3	1			
Teresa	Cindy L	Invoicare – only					
Group 3	Virginia L	Invoicare – only					
Staff	Brian R						
	Eric E		1-3	2			
Martha	Greg H						
Group 4	Steve K	Floor					
Staff	Shauna K						
	David O		4-6	3			
Steve	Rob T						
Staff	Mike P						
Kelly							

Job Duties	#
Prepare /Serve / Clean-up/ Hall monitor/ Breakfast	1
Prepare /Serve / Clean-up/ Hall monitor/ Lunch	2
Laundry	3
Clean activity and Coat closet/ Disinfect Furniture	4
Women's wing: Disinfect / Mop / pull trash / Bathroom	5
Men's wing: Disinfect / Mop / pull trash / Bathroom	6
Cigarette Butts in Back and Housekeeping	

- Ensure that all Job duties are complete before end of shift
- Ensure rounds are done between Shift / Assignments
- Notify Supervisor before taking Breaks
- Ensure if you see Spills, Clean up Immediately
- Keep all areas in the house and Clean.

Notes: Table Monitors- Wipe Tables Sweep Floor

After Clean-up on the weekends set-up for the next meal

E-FILED 04/20/2015 3:54 PM / CONFIRMATION 1035894 / A 1502057 / COMMON PLEAS DIVISION / ECM

Home 500 Staff Assignment Sheet

Date 3 Dec 18

Staff Leader: KoF

Duties: Hazardous Material Checklist, Census, Walkie Talkie, Doors locked at dusk

2nd Staff / Staff Assigned	Resident	Lifts	Mealtime Groups	Job Duties #	Staff Assignments: Name	Staff Assignments: Place	Activities
Group 1	Margarita D	Invacare – only			Christine D	2nd	
Staff	Lauren		#1 Lunch	Lunch	Cindy D	2nd	
	Sue F			5	Danielle D	2nd	
KoF	Tom R				Robin J	2nd	
Group 2	Jack K.				Christine	2nd	
Staff	Judy H			4			
	Edith L		1,2,3				
Tracy	Cindy L	Invacare – only			Cindy G	3rd	
Group 3	Virginia L	Invacare – only					
Staff	Dylan R.			K2			
	Eric E						
Andy	Greg H						
Group 4	Steve K.	Pivot			Christine	2nd	
Staff	Shawn N.		4,5,6	3			
	David O						
Robin	Rob T.						
Staff	Mike P			4			
Christine							

Job Duties	#
Lunch picking/Cooking/Server/Set/ monitor	1
Kitchen Clean up/Mopping/Check Walls/Ceilings/Hall monitor	2
Laundry / Wyckoff bag check/ Set	3
Women's wing: Disinfect / Mop / pull trash / Bathroom	4
Men's wing: Disinfect / Mop / pull trash / Bathroom	4
Disinfect Furniture/ Mop all activity rooms	5
Cigarette Butts / Clean ashtrks and Coat closet	5

- Ensure that all Job duties are complete before end of shift
- Ensure rounds are done between Shift / Assignments
- Notify Supervisor before taking breaks
- Ensure if you see Spills / splashes, Clean up Immediately
- Keep all areas in the house and Clean.
- Report to Disinfect phone/chair / Beds between use

Home wings: 2 Days staff Kitchen Set-up/ Activities/ Linens stocked on

Shift Leader: Brandy
Duties: Hazelton Mental Children, Census, Walkie Talkie, Doors unlocked at 6pm

House 500 Staff Assignment Sheet

1st Shift Date: 3/27/16

Staff Assigned	Residents	Lifts	Meetings Groups	Job Duties #	Staff Reassignments Name	Time	Activities
Group 1	Marguerite B	Showers – only					
Staff	Lauren [redacted] Tom M-F	3rd shift [redacted]					
	Sue F						
Alicia	Tom R			1	Brandy	4	Alicia Air Tickler
Group 2	Jack R						
Staff	Judy H Alicia						
	Edith L			5			
	Cindy L	Showers – only					
Group 3	Virginia L	Showers – only					
Staff	Brian R						
	Eric E		1-3	6			John @ 7:30
Jessica	Greg H						
Group 4	Steve R	Pivot					
Staff	Shauna N						
	David O		4-6	3			
Brandy	Rob T						
Staff	Mike P						

Job Duties	1
Prepare /Serve / Clean-up/ Hall monitor/ Breakfast	2
Prepare /Serve / Clean-up/ Hall monitor/ Lunch	3
Laundry	4
Clean activity and Coat closet/ Disinfect Furniture	5
Women's wing: Disinfect / Mop / pail trash / Bathroom	6
Men's wing: Disinfect / Mop / pail trash / Bathroom	
Cigarette Butts in Shift and Housekeeping	

- Ensure that all Job duties are complete before end of shift
- Ensure rounds are done between Shift / Reassignments
- Notify Supervisor before taking Breaks
- Ensure if you see Spills, Clean up Immediately
- Keep all wings in the house and Clean.

Note: Table Manners- Wipe Tables Sweep Floor

After Clean-up on the weekends set-up for the next meal

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Staff Leader: Andy

Duties: Hazardous Material Checklist, Census Walkie Talkie, Doors locked w Auth.

Home 505 Staff Assignment Sheet

Date: 3/27/06

1st Shift Staff Assigned	Residents	Units	Medicine Groups	Job Duties #	Staff Reassignments: Name	Time	Activities
Group 1 Staff Fred	Margarita H	Terrazas – only		Lunch Packing	Anthony Gabriela		Cooking & Tea
	Lauren						
	Ron F •						
	Tom B.						
Group 2 Staff Rafael	Jack K.		1,3,7	5			Group Tea
	Judy H Sec. desk						
	Edith L						
	Cindy L	Terrazas – only					
Group 3 Staff Kati	Virginia L •	Terrazas – only		Comp & clean-up			
	Brian R.						
	Eric B						
	Greg H						
Group 4 Staff Andy	Steve K.	Pines	4,5,6	3			
	Shawna N.						
	David O						
	Rob T						
Staff Barbara	Mike P			4			

Job Duties	#
Lunch packing/Cooking/Serving/Clean Walls/Ceilings/Mail monitor	1
Kitchen Clean up/Mopping/Clean Walls/Ceilings/Mail monitor	2
Laundry / Workshop bag check Lab	3
Women's wing: Dayroom / Mop / pull mats / Bathroom	4
Men's wing: Dayroom / Mop / pull mats / Bathroom	4
Disinfect Furniture/Mop all activity rooms	5
Cigarette Butts / Clean activity and Coat closet	5

- Ensure that all Job duties are complete before end of shift.
- Ensure rounds are done between Shift / Reassignments.
- Hourly Supervisor before taking Breaks
- Ensure if you see Spills / splashes, Clean up Immediately
- Keep all areas in the house and Clean.
- Return to Disinfect shower/chair / Beds between use.

Home: 2:00pm staff Kitchen Set-up/ Activities/ Linens stocked on wings

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Home 909 Staff Assignment Sheet

Date: 3/23/26

Staff Leader: Alicia Shelby
Duties: Homeless Material Checklist, Census, Walkie Talkie, Doors unlocked at 6am

1st Shift Staff Assigned	Residents	Lifts	Medicine Groups	Job Duties #	Staff Assignments Meal	Staff Assignments Clean	Activities
Group 1 Staff Shayna	Margarita B	Investors – only		2			
	Lauren ● Sam M-F	3rd shift					
	Rini F						
	Tom S.						
Group 2 Staff Alicia	Jack E.			5, 6			
	Judy H						
	Edith L						
	Cindy L	Investors – only					
Group 3 Staff Kalyn	Virginia L	Investors – only	1-3				
	Brian R						
	Idris S						
	Greg H						
Group 4 Staff Shelby	Steve K.	Floor	4-6	3			
	Shawna N.						
	David O						
	Rick T						
Staff	Mike P						

Job Duties	#
Prepare /Serve / Clean-up/ Hall monitor/ Breakfast	1
Prepare /Serve / Clean-up/ Hall monitor/ Lunch	2
Laundry	3
Clean activity and Coat closet/ Disinfect Furniture	4
Women's wing: Disinfect / Mop / pull trash / Bathroom	5
Men's wing: Disinfect / Mop / pull trash / Bathroom	6
Cigarette Butts in Shift and Housekeeping	

- Ensure that all Job Duties are complete before end of shift.
- Ensure rounds are done between Shift / Reassignments
- Notify Supervisor before taking Breaks
- Ensure if you see Spills, Clean up Immediately
- Keep all areas in the house and Clean.

Notes: Table Monitors- Wipe Tables Sweep Floor

After Clean-up on the weekends set up for the next meal

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Lauren [redacted] #2024-05-0174

ABUSE PROTOCOL INVESTIGATIONS

1. Planning the Investigation
   - ☐ Review the Incident Tracking System report (required element)
   - ☐ Review the incident report (required element)
   - ☐ Review the police or Children's Services Board report (where applicable)
   - ☐ Determine who you need to talk to and how soon (initiate the investigation within 48 hours from when report was filed. Some cases require immediate investigation.)
2. Gathering Information – work in conjunction with the police (once the police decide not to accept the case.
   - ☐ Visit the scene to gather evidence as soon as practical (Applicable) A written description of evidence to include date, time, and location of gathering.
   - ☐ Was there injury or could there have been injury?
   - ☐ A written statement from a qualified medical professional (doctor, RN, therapist, EMT) about the injury, age of the injury, probable cause of the injury as needed.
   - ☐ A description of the treatment received or ordered. (If applicable)
   - ☐ Describe the injury; shape, color, size
   - ☐ Take photographs of injuries and of the scene (or sketch the scene). Write on the photo the date the photo was taken and who took it.
   - ☐ Review all relevant documentation of the:
     - PPE - Personnel records, training records, previous disciplinary action, past MDT's, etc.
     - victim - the individual's plan, medical records, past MDT's, etc.
   - ☐ Gather witness statements
   - ☐ A description of the victims reaction to the physical force (ex: pulled, fell backward, etc.).
   - ☐ Conduct and document interviews of the individual, witnesses, and the PPE
   - ☐ Interview others who may have insight (DC, medical professionals, etc.)
   - ☐ Investigate follow-up as needed (with Law Enforcement, CSB, witnesses, etc.)
3. Analysis of the Information
   - ☐ Determine if the preponderance (more than 51%) of the evidence proves the allegation is substantiated or unsubstantiated/insufficient, or unfounded/ Evidence.
4. Completion of the Investigation Report
   - ☐ Will the investigation report to include a clear statement of the allegation, investigative steps taken and the basic question(s) to be answered by the investigation; evaluation of all witnesses and documentary evidence in a clear, complete and non-ambiguous manner; evaluation of the relative credibility of the witnesses: whether the witness's statements are logical, internally consistent, and consistent with other credible statements and known facts (e.g., does the witness appear to know out or not know about information that he/she should know about?); Whether the witness was in a position to hear or see what is claimed; Whether the witness has a history of being reliable and honest when reporting incidents or making statements regarding incidents; Whether the witness has a special interest or motive for making a false statement (e.g., is there a possible bias of the witness?);

Karen Feltner

From: Karen Feltner
Sent: Thursday, May 25, 2006 3:41 PM
To: FILIPIN@odjfs.state.oh.us
Subject: Lauren [redacted]

Hey Nick,

Just wanted to update you on interviews we conducted at Fairfield Center regarding Lauren. We (Patrick Campbell and I) interviewed several staff on 5/18/06 regarding the mark on her arm that appeared to be a burn from a hair dryer. We did not feel anyone had intentionally caused harm to Lauren. Most of the staff stated that when they use the hair dryer on Lauren, she often puts her arms up to block the heat/air. It is possible that someone bumped her arm with the hair dryer and did not realize they had done so, which would explain why it was not report and an incident report not completed. Since this came to light, a new hair dryer was purchased for the home with the "grid" removed. Also, a diffuser was put on the hair dryer with super glue to hopefully avoid future incidents.
None of the staff were aware of how she got the most recent marks on her back either.
Thanks again for your assistance in this case. Please let me know if you have any questions.

Karen Feltner
Investigative Agent
Butler County Board of MRDD
(513) 867-5674

5/25/2006

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Fairfield Center

MI/VI Investigation Form

Individuals Name: Lauren [redacted]

Date of Incident: 5-8-06

Description of Incident: Alleged Abuse

Immediate Action: School notified OIR, OIR notified FC, Nursing assessed, 2 bruise found on back.

Trend/Pattern: Lauren does not have trend of this type of incident.

Summary of Investigation:

5-8-06
Received call from OIR, that IA and Children services representative will be coming out to look at Lauren. Nursing did complete body check of Lauren, found two 2in by 2in purple bruises left lower back just below ,waistline. Possibly 1 day old. Also found two ¼ inch round bruise appears to be 4 to 5 days old bruises here on R inner lower leg. Head checked by 2 nurses and QMRP no burns found, only scar above left side of hairline, no burns behind ears on head or anywhere on body.

Review with IA, current concern is bruises on back.
Burn was on arm around 4-4-06, review with QMRP / nursing notes is that Rash was found on Arm at that time, QMRP had several emails with school over issue.

Review with staff bruises on back were not noticed until 5-8-06, Prior staff that had showered Lauren did not see bruises on 5-7-06. A fall was noted on 5-7-06 by staff and nurse that Lauren was running down hall and fell backwards onto floor, staff stated she fell backwards on her butt. Nurse stated she went to her knees and did not "fall" Nursing noted she got up and was fine, she checked her when doing her vibe find no injuries noted. Either description of is not consistent with this injury.

No incident was reported that would directly explain this incident. Review of home environment and Lauren, the bruises are the same height of 2 beds with corners on the women's wing, the stove (oven handle) a few tables that are the same height. >Hence the shape of the bruises they look more like scrapes than a direct impact. One possible cause if that Lauren backed into table/bed/dresser with a corner and scraped her back. Lauren is very active in the home.

Insufficient evidence to substantiate allegation of abuse at this time.
OIR continues investigation.
Lauren has been placed on daily body checks.

Recommendations/Preventive plan:
Staff to continue to follow plan
Nursing to follow as needed.
IP team to continue to monitor and revise plan as needed

Completed by:

Investigator: _____ **Date:** _____

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Reviewed By

Administrator:_____ Date:_____

BIC:_____ Date:_____

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Fairfield Center

MUSE Follow-up Form

Individuals Name: Lauren [redacted]

Date of Incident: 5-8-06

Description of Incident: Alleged Abuse

Follow up:

On further review with OIR, School had reported possible burn on arm, Nursing had reviewed and stated that the area appeared to be a rash. However the review the incident was possible a week after the initial discovery at school. Review of Initial report with OIR the injury appeared to have 6 even lines. I reviewed the environment and found a hair drier that had a grill on it that would match the marks. I removed the hair drier from the home and replaced with one with a recessed grill. Also staff were trained on hairdryer safety.

OIR and myself interviewed Staff who were assigned to Lauren at the time of the discovery of the possible burn. No one witnessed / reported an incident that would directly explain this injury. Staff were consistent that Lauren does not like to have her hair dried and is defensive she will duck her head and cover her head with her arms and try to push or pinch staff. It is possible that Lauren hit the hair dryer with her arm or staff accidentally hit her with the hairdryer. Staff in the home did not notice this injury.

Insufficient evidence to substantiate allegation of abuse
Lauren has been placed on daily body checks.
Hair Dryer replaced / Staff trained on hairdryer safety
Injures are resolved

Recommendations/Prevention plan:
Staff to continue to follow plan
Nursing to follow as needed.
IP team to continue to monitor and revise plan as needed

Completed by:

Investigator: _____ **Date:** _____

Reviewed by:

Administrator: _____ **Date:** _____

HSC: _____ **Date:** _____

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BUTLER COUNTY CHILDREN SERVICES BOARD DISPOSITIONAL REPORT
PREPARED FOR THE BUTLER COUNTY BOARD OF MRDD

ALLEGED VICTIM(S)	DOB
Laure[redacted]	[redacted]

ALLEGED PERPETRATOR(S)	RELATIONSHIP TO CHILD
unknown	

DATE OF REPORT TO BUTLER COUNTY CHILDREN SERVICES BOARD	10/16

ALLEGATION(S)	Laurie was observed to have two abrasions on her back that looked like they could have been inflicted. There were also historical concerns regarding a burn that appeared to be from a hair dryer.

DISPOSITION	Unsubstantiated Physical Abuse	DATE OF FINDING	12/20

LEGAL ACTIONS INITIATED

REFERRED TO (Police Department)	N/A	DATE	

POLICE ACTION TAKEN TO DATE	N/A

DATE JUVENILE COURT ACTION INITIATED	N/A
ADJUDICATION RESULTS	N/A
DISPOSITION RESULTS	N/A

DATE CRIMINAL CHARGES FILED	N/A
ALLEGED PERPETRATORS CHARGED	N/A

TRIAL RESULTS	N/A

CURRENT LOCATION OF CHILD(REN) (Indicate if child removed from home)	N/A

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CHILD/FAMILY SERVICE NEEDS IDENTIFIED (all investigations)
No additional service needs were identified.

CHILD/FAMILY SERVICES TO BE PROVIDED BY BUTLER COUNTY CHILDREN SERVICES BOARD
None

BUTLER COUNTY CHILDREN SERVICES BOARD CASE STATUS

OPENED		WORKER ASSIGNED		CLOSED	4/2/08

CONCLUSIONS/COMMENTS	The investigation did not yield any evidence of abuse or neglect. It was determined that the marks on Lauren's back and the hair dryer burn were likely to be accidental and not inflicted. Lauren's father did have concerns about her clothing being stolen and about the bathing procedures at the Fairfield Center. He reported that it was his understanding that a male staff had bathed Lauren by himself on at least one occasion.

INVESTIGATIVE WORKER	Rick Pilgrim	SUPERVISOR	Cynthia Klein

DATE OF REPORT	4/2/08

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Karen Feltner

Norm,
I sent out disposition letters today and am unsubstantiating physical abuse. I am going to be out of town next week, but will get you a summary when I get back. thanks....Nick

>>> Karen Feltner <[redacted]> 03/23/2006 3:41 PM >>>
Hey Nick,

Just wanted to update you on interviews we conducted at Fairfield Center regarding Lauren. We (Patrick Campbell and I) interviewed several staff on 3/18/06 regarding the mark on her arm that appeared to be a burn from a hair dryer. We did not find anyone had intentionally caused harm to Lauren. Most of the staff stated that when they use the hair dryer on Lauren, she often puts her arms up to block the heat/air. It is possible that someone bumped her arm with the hair dryer and did not realize they had done so, which would explain why it was not report and an incident report not completed. Since this came to light, a new hair dryer was purchased for the home with the "grid" recessed. Also, a diffuser was put on the hair dryer with super glue to hopefully avoid future incidents. None of the staff were aware of how she got the most recent marks on her back either.
Thanks again for your assistance in this case. Please let me know if you have any questions.

Karen Feltner
Investigative Agent
Butler County Board of MRDD
(513) 867-5674

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8/3/2006

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PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 65

Ohio Department of Developmental Disabilities

Division of Information Systems

EXHIBIT

43

90DD INCIDENT REPORT (ITSI)

Incident Number:		Group Name:		
2021-000-0482		Rubin		
Client Number:	Client Name:	Gender:	Waiver Type on Incident:	Age at Discovery:
[redacted]	[redacted] LAUREN 330 ROSE DRIVE FAIRFIELD, OH 45014	F		14

First Doc Date	Incident Date	Discovery Date	Created Date	Exp Date
05/06/2022		11/30/2021	12/01/2021	

Category Type:
Decided

Alleged Abuse - PHYSICAL	Unknown	
Alleged Neglect	Treatment	Staff
Significant Injury	Injury (Unknown)	

Alleged

Alleged Abuse - PHYSICAL	Unknown	
Alleged Neglect	Treatment	Staff
Significant Injury	Injury (Unknown)	

Substantiated — Was Substantiated

Alleged Abuse - PHYSICAL	Unknown	Substantiated
Alleged Neglect	Treatment	Substantiated

Injuries
Severity: Moderate — Cause: Undetermined — Result: Laceration (s) w/Closure — Location: Neck/Face

Law:
Law Enforcement Involved: No — Outcome: Investigated — Assault

Neglect: Other — Risk Assessment: Substantial
Force: Other — There was injury
Other
unknown, found in bed very little blood.

Living Arrange:
9698260 — ICF/ID

Location: Non-County Operated Program — Residence — ICF/DD

Incident Provider:
0910827 — TARSIA TRAILS

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Ohio Department of Developmental Disabilities

Division of Information Systems

90000 INCIDENT REPORT (ITSI

Residential Provider:	
0910827	TARDEA TRAILS
Adult Day/Employment Provider:	
No Adult Day/Employment Provider	

Notifications		
9035288	Law:	11/30/2021
	Guardian:	11/30/2021
	County:	11/30/2021
	Administrator:	11/30/2021

Consumer Notified:	Accepted:	Autopsy:
Rec. Closure:	Rec. Closure By:	
05/06/2022	Campbell, Patrick	
Incident Review Status:		
Closed		
Closed Date:	Investigated By:	
06/05/2022	Law Enforcement:	
	Campbell, Patrick	
Closed By:	Last Change By:	
Chris E Young	Chris E Young	

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Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contact Number	Provider Name
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Initial Report	12/01/2021	3137532

On 11/30/2021, it was reported to Hollie Metz, ESA On-Call/RCB000 that a laceration was discovered to Lauren [redacted] neck at 7:45am. Lauren was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause unknown.

[redacted] guardian informed that the ER personnel did not believe this was an "accidental" injury. He questioned why Lauren was taken to West Chester Hospital as opposed to Mercy Fairfield, which is one street over from the facility.

Tanya Vance, Takoda Trails investigator reported that police came to the facility and conducted initial investigation, but could not identify any particular cause; no person was named as a suspect. Tanya believed it possibly occurred during an unreported fall, but was still conducting interviews.

Intake IA contacted Fairfield PD records, who advised this was a medic call. Police accompanied, but there is no indication that this has been assigned to Detectives. Intake IA and Assigned IA left messages for the supervisor of investigations with FPD with no response at this time.

<Rebekah Lyons Added on 12/1/2021>

Immediate Action	12/01/2021	3137533

Lauren received treatment upon discovery.

Photographs obtained and reviewed.

It is unclear what happened. Assigned IA to rule out abuse or neglect.

ICF currently investigating, and we are waiting for confirmation from police to see their involvement, if any.
<Rebekah Lyons Added on 12/1/2021>

Interim Report	12/01/2021	3137549

**Intake IA spoke with Sgt. Pete Lagemann, Supervisor of Investigations Fairfield PD. He stated there is an open investigation. They are conducting interviews and do have great concern for this injury. Lauren is blind and could not have done this to herself. Additionally, there was blood in the hallway that had been cleaned up and Lauren was changed and put back to her bed by someone. Category will be changed to suspected physical abuse, PPI still unknown.
<Rebekah Lyons Added on 12/1/2021>

Question	12/02/2021	3137622

With addition of the physical abuse with unknown PPI, is the provider implementing any further immediate actions in the home, with Lauren returning from the hospital?
<Chris E Young Added on 12/1/2021>

Response	12/02/2021	3137976

IA posed this question to the facility; no response yet. Does DODD have any recommendations?

Update: Police are initiating a round of second interviews; IA was invited to sit in. They have no input at this time.
<Rebekah Lyons Added on 12/2/2021>

Extension Request Update	05/04/2022	3157756

IA missed extension request, was out ill last week. This is an on going investigation. Detective Ellie King from Fairfield PD is investigating. She requested all past MUI investigation for Lauren. Complaint was filed with OCI by Ellie, they have completed the survey, IA wait outcome. Lauren injury is reported to be healing well. IA Rai visited the home and Lauren. Data

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Others

environmental check of the home. the provider has removed some broken items from the home such as a mirror frame and covered other items out reach there were old shelves with exposed screws on floor in one of the bathrooms.
<Campbell, Patrick Added on 1/24/2022>

Extension Request Update	02/04/2022	3163545

This is an ongoing investigation. Police are investigating IA received police report 2/3/2022 and need to review with detective. IA not been able to speak to her again.
<Campbell, Patrick Added on 2/4/2022>

Extension Request Update	03/04/2022	3175186

IA has been in contact with Butler County Coroner and seek opinion Coroner. Waiting for them to review case.
<Campbell, Patrick Added on 3/4/2022>

Extension Request Update	03/30/2022	3196853

IA was able to input from Doctor recommended by Butler County Coroner. IA also spoke to the detective from the case to clarify points in her report. At that time it was discovered that one of the staff did not fully cooperate with the investigation and did not return for an interview. IA contact provider and they removed the staff from schedule until interview was arranged. IA is waiting to see if staff complies, and is also seeking to question this staff as well.
<Campbell, Patrick Added on 3/30/2022>

Extension Request Update	04/22/2022	3220313

This is an ongoing investigation. The PPI has not scheduled a follow up interview to date 4/22/2022. IA has requested review of report with DODD before entering.
<Campbell, Patrick Added on 4/22/2022>

Final Report	05/04/2022	3231586

QA of persons interviewed and documents reviewed
All interviews/Statements:
Lauren Carter, Individual
[redacted] Individual
[redacted] Individual
[redacted] Individual
[redacted] Guardian
Tanya Vance, MUI Investigator with Takoda Trails
Ellie King, Detective with Fairfield PD
Sgt. Pete Lagerstein with Fairfield PD
Dr. Gary L. Utz, pathologist
Lisa K. Mireles M.D. Butler County Coroner
Kara Frederick, QA Director with BCBDD
Joyce Katz, DSP with Takoda Trails
Sandra "Sandy" Osterberger, LPN with Takoda Trails
Brian Petrak, AD/ON with Takoda Trails
Vikki Perry, DSP with Takoda Trails
DeSatin Curtis, DSP/PPI with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kuete, DSP with Takoda Trails
Lynnette Whitaker, DON with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Noonan, Program director with Takoda Trails
Michelle Thumb, QA RN with BCBDD
Kathy Talbot, QA RN with BCBDD

Documents Reviewed:

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Others

DODD incident Report
Email notification MUI was filed
Consumer detail report
On-Call report
Incident report
Past MUI's
IP's
Witness Statements
Police report
Court records
Personnel records
Email correspondence
Medical records
Sleep chart
BMI records

QSummary of interview(s) and document(s) reviewed:
AiThe administrative investigation commenced by Rebekah Lyons on 12/1/2021 by gathering and reviewing relevant documents, incident report, law enforcement Notified.

MUI was correctly coded. Yes, Neglect category was added after review of the police report. IA then notified the provider of the outcome of the police report and addition of the category.

Level of supervision – From IP 8/4/2021: Inside the home at Takoda Trails – Visual range (when outside of my bedroom) in eyesight of staff when outside my room. 15 minute checks while in my room.

Tanya Vance stated that at night supervision checks are hourly.

Staff document hourly if individuals are asleep.

Review of past MUI's – (1) previous MUI's since 1999)
No MUI involving current staff noted in history.

One wrote quoted hospitalization for bowel obstruction.

Two previous Significant Injuries:
On 11/18/14, Laure[redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time. All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed the injury was caused from a fall that occurred on 11/2 due to leisure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.

Notified on 10/27/03 that Lauren had received 18 stitches to her left hand/fingers, after getting her hand caught in a door on 10/18/03 Lauren's stitches were a result of her getting her hand caught in a door (details are forthcoming once Patrick locates the Incident Report). Nurse's notes, however, state that Lauren had profuse bleeding on left hand ring finger, and a laceration noted on top 1/3rd of finger front and back. Also, notes that Lauren was transported to Mercy Hospital ER.

Four previous allegations of physical abuse:
On 2/28/08, Kimberly Charles, Medical Records Specialist/Fairfield Center (FC) reported that she observed Brandy Tumblerson, Resident Specialist 1/TC, yell "no" to Laure[redacted] and push Lauren back in her wheelchair with her right arm. She said that Brandy again yelled "No" to Lauren and jerked Lauren's head back by placing her open hand on Lauren's forehead. Kimberly

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immediately addressed this with Brandy and told her that she had seen what occurred. Kimberly reported that Brandy denied any wrongdoing. Another staff person was present and stated that she did not feel Brandy had done anything inappropriate. – Brandy Tomlinson, PPI – Insufficient evidence.

On 3/8/06 Nina Rose, a nurse at Fairfield HS, reported to Cathy Hagin that she had concerns about Lauren. She reported Lauren came to school on 3/23/06 with a bite mark on her left shoulder. On 4/3/06 a burn was noted on her hand and on 5/8/06 two (2) fresh abrasions were noted on Lauren's back. Ms. Rose indicated she has attempted to discuss this with Fairfield County and they become defensive. PPI is unknown at this time. – PPI was unknown / Insufficient evidence

5/3/1999 Community Support Services was informed that a nurse at Abilities First Foundation was physically and verbally abusive to Lauren. A police report was filed with law enforcement. This case is currently under investigation. – Carol Schauer, PPI – Substantiated. (Occurred with Abilities First.)

On 2/25/1998, community support services received a report from abilities first foundation stating a staff person was observed pinching Lauren and threatening to break her arm. this incident was witnessed by two other staff members. the accused employment was terminated effective immediately. (PPI not listed, Occurred with Abilities First.) – Substantiated.

Two alleged neglect:
On 10/2/14, two Takoda Trails staff were found sleeping while on duty to care for several individuals including Lauren [redacted]. The residents were in the same room with the two staff at the time and no injuries were noted to the residents. The amount of time the staff were sleeping is unknown, but the amount of time from when the resident(s) arrived home until the discovery of staff sleeping was 45-60 minutes. Two of the residents have PICA behavior and are on visual range supervision. The other 3 are to be checked every 15 minutes. – Diana Simpson and Tanisha Hamrick, PPI's – Substantiated.

On 7/21/11, Lauren [redacted] was left on a bus without proper care and supervision from approximately 10:15am until 11:45am after the bus arrived at The Creative Learning Workshop (CLW). The PPI failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:45am when staff/individuals were leaving for an outing. – Cheryl Collins, PPI – Substantiated

One unapproved behavioral support:
Tanya Vance, Takoda Trails reported to Patrick Campbell, IA on 1-7-10 that while following up on concern from family member on 1-6-09, she discovered that CLW / workshop staff were using Lauren's wheelchair and seatbelt during mealtime to keep her in place, this is not approved in her IP.

Background information:
Lauren is a 34-year-old female that lives in Fairfield Ohio at Takoda Trails an ICF.

From her IPP 10/29/2021 – My favorite thing to do is listen to music (especially country music). I will often seek out the sources of music in my environment. While listening to music I appreciate sitting and rocking for self-stimulation. I also enjoy going for walks.

GROSS MOTOR
I have good gross motor skills. I am able to grasp items and manipulate them from hand to hand. I am able to utilize all my major muscle groups without any difficulty. I exhibit decent posture and balance. I am able to lift, bend, and carry light objects without any difficulty. I show dominance with my left hand.

FINE MOTOR
I am able to reach grasp and manipulate item from hand to hand. I am able to carry items. I would have some difficulty opening containers of various types such as milk cartons. I can hold a pen but do not have legible handwriting.

MOBILITY SKILLS
I ambulate independently within the home and other familiar areas. I may occasionally sustain minor injuries while doing so.

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Others

Due to visual impairment...A gait belt is used for me in unfamiliar environments and on wheelchair lift. The Team felt that as the injuries are almost always very minor, it is not appropriate to limit my independence while ambulating within familiar areas. Only acceptable when staff note that obstacles or other hazards make injury imminent. Whenever I am ambulating outside of my home or other familiar areas (i.e. My group's room at CLW) staff should use one-person assistance with a gait belt. When getting on or off of a bus I should be accompanied by staff on the bus lift with the use of a gait belt.

EXPRESSIVE COMMUNICATION:
I am non-verbal. I communicate via vocalizations and avoidance. I make requests by reaching for or touching a desired object. I show rejection by vocalizing and moving/pushing away. I do not typically offer any sort of greeting, nor will I initiate communication with consistency.

RECEPTIVE COMMUNICATION:
I recognize familiar voices and am able to localize sound. I respond to environmental noise/ speech at conversational levels. I recognize my name. I am able to follow routine one-step commands with verbal or physical prompts and additional processing time. I am unable to follow more complex directions. I am also unable to respond verbally or nonverbally to yes/no/wh questions. I'm not able to identify objects by label or function. I cannot comprehend basic concepts of size, shape, position or body parts. I cannot point to named objects and do not exhibit object manipulation skills which is likely limited by tactile defensiveness.

TOILETING:
I am incontinent. I wear medium (Attends). I will not indicate a need to be toileted and may offer resistance during toileting/changing. I need total assistance with all aspects of toileting and changing. I have a program to hold a clean utensil while staff changes the soiled one. I wear a body suit to prevent me from smearing fecal matter.

SHOWERING:
I demonstrate limited insight and functional ability regarding showering. I need full assistance with all showering-related tasks. I cannot do any task regarding showering on my own. I have a program to wash my torso.

INTERACTION WITH OTHERS:
My interaction with peers is very limited. I prefer to avoid other people and engage in individual activities (e.g. music, rolling ball,). I am very tactile-defensive. This interferes with most attempts at physical interaction with me. When agitated, I may scratch or hit others around me. I typically do not go out of my way to aggress toward other people.

I have behavior strategies that address my noncompliance, hitting, pinching, and scratching self. I have to have my dental appointments under GA due to noncompliance. Over the last 3 months (from plan 10-28-2021) I have had 6 instances of SIB. I wear a swim suit that does not restrict me but does delay me getting to and possible pulling out my tube. Team will continue tracking the behaviors of non compliance and SIB.

BEHAVIORAL STRATEGIES:
Disruptive Behavior (noncompliance)
-If I am noncompliant with a request

SIB
1. Let me know what you are doing (hygiene, medication, etc)
2. Let me know you will be done as quickly as possible
3. Ensure that country music is playing in the background as this tends to calm me.
4. Give her over exaggerated praise as she may or may not be more compliant with praise
-Redirect me from any SIB.
-Intervene if redirection is not accepted.

Adaptive Equipment:
While therapy recommended I use a Hi Lo bed, my guardian has selected and insisted on a regular bed with no modifications

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Others

dispite recommendation. I also have a gait belt. (worn out)

Height: 4'4", Weight 66 lbs

Diagnosis: Profound MR, Cerebral Palsy, Seizure Disorder, Cortical Blindness, Multiple Otitis Media, S/P PE Tubes, Hx of Intermittent Herpetic Stomatitis, Allergic Rhinitis,
Constipation, S/P Gastrostomy with Nissen, Myopic Astig, Chronic Periodontitis,
Nuclear Cataract, Amblyopia, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes (Hpvi Level

Medications: Tylenol 160mg q4h/prn-elevated temperature, Diastat 10mg PRN-seizures, Miralax 17gm DD-constipation, Claritin 10mg qd-allergic rhinitis, Keppra 1000mg bid
seizures, Fluticasone Nasal Spray 50mcg qd-allergic rhinitis, Lamictal 100mg qd
seizures, Bactroban-Clotrimin Cream to G-Tube site bid-prevention.

MENTAL HEALTH/EMOTIONAL DEVELOPMENT
I function within profound range of mental retardation. I scored a 1 year 2month old in the communication domain of the Vineland Adaptive Behavior Scales development. My daily living was 3 month old while my (socialization skill) were 6 month old. My adaptive behavior composite was 6 months. I have Behavior strategies that addresses my disruptive (noncompliance) and my SIB
(hitting, pinching, scratching). Over the last 6 months from May thru Sept. I have not had any instances of SIB

Guardian [redacted]

Interview of Victim: Police investigated.

IA visited Lauren on 12/7/2021. IA was not able to communicate with Lauren by any means. Lauren was on her bed sitting on her mattress rocking with her head tucked down and she repetitively brought her right arm up toward her face. IA went in looking directly at her neck but with her head tucked and arm up was not able to immediately make out the injury. However, once she lowered her arm I was able to see the injury. It was uncovered with her head still tucked down.

The outcome of reviewing the scene of the incident: IA visited the scene on 12/7/2021.

Tanya Vance was with IA we looked over her room, the rooms on Lauren's Hallway, kitchen, and dining room area. There were no obvious hazards in her room. The only hazards that were noted were in the bathroom down the hall with the adaptive tub, which had shelving in the corner that was just lying in the corner, with screws sticking out of them. The corner was blocked by pipes for the tub and shower chair and shower current. Tanya stated she found them in the corner, with no sign of blood in this room.

A broken mirror was mentioned that had been in [redacted] room.

IA viewed [redacted] room where the mirror was found and the mirror has already been removed and was in the QDP office in another home. IA went over to that home and checked the mirror and the shirt that Lauren was found in. Tanya stated the mirror was attached to the wall in [redacted] room. No broken mirror or broken pieces of frame were noted, the mirror apparently had been broken several days if not weeks earlier.

Review of physical evidence/photos:

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Others

Tanya dated photos were taken of Lauren's injury by Sandy Osterberger after she discovered the injury before she was sent to the hospital on 11/30/2001.

Photo's of blood after the incident was discovered.

Photos of injury from the hospital.

The mirror that was hanging on the wall in [redacted] room that was mentioned as broken. The frame is plastic and this was the part of the mirror that is broken. It was reported to have been broken for several weeks prior to this incident. Brian Petrak ADOM came over and verified it was attached to the wall in [redacted] room by the screw seen on upper right part of the mirror in [redacted] room and for removal it. The photo was taken in another home, they had moved the mirror to the QSP's office. This is not a photo of the mirror in [redacted] room.

Brian showing approximately how the mirror was hanging on the wall. Brian did not indicate that any parts were protruding from the wall. Photos of close-ups of the mirror frame.

While on the subject of the mirror it was noted in the police report that Tammy Noonan, Program director with Takoda Trails, retrieved the piece of mirror from Lauren's room, and was asked not to. IA followed up with Tammy and the Detective on this matter to clarify if a piece of the mirror was found in Lauren's room. Tammy stated that someone had taken the mirror out of [redacted] room and it was in Lauren's room. After the discovery of the incident, She stated she did not want to leave the mirror in Lauren's room and was going to take it to the office when the police officer told her not to move it. It was the whole mirror and not a piece of the mirror. She did not observe any broken pieces of the mirror in Lauren's or [redacted] room. The Detective verified this as well that they only found the mirror frame to be broken and no pieces off of the frame were found in any of the rooms, the mirror was originally found in [redacted] room.

Where Mirror was located in [redacted] room. You can see in this photo the screw holes just below the poster on the wall.

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Others

Photos of the top Lauren was in when found with injury. Dried blood seemed to be only on the collar and a few small spots on the front of the top. The material was soft and stretchy around the collar, except for the dried blood area in front.

Lauren's bathroom, where staff stated they showered Lauren the morning of the incident. The shower hose was damaged and taped up. No sharp edges were noted on the hose. Tanya stated the hose was taped prior to the discovery of the injury.

Other side of Lauren's bathroom, only noted corner of the sink came to a point.

Her hygiene bucket, noted nail clippers.

Lauren's bedroom from standing in the bathroom doorway. Lauren sitting on her bed rocking. No sharp objects were found in the room. The bed frame is wood no sharp edges noted.

The other side of Lauren's room faces towards the bathroom door, looking into her closet.

Tanya Vance pointed to approximately where drops of blood were seen in the hallway, IA pointing to the door on the left, Lauren's room. Tanya is just past [redacted] room (the open doorway).

The bathroom in the same hallway as Lauren's bedroom which has a walking-in bathtub. Tanya found shelving that was off the wall and was in the corner where you can see the white privacy screen, but the path to the shelves would been blocked by shower chair and pipes from the wall. The shelving still had screws attached to brackets. Shelving was still in the room under the cabinet on the wall.

Stove in the kitchen area, pointed corners but not sharp.

Pantry

Laundry room
Kitchen and dining area

Notification of Law Enforcement / CS: 11/30/2021 7:47 am Fairfield PD, Thomas Portalatin 135
The outcome of Law Enforcement / CS: Detective Ellie M. King, Investigations with Fairfield Police Department

IA had access to the police report but did not include the report in this document as the police report cannot be re-released by the Butler County Board of DD. Time and information in this report are from witness statements received from the provider and interviews by IA.

The case was reviewed with the prosecutor and at this time no charges were filed.

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Others

IA spoke to Sgt. Pete Lagemann, with Fairfield PD and he gave permission to use the Detective's summary in my report. IA has a copy of the police report, but it is noted on the report that it is for Butler County Board of DD – "We were asked to forward a copy of our investigative report to Butler County DD concerning Lauren Carter at Takoda Trails. This is an investigative report that is the property of the Fairfield Police Department and it is not meant for public release."

Summary from the police report:
"Although I believe DeSalvo Curtis was aware of Lauren [redacted] injury, I am unable to prove where and when the injury occurred. Based on several medical professionals the injury would have had to happen on DeSalvo's shift, several hours before Lauren received medical attention. DeSalvo was the only employee in Lauren's House in the time frame the injury occurred.

Secondly, the wound would have bled significantly at the time of the cut. DeSalvo either caused the injury herself or someone else did, possibly a resident, but either way the end conclusion is DeSalvo knows what happened and failed to seek medical attention for Lauren. In any medical event DeSalvo is to, at the very least, contact the On Call Nurse, Tracy Hacker, and she failed to do so. Someone had to have cleaned up the scene and no resident would have been able to do so physically and without DeSalvo knowing. If a stranger came into the building to harm Lauren, they certainly would not have stopped to clean up the scene, and again without DeSalvo knowing.

DeSalvo was the only employee to have several inconsistencies in her statements to police. DeSalvo was named in a prior incident with another resident who was injured roughly a month before. She was not cooperative in the facility's investigation and was documented as having a story that "did not make sense." When questioned further she refused to review the incident with the supervisor." This was an IA incident and the provider addressed the matter with disciplinary action.

Summary of review of documents:

11/29/2021 – approximately 3:00 pm – 11:00 pm – DSP Vikki Perry was assigned to Lauren – Lauren went to sleep after her dinner – no injury observed – DeSalvo didn't want to do rounds when she came in

11/29/2021 – approximately 3:00 pm – 11:00 pm – DSP Prosper Rumi – no injury observed

11/29/2021 – approximately 11:00 pm – DSP – DeSalvo Curtis came on shift, Lauren was already in bed.

11/30/2021 – approximately 1:00 am – 2:00 am Tracy Hacker, LPN – came to home for about an hour. Did not see DeSalvo, looked into Lauren's room and saw her on her bed sitting with back against wall, likely asleep. Believes was in same top.

Witness statements from provider:
DeSalvo Curtis 11/30/2021 – At 6:30 am, I gave Lauren [redacted] bath because she has pooped all over herself, it took about 15 minutes for me to bath and dress her. I was out of her room by 6:45 am, I proceeded to go and get my other residents cleaned, changed and dressed. I left out for a break at 7 something (7:15-7:30 am) after 1st shift staff came in. I came back in the building at 7:30 am to start breakfast, by 7:45 am, by 7:45 I was notified about Lauren C.

Sandy Odenbarger, LPN – Reporter – 11/30/2021 7:45 am Home #5, When I went in to do residents meds and betsy resident was sitting on her bed. I approached her to hook up her tube and she lifted her head up and I seen a laceration on her neck. I yelled for Brian. We called 911. Resident sent to UC West Chester Hospital for evaluation. – Tanya Vance added note –Entered home 5 at 7:15 am passed meds @ 7:45 am

Brian Petrak, ADON – 12/1/2021 7:48 am Home 5 – On above time and date this writer entered Lauren [redacted] room for her am tube feed and medications. Upon arrival in her room a laceration was noted to be on the right side of her neck and after limited examination, due to non-compliance the laceration appeared to be approximately 4-6" long and open very little blood. Was noted on the area or anywhere in the general location. Pressure was unable to be applied to the area due to non-compliance issues. 911 was called and Lauren was sent out and appeared to be in stable condition.

Joyce Kats, DSP 11/30/2021 – I picked up the shift for another staff that day so I did check in till about 6:45 am came to the

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Others

home 5 about 6:47 are when I came in I DeSatin in the room with Lauren so at that time I though she had that group so I sat down in the living room to watch a little bit of the news which is what I do every morning before I started to get my group up at about 7:15 am Brian came in and ask where Lauren slept because he was helping out with the other nurse so at the time I went to show him and Lauren came out of her room I took her by the hand and ask her to go back in her room then I went and showed Brian were [redacted] sleeps. Then on my way back down the hall I noticed another resident in the shower [redacted] and at that point DeSatin was done with Lauren and went out to her car so I went in that resident's room to get her out of the shower and help her get dressed which is right across from Lauren room after I was done Brian asked me where [redacted] sleeps I said follow me for on my way down to get her up now that was about 7:30 am so I went to get [redacted] up and DeSatin came in the room and ask if I heard a Big Bang I said no and she told me about Lauren

11/30/2021 7:47 am – 911 received call
11/30/2021 7:54 am – 911 arrived
11/30/2021 8:25 am– Arrived in ED (Photos taken in ED around this time.)

A – Where Lauren was reportedly found with injury, on her bed.
B – Approximately location of where drops of blood were found in the hallway
C – Wall that [redacted] mirror was attached to.
D – Wall where [redacted] mirror was against.
E – Approximately where [redacted] was reportedly found in the shower.
F – Location of shelves with screws still attached in corner of the room. Pipes from wall to tub, and privacy screen were blocking.
G – In Lauren's shower, the metal base was taped.

Two staff were on second shift from approximately 3:00 pm – 11:00 pm on 11/29/2021.
Vikki Perry, DSP was assigned to Lauren and stated that Lauren went to sleep after her shower, she did not observe any injuries. She stated that she did not do rounds with 3rd shift staff DeSatin Curtis, she had asked but DeSatin didn't want to do rounds when she came in. Lauren was in her usual routine.

IA spoke with Vikki and the Detective and clarified that the Detective had shown Vikki a pink nightgown and Vikki confirmed it was the same top she put her to bed in.

Prosper Kum, DSP was the other second shift staff and did not observe any injuries.

DeSatin Curtis, DSP came to work the third shift at approximately 11/29/2021 11:00 pm – 11/30/2021 DeSatin stated that Lauren was in bed when she came on shift.
Tanya Vance indicated that at night when individuals are in bed, they are all on hourly checks.

This is documented on "Home #5 Sleep Tracker" form. The form for 11/29/21 indicated at 9:00 pm Lauren was awake and out of bed, then at 10:00 pm she is Sleeping. (they can also document awake and in bed per the key) From 11:00 pm to 5:00 am 11/30/2021. All the documentation is consistent on it's marking of a single letter but it does not appear to match the key. Nothing is documented for the 6:00 am time frame on 11/30/2021. That is the last time frame of the documentation.
IA was not able to contact DeSatin to clarify, the Detective stated she indicated all the individuals were asleep in bed. IA did compare DeSatin's witness statement and the x's in the statement do appear to match the documentation to indicate and s for sleep. (see below for samples.)

From the witness statement from DeSatin

From Home #5 sleep tracker, no staff signature or initials on the form.
Third shift nurse, Tracy Hasher, LPN indicated that she came to the home for about an hour, Approximately 1:00 am to 2:00 am. Did not see DeSatin, looked into Lauren's room and saw her on her bed sitting with her back against wall, likely asleep.

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Others

bedroom was in the same top; No injury was observed (verified with the Detective the same pink nightgown she showed Vikki.)

Nursing notes:
Last note prior 11/19/2021 8 PM no signs or symptoms of distress noted.

11/20/2021 7:45am – Upon entering residents room to administer her meds and bolus, resident noted to have laceration to neck. Unable to do a full assessment to neck due to non-compliance. 911 called tried to apply pressure unable to due to non-compliant. Minimal amount of blood noted on bed. All parties make aware. S/O (Sandy Ostrofsky,rn)

11/20/2021 8 pm – Resident returned home with Dx of laceration of neck. 12 sutures O/I to neck. Father at bedside. Paperwork states to keep bandage on for 24 hours however no bandage in place. Father states no bandage was applied. He also states if we place a bandage on she will not tolerate it well. Sutures are to be removed by Dr. Srivastava or in ER. TDAP given in ER today. Received No New Orders. Note sutures to be evaluated in 7 days by MD. Resident re-load at this time shows no sign symptoms of distress. S/O

12/1/21 I am resting in bed quietly in bed rm easy and unlabored. Answers easily to verbal stimuli. No signs/symptoms of distress noted.

12/3/2021 1 am Staff called nurse to inform resident has a change in condition. Nurse assessed and Resident appeared to be fine at this time: T 98.9 B/P 123/108 HR 103 this nurse administered PRN Tylenol.

12/3/2021 10:31pm Resident arrived from hospital in car with dad. He stated he want to talk to the nurse I came out to talk to him because I was here when we sent her out. He asked me what happened and I told him that she was not able to bear weight on her Right leg and was showing pain to touch and weakness. Right hand was turned blue but when I rubbed it, it returned to normal, her eye were were rolling back and she was drooling excessively and blowing bubbles, not acting normal would not cooperate with getting stats or I called OCN and told her we were going to send her out for eval and she said that was okay.

12/3/2021 12:55 am Resident in room alert walking around, no sign/symptom of distress noted at this time ROM done. No sign symptom of pain noted at this time will cont. to monitor.

12/4/2021 8 am Resident continues to not bear weight on right leg, bruise noted to right hip and knee area. Forwarded to Dr. Srivastava received o/o x-ray Right hip and knee mobilen. 1 Tem Ibuprofen given due to sign/symptoms of pain. Tolerated well resident continues to not want to bear weight on right side X-ray results to MD, no dislocations/fractures noted.

(spoke to Tanya there were no reports of issues of her walking prior to 12/3/2021, and there were no observed incidents/falls.)

12/10/2021 Resident transported to hospital or suture removal 9:45 am, back to facility 12:25 pm, transported by father. Laceration to neck sutures removed. Area red in color. No drainage noted.

12/13/2021 Resident cont. to favor right side ambulating in hallway.

Seen in podiatry clinic, 12/17/2021 with new order to apply TAO to under foot calcilus and cover with moplex daily.

Lauren was seen by Dr. Srivastava 12/21/2021 no new orders.

Review of medical reports:

EMS report:
CFFD M23 A1532 emergent response to above location for a 34 y/o F with a laceration to her neck. Upon arrival, crew was met by facility staff who walked us to the Pt who presented sitting in her bed. There was very little blood noted. Pt had a laceration approximately 4 inches long and 1.5 inches wide to the right side of her neck. Pt is non verbal, blind and staff was unable to tell us where the injury occurred or when it occurred. Pt does not appear to be in any pain. Pt is transferred to cot via EMS at this

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Others

a under arm carry. Pt secured to cot rails x2 straps x2. Vitals attempted to the best of crew ability. Pt did not comply with most of the vitals attempts. A lead was unable to be obtained. The decision was made to transport the Pt to West Chester ED. Notification call made to West Chester ED while en route. Pt status monitored throughout transport, no changes noted. Upon arrival at ED, Pt taken to Bed 23, transferred via sheet drag and secured rails x2. Verbal report given to RN, transferred care of Pt to ED staff. Crew clear of hospital and returning to the city. Andrew Bennett Firefighter/Medic #90

IA was not able to determine why she was taken to Westchester ER, instead of Mercy ER which is closer but the EMS made the determination to do so. It was suggested that if Mercy's ER was very busy they may have been directed there, but this was is not known.

Medical records
11/30/2021 – 8:25 am Patient arrived in ED

Triage physical exam in ED
Constitutional: Comments: Frail appearing female with 10cm laceration noted to the right lateral/anterior neck.
Neck: Comments: 10cm Laceration noted to the right lateral/anterior neck, starting at the angle of the mandible and extending anteriorly through zones 2 and 3. Does not cross platysma. Laceration appears to be a clean cut, no jagged edges noted.
Skin: Comments: 10cm laceration to the right sided neck/anterior neck. Scratch marks noted to left sided neck, small bruises in different stages of healing noted to extremities.
Patient undressed and full skin assessment without other acute injuries noted.

Images from internet research, to help with location of injury and medical descriptions

Patient presents to the Emergency room via EMS with a complaint of a laceration to her right-sided neck. Unsure the age of the wound, however given lack of active bleeding, concern that it is at least several hours old. No significant bleeding noted on her shirt, no active bleeding from the wound. Patient is unfortunately MROD: nonverbal. This laceration is a zone 2 laceration of the neck, fortunately does not cross the platysma, no concern for structural injury. Patient was given Haldol and Versed IM initially prior to assessment of the laceration, we did attempt to get an IV line for further sedation as needed to facilitate repair, however were unable to obtain an ultrasound-guided IV line. Patient was subsequently given another dose of IM Haldol and Versed. Patient's wound was closed as noted above, with copious irrigation, and good wound approximation. Patient did tolerate the procedure with minimal difficulty. Seriously, and local PO are reviewed due to the unclear nature of the laceration.

ED provider notes by Jessica Stonko, NP – Lac Repair performed by – Graduate Education
Frontier Nursing University – Hyden, KY (NP/Master of Science in Nursing, Family Nurse Practitioner)
Undergraduate Education Cedarville University – Cedarville, OH

Authorized by Robbie E Paulsen, MD – EDUCATION/CREDENTIALS
Residency: University of Cincinnati
Medical Degree: Emory University School of Medicine
Bachelor of Arts: Washington University in St. Louis
SPECIALTIES: Emergency Medicine

Review PI's / MLA's for peers in home.

Peers on same side of home

[redacted] ...ently around living area. Demonstrate limited ...gle communication.

[redacted]

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Others

[redacted]

Peers on other side of home:

[redacted]

Did the agency provider conduct an internal review? Yes
Did the agency submit a review within 14 days of becoming aware of the incident? No, Police were conducting investigation.

Summary of interviews:

Ellie King, Detective with Fairfield PD, complaintd interviews.

[redacted] Guardian
Tonya Vance, MUI investigator with Takoda Trails
Joyce Katz, DSP with Takoda Trails
Sandra "Sandy" Ostenberger, LPN with Takoda Trails
Brian Petrak, ADON with Takoda Trails
Vikki Perry, DSP with Takoda Tails
DeSatie Curtis, DSP with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kumi, DSP with Takoda Trails
Lynnette Whitaker, DSN with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Noonan, Program director with Takoda Trials

IA Spoke to the following

[redacted] individual – Terry is nonverbal, but is able to gesture. He did not make any indication of knowledge of the incident.

[redacted] individual – did not make any indication of knowledge of the incident.

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Others

[redacted] individual by Tanya Vance – no indication of knowledge of incident.

Other residents were in home were not reported to be on this side of the home, or were non ambulatory [redacted]

Tanya Vance, MAR investigator with Takoda Trails – IA has spoken to Tanya several times, we met at home to review scene. And throughout the investigation. IA reviewed the summary of the police report with her and again with her and William Maynard. Notified her of DeSalin not scheduling a follow up interview with the Detective.

Ellie King, Detective with Fairfield PD

Joyce Katz, DSP with Takoda Trails – IA spoke to Joyce on two occasions once in person at the facility and once on the phone, she stated her account and this was consistent with statement and police interview. IA had ask for clarification on when she found Lauren in the hallway – Joyce found Lauren out in the hallway and led her back to her room by placing hand on her back. Lauren did not want get in bed and she left her standing in her room with music playing she did not notice the injury or blood. There were a few drops of blood in the hallway approximately where she found Lauren. Joyce does state that it is possible Lauren could have been injured then and that she did not notice. At this time DeSalin was not in the area. Lauren routinely keeps her head down. Joyce brought up she thought DeSalin was acting odd. When she came to her after seeing the injury she asked did you hear a big boom? When she asked why DeSalin told her about Lauren injury and they went to see her. She also stated it was odd to have found [redacted] in the bathroom naked and with the shower going when she went back to the wing. To her knowledge [redacted] has never done this. She stated DeSalin was acting odd a few days after the incident, making people stay with her on third shift. She also brought up she thought it was odd that laundry was already completed, as they normally wait until they get everyone before doing it. But she also stated she may have extra laundry from the night before to do. Joyce could not think of any causes and hoped no one would have done that to Lauren. Joyce did not notice any concerns with Lauren walking or changes in her gait at the time she saw her.

Brian Petrat, ADON with Takoda Trails – IA spoke to Brian on two occasion once in the home when he confirmed where the mirror was in [redacted] room and once on the phone, to clarify if he had seen Lauren in the hallway when Joyce stated she saw her and took her back to her room. He indicated he did not see her prior to Sandy discovering the injury he was in home helping pass medications. He did ask Joyce for help to see where individuals were.

Vikki Perry, DSP with Takoda Trails – IA spoke to Vikki on the phone she confirmed that when she spoke to the Detective and saw the pink gown that she had told the Detective that is what she thought she put her to bed in that night. She indicated she did not see any injuries or change in Lauren's behavior before she left her shift.

Tammy Nocenas, Program director with Takoda Trails- IA spoke to Tammy on the phone, to confirm if she had picked up a piece of the mirror in Lauren's room. She indicated that no she had not seen any pieces of the mirror. But the someone had moved the mirror into Lauren's room and she did try to move it but she was going to put it in office as it was broken and was a hazard. But the officer told her not to move it.

[redacted] Guardian, IA spoke to the guardian. He had requested records past MAR records. IA forwarded records to him. He was concerned with the number of incidents over the years and the provider never knowing what happened. He voiced concerns with the provider and her placement, he was hoping this incident would get the provider to more closely monitor Lauren. IA talked to him about being able to get a SSA assigned and they could speak to him about placement options [redacted] talked about wanting to add a camera to her bedroom.

Interview medical professionals

Michelle Truett, QA RN with BCBDD – Reviewed photos of injuries with Michelle. She did think that there would have been more bleeding than what the photos show. That the way Lauren holds her head could have naturally help put pressure on the wound. She was not sure about estimating how old the wound was. The review was mainly for any possible thoughts or cause or what to look for, mainly a sharp object.

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Others

Kathy Talbot, QA RN with BCBDD– Reviewed photos of injuries with Kathy, she contact IA the was not sure how such a injury could occur accidently, but would have been from a sharp object the cut was very clear. IA had seen photos of kids string injuries and she reviewed them as well. She advised to check the shirts collar and blanket. IA did check the shirt and bedding at home visit and did not find any sharp objects.

IA left messages for ER personnel at the hospital but did not receive a return call.

IA contacted Lisa K. Manny M.D. Butler County Coroner and asked her opinion on the age of the wound, when she spoke to the Detective. She stated she was not able to give an opinion on how old the wound was, but said she would refer me to the Pathologist that they have on contract. Dr. Gary Utz.

Dr. Gary L. Utz is a pathologist in Cincinnati, Ohio. He received his medical degree from University of Cincinnati College of Medicine and has been in practice for more than 20 years.

Dr. Gary Utz – stated that it is hard to know age, and bleeding can vary from his experience of seeing people attempt to cut themselves. Laceration is a cut on a irregular fashion, Incision is defined as a very regular cut made by sharp object. IA sent him photos of laceration and hospital records.

His response: This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear incorporation above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

IA asked to clarify if he thought there would be more bleeding after seeing the photos, and how long he thought it would take for drops of blood to dry.

His response: There does appear to be dried blood around the wound and smeared blood on her hand. It would seem that more blood would be present, suggesting that it was wiped away but I am not certain about that. As for the time for blood spots to dry, in my experience crime scene techs seem to have better handle on that. It would be easy to test. (IA did not locate same to get a estimate of time.)

Evaluation of credibility

PFI: Per the Detective, PFI had inconsistency in her account.

The Detective indicated that DeSalvo did not schedule a follow-up interview when requested. DeSalvo stated she could not because of her schedule. The Detective was going to offer a VSA in this interview but did not get a chance to. When IA was made aware of this, IA contacted the provider and they placed DeSalvo on leave until she scheduled an interview with the Detective. To date, she has not scheduled the interview. The provider is moving to terminate based on not cooperating with the investigation.

One of the witnesses IA interviewed stated she thought it was odd that the PFI, after seeing the injury, came and asked her about a "big bacon" before telling her Lauren was injured. (The witness stated the big bacon related to DeSalvo thinking someone possibly fell, but she was not aware of any incident falling.)

Reporter: Per the Detective, the reporter had a credible account.
Witnesses: Per the Detective witnesses have credible accounts.

Items in dispute:
PFI denies witnessing the injury until she was told about it by the nurse.

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Others

From the Detective's summary (see details above) medical opinions she obtained stated the wound would have likely occurred on the PPI shift when she was the only person on staff.

Medical opinion also stated that the wound have bled significantly at the time it occurred.
Detective believed that the blood was cleaned from the scene.

PPI may not have caused the injury but would have been aware and did not seek appropriate medical attention.

Opinion from pathologist
It is hard to determine the age of a wound, and amount of bleeding can vary. This is based on his experience from seeing people attempt to cut themselves. After reviewing medical records and photos he stated it would seem that more blood would be present. He suggested it was possibly wiped away, but there was no absolute certainty.

This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear excoriations above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self-inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

Witness also reported the shower to be dry after the discovery of the injury and blood drops that were found at the time of discovery of the incident were dry as well. IA did not find definite times but some research suggested a drop of blood could dry in about an hour. IA tested dry times.

Witness also found [redacted] in her shower with water running. From review with witness and Tanya Vance starting a shower on her own is not something she does, she normally requires help in showering. It was proposed that PPI may have started showering her and left. This was an unusual situation they had not seen [redacted] do this on her own.

A search of past IMLA for PPI:
No previous IMLA noted.

A search of court records for PPI:
Overtaking/Passing to Left Ctr – not entered – 9/22/2021
Insurance Required Convicted – 6/30/2015
Assured Clear Distance Ahead Convicted – 3/30/2015

Personnel file review:
Final written warning for use of cell phone, insubordinate behavior 7/2021.

On July 9th your supervisor approached you to review an injury incident of a resident that occurred while you were on shift. During this review your supervisor was to deliver an in-service and review preventative measure to ensure resident safety to you prior to you being able to work another shift. You were found in your car and reluctantly came into the home with your supervisor. You reluctance to get off the phone in order to be in-serviced on necessary tasks for your position. Your lack of cooperation and attention necessary to obtain preventative training is a direct violation of the above noted work rule.

Incident Specific Requirements – Physical Abuse:
1. Provide written statements that include a description of the amount of physical force used which may include, but is not limited to, speed of the force, range of motion, open or closed hand (fist), the sound made by impact, texture of surface if the individual was dragged or pulled, and the distance the individual was dragged, pulled, or moved.

No statements from witnesses indicated, the amount of physical force used.

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Others

Dr. Gary Utz, reviewed - This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear abrasions above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self-inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

From Detective - Although I believe DeSalvo-Curtis was aware of Lauren [redacted] injury, I am unable to prove where and when the injury occurred.

PPI is unknown, for the physical abuse. Though DeSalvo is the primary suspect, the Detective also has other possibilities such as individuals or strangers.

2. Provide a description of the individual's reaction to the physical force used (e.g., the individual fell backward or the individual's head or other body part jerked backward) and any indications of pain or discomfort experienced by the individual which may include words, vocalizations, or body movements.

No one observed an acute change in behavior.

3. Include comments made during the incident by the primary person involved.

Unknown

4. Document how the harm to the individual is linked to the physical force used by the primary person involved.

Unknown

It is still possible this incident could be caused by an accident, however, if an accident, the object/cause should have been found. Evidence has shown that the cause of the injury would most likely have been a blade-like object. This object would likely have had blood on/near it, and was accessible to Lauren, if accidental. Where blood was found, in the hallway, on her bed and blankets, there was no such object/hazard found that would likely have caused the injury. The pathologist stated the injury likely occurred from a "blade-like" object. It is less likely to have been caused by a fall into a corner of a piece of furniture, or a wheelchair for example. As in those examples would likely produce bruising as a result.

Therefore, it is more likely than not, that this was a homicide/fatal injury, caused by an object sharp enough to cause an incised wound. It is also more likely than not, that the object was purposefully removed, or covered up, as the object was not found on the scene.

It is not likely Lauren caused the injury herself. Lauren does not routinely grasp items. She would have to have grasped a sharp object and cut herself across the throat. Due to the length of the injury this likely she would have stopped. She is not known to be self-injurious in this way.

It is not likely that the injury was caused by peers.

If she were to fall or run into a fixed blade-type object, none was found. No hazards were found that would explain the cause of this injury. A mirror's frame was broken that was plastic and had some sharp edges but this was hanging on a wall and had been already noted as being broken. No loose pieces or protruding pieces were noted.

Shelving with exposed screws was found in corner of the bathroom that was blocked by shower chair, privacy screen, and piping.

Both of these hazards would have been hard for Lauren to access/fall onto and would more likely produce a laceration with

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Others

Hearing,

Again no objects were found by police or staff that would explain the injury. With the lack of explanation of an accidental injury, the injury is more likely than not to be physical abuse.

Note injuries report from hospital – Right laceration to the right-sided neck/anterior neck. Scratch marks noted to left-sided neck, small bruises in different stages or healing noted to extremities.

On 12/4/2021 she was noted to be no bearing weight on right leg and bruising noted to right hip. X-ray completed not fracture noted. She was not as verbalizing with no signs/symptoms of distress noted prior to 12/4/2021.

Reviewed preliminary findings or status within fourteen working days:
N/A, this was a police investigation. However, IA reviewed outcome of police investigation with provider when outcome was received.

Is there evidence that a separate investigation needs to occur? Neglect was added. There was an incident mentioned related to DeSalvo not cooperating with a previous incident, this was reviewed and was a UI.

Incident Specific Assessments – Neglect
1. Verify and document the duty of the primary person involved to provide care to the individual.

Provider and PPI verified that she was working the night shift. She was the only staff on duty in that home. Note: there are 6 other homes on campus, each with staff. Staff should not leave their homes at night as they are typically only one staff in each home at night. No other staff, individuals from other homes or outside visitors were reported in the home.

2. Document the medical care, personal care, or other support required but not provided by the primary person involved that consequently resulted in serious injury or placed the individual or another person at risk of serious injury. Include the time period of the alleged neglect.

From police investigation based on several medical opinions, it is thought the wound was several hours old before she received treatment. That the wound most likely occurred on PPI's shift when she was the only staff on duty. There was also a concern from medical opinions that the wound would have bled leaving more blood than was found when the wound was discovered. The lack of bleeding found after discovery leads to the blood likely having been cleaned up. Also, it was noted that the blood was dry at the time of discovery.

This leads to the PPI more likely than not having knowledge of the injury but did not seek appropriate medical treatment.

3. Verify and document the primary person involved had knowledge that the withheld medical care, personal care, or other support was needed by the individual. Such documentation might include the individual's plan of care, medical information available to the primary person involved, statements made by others to the primary person involved, statements made by the primary person involved, or training received by the primary person involved.

Police investigated and PPI denied knowledge of the injury, stating at around 6:45 am when she finished with Lauren she was not injured.

Shower was dry – this was noted witnesses, it not known for sure how long shower takes to dry, some witnesses were suspicious if a shower occurred, but it was noted by one witness that clothing was bagged outside the door of her bed room so and her top was changed at the least.

Blood was dry – this may help confirm that the injury had not happen immediately at the time of discovery.

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Others

Very little blood was found – was a major point of the police investigation of the scene being cleaned up.

Laundry was already ran - this was noted as odd by one of the witnesses.

DeSalvo had observed the injury when notified by the nurse, and went to tell Staff Joyce C. and she first stated did you hear a big boom, and then told Joyce that Lauren was injured.

Joyce found Lauren out in the hallway and led her back to her room by placing hand on her back. Lauren did not want get in bed and she left her standing in her room with music playing she did not notice the injury or blood. There were a few drops of blood in the hallway approximately where she found Lauren. Joyce does state that it is possible Lauren could have been injured then and that she did not notice. At this time DeSalvo was not in the area. Lauren routinely kept her head down.

4. Verify that the action or inaction of the primary person involved resulted in serious injury or placed the individual or another person at risk of serious injury.

From the police's report finding it is more likely than not that DeSalvo was aware of Lauren's injury and did not seek appropriate medical care.

5. Specifically describe the serious injury or risk of serious injury caused by the action or inaction by the primary person involved.

See description of injury above. If PPI was aware of the injury then there is reasonable risk, due to failure to provide timely medical treatment.
<Campbell, Patrick: Added on 1/6/2022>

Findings and Conclusions	05/06/2022	3201587

Statement of MUI rule:
Physical abuse means the use of physical force that can reasonably be expected to result in physical harm to an individual. Such physical force may include, but is not limited to:
hitting, slapping, pushing, or throwing objects at an individual.

Statement of allegation:
On 11/30/2021, it was reported to Hollie Metz, SSA On-Call/BCBDD that a laceration was discovered to Lauren Carter's neck at 7:45 am. Lauren was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause unknown. [redacted] guardian informed that the ER personnel did not believe this was an "accidental" injury. He questioned why Lauren was taken to West Chester Hospital as opposed to Mercy Fairfield, which is one street over from the facility. Takoda Trails investigator reported that police came to the facility and conducted initial investigation, but could not identify any particular cause; no person was named as a suspect. Takoda Trails investigator believed it possibly occurred during an unreported fall, but was still conducting interviews. Intake IA spoke with Supervisor of Investigations Fairfield PD. He stated there is an open investigation. They are conducting interviews and do have great concern for this injury. Lauren is blind and could not have done this to herself. Additionally, there was blood in the hallway that had been cleaned up and Lauren was changed and put back to her bed by someone.

Based on the information obtained, it is the findings of this investigator that the allegation of physical abuse is substantiated due to the following:

It is still possible this incident could be caused by an accident, however, if the cause was an accident, the object/cause should have been found. Evidence has shown that the cause of the injury would most likely have been a blade-like object. This object would likely have had blood on/near it, and was accessible to Lauren, if accidental. Where blood was found, in the hallway, on her bed and blankets, there was no such object/hazard found that would likely have caused this injury. The pathologist stated the injury likely occurred from a "blade-like" object. It is less likely to have been caused by a fall into a corner of a piece of

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Others

furniture, or a wheelchair for example. All of these examples would likely produce tearing as a result.

Lauren's environment is setup to reduce her risk of injury, with her bed low to the floor, padding on wall near bed, linen bag, dresser in closet, with no obvious hazards in her room to explain this injury.

Therefore, it is more likely than not, that this was a nonaccidental injury, caused by an object sharp enough to cause an incised wound. It is also more likely than not, that the object was purposefully removed, or covered up, as the object was not found on the scene.

It is not likely Lauren caused the injury herself. Lauren does not routinely grasp items, she would have to have grasped a sharp object and cut herself across the throat. Due to the length of the injury this likely she would have stopped, she is not known to be self-injurious in this way.

It is not likely that the injury was caused by peers.

If she were to fall or run into a fixed blade-type object, more was found. The police and the provider did search the day of discovery and no hazards were found that would explain the cause of the injury. A mirror's frame was broken that was plastic and had some sharp edges but this was hanging on a wall and had been already noted as being broken. No loose pieces or protruding pieces were noted.

Shelving with exposed screws was found in corner of the bathroom that was blocked by shower chair, privacy screen and piping.

Both of these hazards would have been hard for Lauren to access/fall onto and would more likely produce a laceration with tearing.

Again no objects were found by police or staff that would explain the injury. With the lack of explanation of an accidental injury, the injury is more likely than not to be physical abuse.

PPI is unknown for the physical abuse. Though a PPI was listed in the police report related to Neglect, the Detective also lists other possibilities for the cause of the injury such as individuals or stranger. The Detective stated she believed PPI Curtis was aware of Lauren Carter's injury. I am unable to prove where and when the injury occurred.

Statement of NOJI rule:
Neglect means when there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

Statement of allegation: see above.

Based on the information obtained, it is the findings of this investigator that the allegation of neglect is substantiated due to the following:

Police investigated and PPI denied knowledge of the injury, stating at around 6:45 am when she finished with Lauren she was not injured.

From police investigation based on several medical opinions, it is thought the wound was several hours old before she received treatment. That the wound most likely occurred on PPI's shift when she was the only staff on duty. There was also a concern from medical opinions that the wound would have bled leaving more blood than was found when the wound was discovered. The lack of bleeding found after discovery leads to the blood likely having been cleaned up. Also, it was noted that the blood was dry at the time of discovery.

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Others

Tim leads to the PPI more likely than not of having knowledge of the injury but did not seek appropriate medical treatment.

PPI was noted to have some credibility concerns:
Per the Detective, PPI had inconsistency in her account.

The Detective indicated that PPI did not schedule a follow-up interview when requested, PPI stated he could not because of her schedule. The Detective was going to offer a VSA in this interview but did not get a chance to. When IA was made aware of this, IA contacted the provider and they placed PPI on leave until she scheduled an interview with the Detective, to date, she has not scheduled the interview the provider is moving to term her based on not cooperating with the investigation.
<Campbell, Patrick Added on 5/6/2022>

Cause And Contributing Factors	05/06/2022	3301588

From pathologist:
The cause is likely from a sharp blade being drawn across the neck.
Could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it.

<Campbell, Patrick Added on 5/6/2022>

Prevention Plan	05/06/2022	3301589

PPI was removed from working in the home, later PPI was placed on leave due to failure to cooperate with the investigation, she has not scheduled a follow-up interview with the Detective as of the date of this report. The provider is moving to terminate based on this.

Staff trained on 12/1/2021 – Lauren is visual range monitoring when out of her room. She is now 15-minute checks at night time. Please ensure you check and dispose of anything in Lauren's room that may be sharp or may be harmful to her.

Lauren had seizures reviewed on 12/10/2021 at the hospital.

Lauren followed up with PCP on 12/21/2021with no new orders.

Injury has healed.

Guardian had asked for a camera to place in her bedroom, that was approved by the facility but to date has not been implemented according to the provider over how to get internet access, which Lauren or the Guardian would need to pay for.

(did need input from provider from their report.)
<Campbell, Patrick Added on 5/6/2022>

Question	05/13/2022	3303747

1. Any update from provider if the PPI was terminated based on prevention?

2. Any update on the camera situation at this time?

3. Please clarify information from the prevention, which states:
(did need input from provider from their report.)

<Chris F Young Added on 5/13/2022>

Response	05/19/2022	3307681

1. PPI was terminated.
2. The provider has approved the use of the camera but at this time the guardian has not moved forward with this.
3. IA has not received the providers report yet. IA was in contact with Tanya Vance she stated she has completed her report.

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Others

but they wanted to review it before with supervisor before submitting it. She did not indicate any additional preventive measures.
<Campbell, Patrick Added on 5/19/2022>

Question	**06/01/2022**	**3211701**

1. In follow-up to #3, has IA obtained the ICF report at this time? If so, is there any further information that should be added from the ICF report?
If not received, has this been addressed with the provider?

2. Did ICF reach the same findings/conclusions?
Thanks
<Chris C Young Added on 6/1/2022>

Response	**06/02/2022**	**3212590**

1. IA received provider report 6/2/2022.

The following was listed:

Prevention Measures:
Prevention Plan as submitted by individual's Team.
24 hr body checks have been added to the MARS by Nursing department.
There is also an increase in supervision for 10 minute checks while Lauren is in her room.
Lauren's sutures will be removed at West Chester Hospital on 12-9-21.

2. They did official appeal the outcome - also from provider report:

ADDENDUM 5-12-22:
This facility received Butler County MUI summary on 5-4-22 and then a summary synopsis on 5-12-22.
Report states that due to findings that were not shared with this facility I can only access what the facts are at hand. There have been 3 separate findings on this incident. The first finding being a Significant Injury which this incident clearly falls under this category. Lauren was required to seek medical treatment which the facility provided within a timely manner as soon as it was reported. She was accessed and treated and follow up was done in time frame for suture removal. The wound has healed and there have been no issues since then. She has returned to her normal activities.
Desarie Curtis was asked to do a follow up interview with Fairfield Police Dept. Detective Ellie King, Butler Co. IA Patrick Campbell relayed information to me that the Detective was waiting for a call back to set up an additional interview with Ms Curtis and set up a polygraph test. Ms. Curtis told the Detective she would need to check her schedule. Talbots Trails HR Dept as well as the investigator, attempted to call Desarie but received no call back. A letter was sent out to Ms. Curtis, registered, that if we did not hear from her that her employment would be terminated due to failure to comply with an investigation. As of 5-13 she had not complied and her employment has been terminated.

As far as the other 2 classifications, the facility has nothing to base a determination on for Physical Abuse and Neglect as there is a lack of evidence. The original PDC for an increase in LOS for Lauren is still in place and will continue to provide more eyes on and monitoring for Lauren's safety.
The guardian has indicated that he will be placing a camera in Lauren's room in an effort to be able to check in on her more frequently. Facility Administrator and Social Services Director has spoke with the guardian and will assist as requested with this process.

<Campbell, Patrick Added on 6/2/2022>

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MUI Report

BUTLER COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Date of Report: 5/4/2022

Individual: Lauren [redacted] Incident Number: 2021-009-0402
Investigator: Patrick Campbell Category: Alleged Physical Abuse; Significant Injury & Neglect

INITIAL STATEMENT:
On 11/30/2021, it was reported to Hello Nets, 516 On-Call/BCBDD that a laceration was discovered on Lauren [redacted] neck at 7:45 am. Lauren was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause unknown.

[redacted] guardian informed that the OE personnel did not believe this was an "accidental" injury. He questioned why Lauren was taken to West Chester Hospital as opposed to Mercy Fairfield, which is one street over from the facility.

Tanya Vance, Takoda Trails investigator reported that police came to the facility and conducted initial investigation, but could not identify any particular cause; no person was named as a suspect. Tanya believed it possibly occurred during an unreported fall, but was still conducting interviews.

Intake IA contacted Fairfield PD records, who advised this was a medic call. Police accompanied, but there is no indication that this has been assigned to Detectives. Intake IA and Assigned IA left messages for the supervisor of investigations with FPD with no response at this time.

IMMEDIATE ACTION:
Lauren received treatment upon discovery.

Photographs were obtained and reviewed.

It is unclear what happened. Assigned IA to rule out abuse or neglect.

ICF currently investigating, and we are waiting for confirmation from police to see their involvement, if any.

= Interim Report =
Intake IA spoke with Sgt. Pete Lagemann, Supervisor of Investigations/Fairfield PD. He stated there is an open investigation. They are conducting interviews and do have great concern for this injury. Lauren is blind and could not have done this to herself. Additionally, there was blood in the hallway that had been cleaned up and Lauren was changed and put back to her bed by someone. Category will be changed to suspected physical abuse, PPI still unknown.
= Rebekah Lynne on 12/1/2021 =

LIST OF PERSONS INTERVIEWED AND DOCUMENTS REVIEWED
Interviews Statements:
Lauren [redacted] Individual
[redacted], Individual
[redacted] Individual
[redacted], Individual
[redacted] terview
Tanya Vance, MUI investigator with Takoda Trails
Ellie King, Detective with Fairfield PD
Sgt. Pete Lagemann with Fairfield PD
Dr. Gary L. Orr, pathologist
Lisa K. Mosier, M.D. Butler County Coroner
Kara Frederick, QA Director with BCBDD
Joyce Katz, ISP with Takoda Trails
Sandra "Sandy" Osterberger, LPN with Takoda Trails
Brian Perrak, ADOM with Takoda Trails

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Vikki Perry, DSP with Takoda Trails
DeSabie Carns, DSP/FPI with Takoda Trails
Tracy Harbor, LPN with Takoda Trails
Prosper Hunt, DSP with Takoda Trails
Lynnette Whitaker, DON with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Keenan, Program director with Takoda Trails
Michelle Truett, QA RN with BCBHS
Kathy Talbot, QA RN with BCBHS

Documents Reviewed:
DODD Incident Report
Email notification MIII was filed
Consumer detail report
On-call report
Incident report
Past MIII's
IP's
Witness statements
Police report
Court records
Personnel records
Email correspondence
Medical records
Sleep chart
BM records

SUMMARY OF INTERVIEWS/DOCUMENTS REVIEWED

The administrative investigation commenced by Rebekah Lyons on 12/3/2021 by gathering and reviewing relevant documents, incident report, law enforcement Notified.

MIII was correctly coded: Yes. Neglect category was added after review of the police report. SA then notified the provider of the outcome of the police report and addition of the category.

Level of supervision – From IP 0/8/2021: Inside the home at Takoda Trails – Visual range (when outside of my bedroom) is eyesight of staff when outside my room. 15 minute checks while in my room.

Tonya Vance stated that at night supervision checks are hourly.

Staff document hourly if individuals are asleep.

Review of past MIII's – (11 previous MIII's since 1999)
No MIII involving current staff noted in history.

Has previously had hospitalizations for bowel obstruction.

Two previous Significant Injuries:
On 11/13/14, Laure[redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or Neglect are not believed to be a factor at this time. All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/13. This was based on observation the same day of leaving by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely

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occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.

Notified on 10/27/03 that Lauren had received 18 stitches to her left hand/fingers, after getting her hand caught in a door on 10/ 18/03 Lauren's stitches were a result of her getting her hand caught in a door [details are forthcoming, once Patrick locates the Incident Report]. Nurse's notes, however, state that Lauren had profuse bleeding on left hand ring finger, and a laceration noted on top 1/3rd of finger front and back. Also, notes that Lauren was transported to Mercy Hospital ER.

Four previous allegations of physical abuse:
On 2/20/98, Kimberly Charles, Medical Records Specialist/Fairfield Center (FC) reported that she observed Brandy Tomlinson, Resident Specialist I/FC, yell "no" to Lauren Carter and push Lauren back in her wheelchair with her right arm. She said that Brandy again yelled "No" to Lauren and pushed Lauren's head back by placing her open hand on Lauren's forehead. Kimberly immediately addressed this with Brandy and told her that she had seen what occurred. Kimberly reported that Brandy denied any wrongdoing. Another staff person was present and stated that she did not feel Brandy had done anything inappropriate. – Brandy Tomlinson, PPI – Insufficient evidence.

On 5/8/98 Nina Rose, a nurse at Fairfield HS, reported to Cathy Hagins that she had concerns about Lauren. She reported Lauren came to school on 5/23/96 with a bite mark on her left shoulder. On 6/3/96 a burn was noted on her hand and on 5/8/98 two [2] fresh abrasions were noted on Lauren's back. Ms. Rose indicated she has attempted to discuss this with Fairfield Center and they become defensive. PPI is unknown at this time. – PPI was unknown – Insufficient evidence

9/2/1999 Community Support Services was informed that a nurse at Abilities First Foundation was physically and verbally abusive to Lauren. A police report was filed with law enforcement. This case is currently under investigation. – Carol Schaaf, PPI – Substantiated. (Occurred with Abilities First.)

On 2/25/1999, community support services received a report from abilities first foundation stating a staff person was observed pinching Lauren and threatening to break her arm. this incident was witnessed by two other staff members. the accused employment was terminated effective immediately. [PPI not listed] Occurred with Abilities First.) – Substantiated.

Two alleged neglects:
On 10/2/14, two Takoda Trails staff were found sleeping while on duty to care for several individuals including Lauren [redacted]. The residents were in the same room with the two staff at the time and no injuries were noted in the residents. The amount of time the staff were sleeping is unknown, but the amount of time from when the residents arrived home until the discovery of staff sleeping was 45-60 minutes. Two of the residents have PEA behavior and are on visual range supervision. The other 5 are to be checked every 15 minutes. – Diane Simpson and Tamika Thornhill, PPI's – Substantiated.

On 7/21/13, Lauren [redacted] was left on a bus without proper care and supervision from approximately 10:15am until 11:45am after the bus arrived at The Creative Learning Workshop [CLW]. The PPI failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:45am when staff/individuals were leaving for an outing. – Cheryl Golden, PPI – Substantiated

One unapproved behavioral support:
Tanya Vance, Takoda Trails reported to Patrick Campbell, IA on 1-7-10 that while following up on concern from family member on 1-6-10, she discovered that CLW / workshop staff were using Lauren's wheelchair seat belt during mealtime to keep her in place, this is not approved in her IP.

Background information:
Lauren is a 34 year old female that lives in Fairfield Ohio at Takoda Trails on ICF

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from her IPP 10/29/2021 – My favorite thing to do is listen to music (especially country music). I will often seek out the sources of music in my environment. While listening to music I appreciate sitting and rocking for self stimulation. I also enjoy going for walks.

GROSS MOTOR
I have good gross motor skills. I am able to grasp items and manipulate them from hand to hand. I am able to utilize all my major muscle groups without any difficulty. I exhibit decent posture and balance. I am able to lift, bend, and carry light objects without any difficulty. I show dominance with my left hand.

FINE MOTOR
I am able to reach grasp and manipulate items from hand to hand. I am able to carry items. I would have some difficulty opening containers of various types such as milk cartons. I can hold a pen but do not have legible handwriting.

MOBILITY SKILLS
I ambulate independently within the house and other familiar areas. I may occasionally sustain minor injuries while doing so due to visual impairment. A gait belt is used for me in unfamiliar environments and on wheelchair lift. The Team felt that as the injuries are almost always very minor, it is not appropriate to limit my independence while ambulating within familiar areas. Only acceptable when staff note that obstacles or other hazards make injury imminent. Whenever I am ambulating outside of my home or other familiar areas (i.e. My group's room at CLW) staff should use one-person assistance with a gait belt. When getting in or off of a bus I should be accompanied by staff on the lift with the use of a gait belt.

EXPRESSIVE COMMUNICATION
I am non-verbal. I communicate via vocalizations and sounds. I make requests by reaching for or touching a desired object. I show rejection by vocalizing and moving/pushing away. I do not typically offer any sort of greeting, nor will I initiate communication with consistency.

RECEPTIVE COMMUNICATION
I recognize familiar voices and am able to localize sound. I respond to environmental cues/ speech at conversational levels. I recognize my name. I am able to follow routine one-step commands with verbal or physical prompts and additional processing time. I am unable to follow more complex directions. I am also unable to respond verbally or nonverbally to yes/no/wh questions. I'm not able to identify objects by label or function. I cannot comprehend basic concepts of size, shape, position or body parts. I cannot point to named objects and do not exhibit object manipulation skills which is likely limited by tactile defensiveness.

TOILETING
I am incontinent. I wear medium attends. I will not indicate a need to be toileted and may offer resistance during toileting/changing. I need total assistance with all aspects of toileting and changing. I have a program to hold a clean attend while staff changes the soiled one. I wear a body suit to prevent me from removing boat scatter.

SHOWERING
I demonstrate limited insight and less than usual ability regarding showering. I need full assistance with all showering related tasks. I cannot do any task regarding showering on my own. I have a program to wash my torso.

INTERACTION WITH OTHERS
My interaction with peers is very limited. I prefer to avoid other people and engage in individual activities (e.g. music; rolling ball). I am very tactile-defensive. This interferes with most attempts at physical interaction with me. When agitated, I may scratch or hit others around me. I typically do not go out of my way to aggress toward other people.

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I have behavior strategies that address my noncompliance, hitting, pinching and scratching self. I have to have my dental appointments under GA due to noncompliance. Over the last 3 months (from prior 10/29/2021) I have had 6 instances of SIB. I wear a swim suit that does not restrict and but does delay me getting to and possible pulling out my tube. Team will continue tracking the behaviors of non compliance and SIB.

BEHAVIORAL STRATEGIES:
Disruptive Behavior (noncompliance)
-If I am noncompliant with a request

SIB
1. Let me know what you are doing (hygiene, medication, etc).
2. Let me know you will be done as quickly as possible
3. Ensure that country music is playing in the background as this tends to calm me.
4. Give her over exaggerated praise as she may or may not be more compliant with praise
-Redirect me from my SIB.
-Intervene if redirection is not accepted.

Adaptive Equipment:
While therapy recommended I use a Hi Lo bed, my guardian has selected and insisted on a regular bed with no modifications despite recommendations. I also have a gait belt, restraint

Height: 4'4", Weight 66 lbs.

Diagnosis: Profound MR, Cerebral Palsy, Seizure Disorder, Corneal Blindness, Multiple Otitis Media, S/P PE Tubes, Hx of Aspiration Pneumonia, Herpetic Stomatitis, Allergic Rhinitis,
Constipation, S/P Gastrostomy with Nissen, Myositis Nodo, Chronic Pyelonephritis,
Neonatal Cataract, Retinitis, Dermatophytosis of Nail, Mechanical Ptosis, Strabismus Both Eyes,
Impair Level.

Medications: Tylenol 160mg q4h/prn elevated temperature, Diastat 10mg PRN seizures, Miralax 17gm QD constipation, Claritin 10mg qd allergic rhinitis, Keppra 400mg bid-
seizures, Flarex nasal Spray 50mg qd allergic rhinitis, Lamictal 100mg qd-
seizures, Bactroban Ointment to G/Tube site bid prn-irritation.

MENTAL HEALTH/EMOTIONAL DEVELOPMENT
I function within profound range of mental retardation. I scored a 1 year 2month old in the communication domain of the Vineland Adaptive Behavior Scales development. My daily living was 3 months old while my socialization skills were 6 month old. My adaption behavior composite was 8 months. I have Behavior strategies that address my disruptive (noncompliance) and my SIB (hitting, pinching, scratching). Over the last 6 months from May thru Sept, I have not had any instances of SIB

Guardian: [redacted]

Interview of Victim: Police investigated

IA visited Lauren on 12/7/2021. IA was not able to communicate with Lauren, by any means. Lauren was on her bed sitting on her mattress rocking with her head tucked down and she repetitively brought her right arm up toward her face. IA went in looking directly at her neck but with her head tucked and arm up was not able to immediately make out the injury. However, once she lowered her arm I was able to see the injury, it was uncovered with her head still tucked down.

The outcome of reviewing the scene of the incident: IA visited the scene on 12/7/2021.

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Tanya Vance was with IA, we looked over her room, the rooms on Lauren's hallway, kitchen, and dining room area. There were no obvious hazards in her room. The only hazards that were noted were in the bathroom down the hall with the adaptive tub, which had shelving in the corner that was just [illegible] the corner, with screws sticking out of them. This corner was touched by pipes to the tub and shower (hot and shower current. Tanya stated she found them in the corner, with no sign of blood in this room.

A broken mirror was mentioned that had been in [redacted] room.

IA viewed [redacted] room where the mirror was found and the mirror has already been removed and was in the QRF office in another locker. IA went over to Qbf home and checked the mirror and the shirt that Lauren was found in. Tanya stated the mirror was attached to the wall in [redacted] room. No broken mirror or broken pieces of frame were noted, the mirror apparently had been broken several days if not weeks earlier.

Review of physical evidence/photos:



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Tonya dated photos were taken of Lauren's injury by Sandy Osterberger after she discovered the injury before she was sent to the hospital on 11/30/2021.

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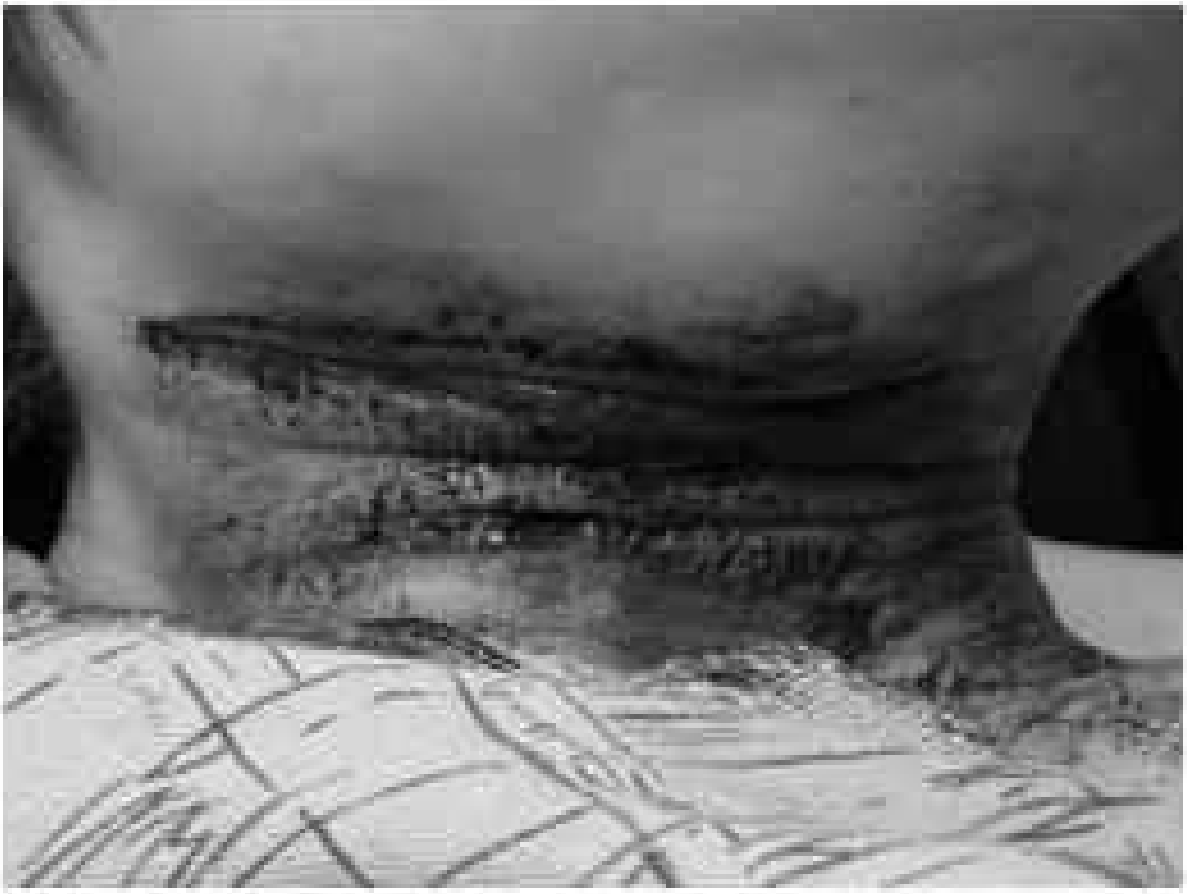


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Photo of blood after the incident was discovered.

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Photos of injury from the hospital.

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The mirror that was hanging on the wall in [redacted] room that was mentioned as broken. The frame is plastic and this was the part of the mirror that is broken. It was reported to have been broken for several weeks prior to this incident. Brain Petrak, ADON came over and verified it was attached to the wall in [redacted] room by the screw seen on upper-right part of the mirror in [redacted] room and he removed it. The photo was taken in another house, they had moved the mirror to the QIDP's office. This is not a photo of the mirror in [redacted] room.



Brian showing approximately how the mirror was hanging on the wall. Brian did not indicate that any parts were protruding from the wall. Photos of close-ups of the mirror frame.

While on the subject of the mirror it was noted in the police report that Tammy Nieman, Program director with Toledo Trails, removed the piece of mirror from Lauren's room, and was asked not to. IA followed up with Tammy and the Detective on this matter to clarify if a piece of the mirror was found in Lauren's room. Tammy stated that someone had taken the mirror out of [redacted] room and it was in Lauren's room. After the discovery of the incident. She stated she did not want to leave the mirror in Lauren's room and was going to take it to the office when the police officer told her not to move it. It was the whole mirror and not a piece of the mirror. She did not observe any broken pieces of the mirror in Lauren's or [redacted] room. The Detective verified this as well that they only found the mirror

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trauma to be broken and no pieces of the frame were found in any of the rooms, the mirror was originally located in [redacted] room.



Where Mirror was located in [redacted] room. You can see in this photo the screw holes just below the poster on the wall.



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Photos of the top Lauren was in when found with injury. Dried blood seemed to be only on the collar and a few small spots on the front of the top. The material was soft and stretchy around the collar, except for the dried blood area in front.

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Laurent's bathroom, where staff stated they discovered Lauren the morning of the incident. The shower liner was damaged and taped up. No sharp edges were noted on the liner. Tanya stated the liner was taped prior to the discovery of the injury.

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Other side of Laurens's bathroom, only actual corner of the sink came in a years...



Her hygiene bucket netted nail clippers.

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Lauren's bedroom front standing in the bathroom doorway. Lauren sitting on her bed rocking. No sharp pointers were found in the room. The bed frame is round no sharp edges noted.

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The other side of Lauren's room faces towards the bathroom door, looking into her closet.

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Tanya Vance pointed to approximately where drops of blood were seen in the hallway, lit pointing to the door on the left, Lauren's room. Tanya is just past [redacted] room (the open doorway).

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The bathroom in the same hallway as Lauren's bedroom which has a walking-in bathtub. Tanya forced shelving that was off the wall and was in the corner where you can see the white privacy screen, but the path to the shelves would have been blocked by shower chair and pipes from the wall. The shelving still had screws attached to brackets. Photographer still in the room under the cabinet on the wall.

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Stove in the kitchen area, provided, corners but not sharp.

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Pantry

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laundry room

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Kitchen and dining area.

Notification of Law Enforcement / CS: 11/30/2021 7:47 am Fairfield PD Thomas Portalatin LH
The outcome of Law Enforcement / CS: Detective Ellis M. King investigations with Fairfield Police Department

IA had access to the police report but did not include the report in this document as the police report cannot be re-released by the Butler County Board of DD. Time and information in this report are from witness statements reviewed from the provider and interviews by IA.

The case was reviewed with the prosecutor and at this time no charges were filed.

IA spoke to Sgt. Pete Lagemann, with Fairfield PD and he gave permission to use the Detective's summary in my report. IA has a copy of the police report, but it is noted on the report that it is for Butler County Board of DD – "We were asked to forward a copy of our investigative report to Butler County DD concerning Lauren [redacted] at Takoda Trails. This is an investigative report that is the property of the Fairfield Police Department and it is not meant for public release."

Summary from the police report:
"Although I believe DeSalle Curtis was aware of Lauren [redacted] injury, I am unable to prove where and when the injury occurred. Based on several medical professionals the injury would have had to happen as DeSalle's shift, several hours before Lauren received medical attention. DeSalle was the only employee in Lauren's House in the time frame the injury occurred.

Secondly, the mental would have hiked significantly at the time of the cut. DeSalle either caused the injury herself or someone else did, possibly a resident, but either way the end conclusion is DeSalle knows what happened and failed to seek medical attention for Lauren. In any medical event DeSalle is

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to, at the very least, contact the On Call Nurse, Tracy Hacker, and she failed to do so. Someone had to have cleaned up the scene and no resident would have been able to do so physically and without DeSatis knowing. If a stranger came into the building to harm Lauren, they certainly would not have stopped to clean up the scene, and again without DeSatis knowing.

DeSatis was the only employee to have several inconsistencies in her statements to police. DeSatis was named in a prior incident with another resident who was injured roughly a month before. She was not cooperative in the facility's investigation and was documented as having a story that "did not make sense." When questioned further she refused to review the incident with the supervisor." This was an OI incident and the provider addressed the matter with disciplinary action.

Summary of review of documents:

11/29/2021 – approximately 3:00 pm - 11:00 pm – DSP Vikki Perry was assigned to Lauren - Lauren went to sleep after her shower – no injury observed – DeSatis didn't want to do rounds when she came in.

11/29/2021 – approximately 3:00 pm - 11:00 pm – DSP Prosper Kumi – no injury observed.

11/29/2021 – approximately 11:00 pm – DSP - DeSatis Curtis came on shift, Lauren was already in bed.

11/30/2021 – approximately 1:00 am – 2:00 am Tracy Hacker, LPN – came to home for about an hour. Did not see DeSatis, looked into Lauren's room and saw her on her bed sitting with back against wall, likely asleep. Believes seat to same top.

Witness statements from providers:
DeSatis Curtis 11/30/2021 - At 6:00 am, I gave Lauren [redacted] bath because she has prepped all over herself, it took about 15 minutes for me to bath and dress her. I was out of her room by 6:45 am, I proceeded to go and get my other residents cleaned, changed and dressed. I left out for a break at 7 something (7:15-7:20 am) after 1st shift staff came in, I came back to the building at 7:30 am to start breakfast, by 7:45 am, by 7:45 I was notified about Lauren C.

Sandy Osterberger, LPN – Reporter – 12/30/2021 7:45 am Home #5. When I went in to do residents meds and bolus resident was sitting on her bed. I approached her to hook up her tube and she lifted her head up and I saw a laceration on her neck. I yelled for Brian. We called 911. Resident sent to UC West Chester Hospital for evaluation. – Tonya Vance added note – Entered home 5 at 7:15 am passed meds @ 7:45 am

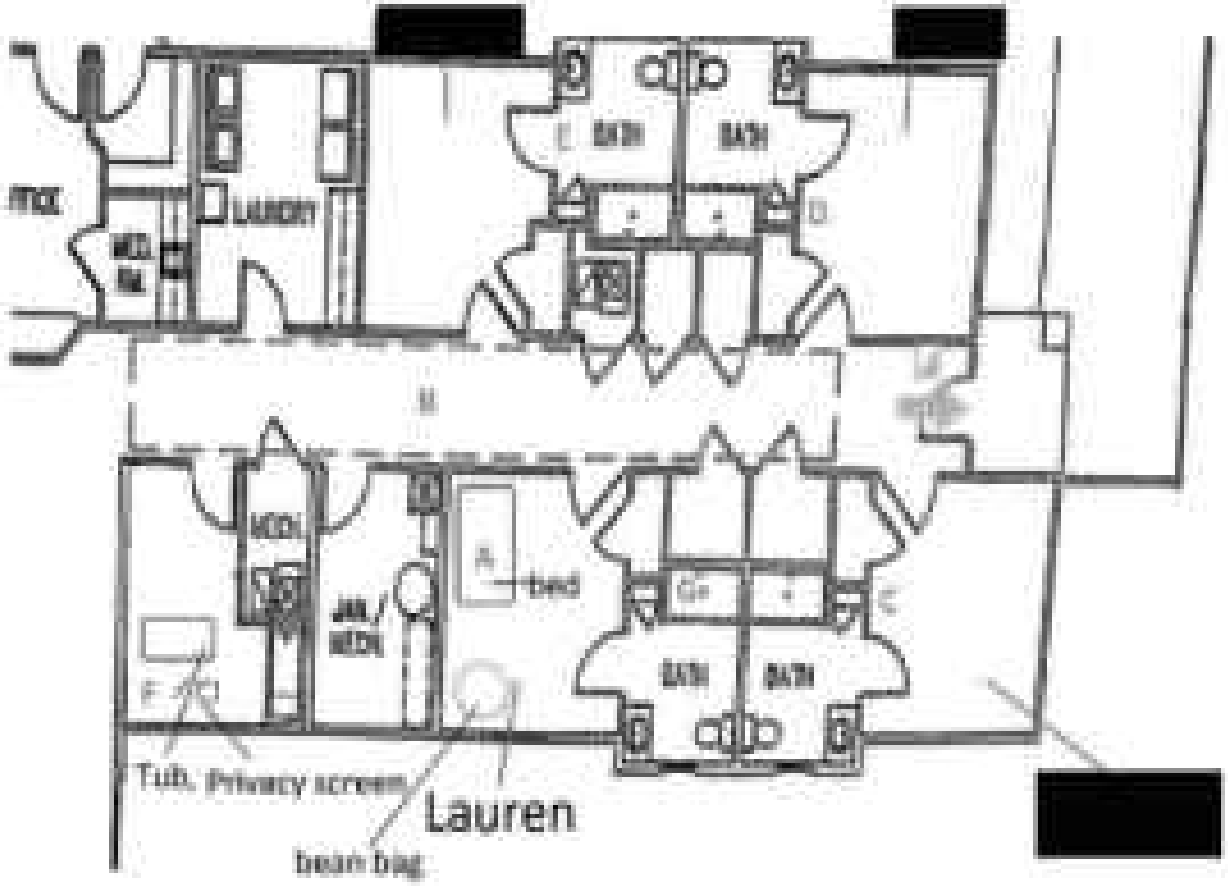
Brian Patrick, ADON – 12/1/2021 7:40 am Home 5 – On above time and date this writer entered Lauren [redacted] room for her am tube feed and medications. Upon arrival to her room a laceration was noted to be on the right side of her neck and after limited examination, due to non-compliance the laceration appeared to be approximately 4-6" long and spurt very little blood was noted on the area or anywhere in the general location. Pressure was outside to be applied to the area due to non -compliance issues. 911 was called and Lauren was sent out and appeared to be in stable conditions.

Joyce Kata, DSP 11/30/2021 – I picked up the shift for another staff that day so I did check in till about 6:45 am, came to the home I about 6:47 am when I came in I DeSatis in the room with Lauren so at that time I thought she had that group so I sat down in the living room to watch a little bit of the news which is what I do every morning before I started to get my group up at about 7:15 am Brian came in and ask where Lauren slept because he was helping out with the other nurse so at the time I went to show him and Lauren came out of her room I took her by the hand and ask her to go back in her room then I went and showed Brian were [redacted] sleeps. Then on my way back down the hall I noticed another resident in the shower [redacted] and at that point DeSatis was done with Lauren and went out to her car so I went in that resident's room to get her out of the shower and help her get dressed which is right across from Lauren room after I was done Brian asked me where [redacted] sleeps I said follow me I'm on my way

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down to get her up now that was about 7:30 am so I went to ge[redacted] up and Dellatia came in the room and ask if I heard a Big Bump I said no and she told me about Lauren

11/30/2021 7:47 am – 911 received call
11/30/2021 7:54 am – 911 arrived
11/30/2021 8:25 am- Arrived in ED (Photos taken in ED around this time.)



A – Where Lauren was reportedly found with injury, on her bed.
B – Approximately location of where drops of blood were found in the hallway
C – Wall that [redacted] mirror was attached to.
D – Wall where [redacted] mirror was against.
E – Approximately where [redacted] was reportedly found in the shower.
F – Location of shelves with screws still attached in corner of the room. Pipes from wall to tub, and privacy screen were blocking.
G – In Lauren's shower, the metal base was taped.

Two staff were on second shift from approximately 3:00 pm – 11:00 pm on 11/29/2021.
Vikki Perry, DSP was assigned to Lauren and stated that Lauren went to sleep after her shower, she did not observe any injuries. She stated that she did not do rounds with 3rd shift staff Dellatia Curtis, she had asked but Dellatia didn't want to do rounds when she came in. Lauren was in her usual routine.

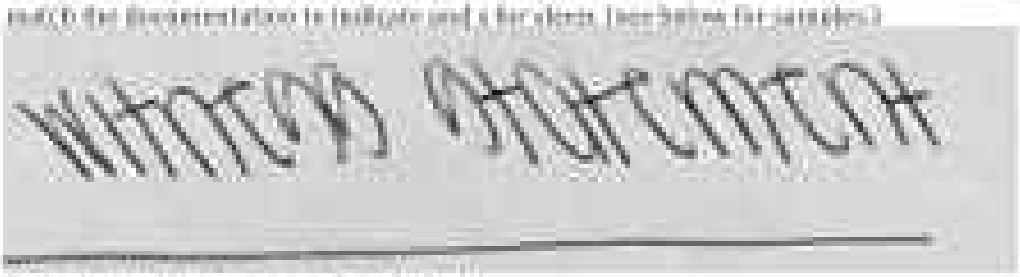
IA spoke with Vikki and the Detective and clarified that the Detective had shown Vikki a pink nightgown and Vikki confirmed it was the same top she put her to bed in.

Prosper Hunt, DSP was the other second shift staff and did not observe any injuries.

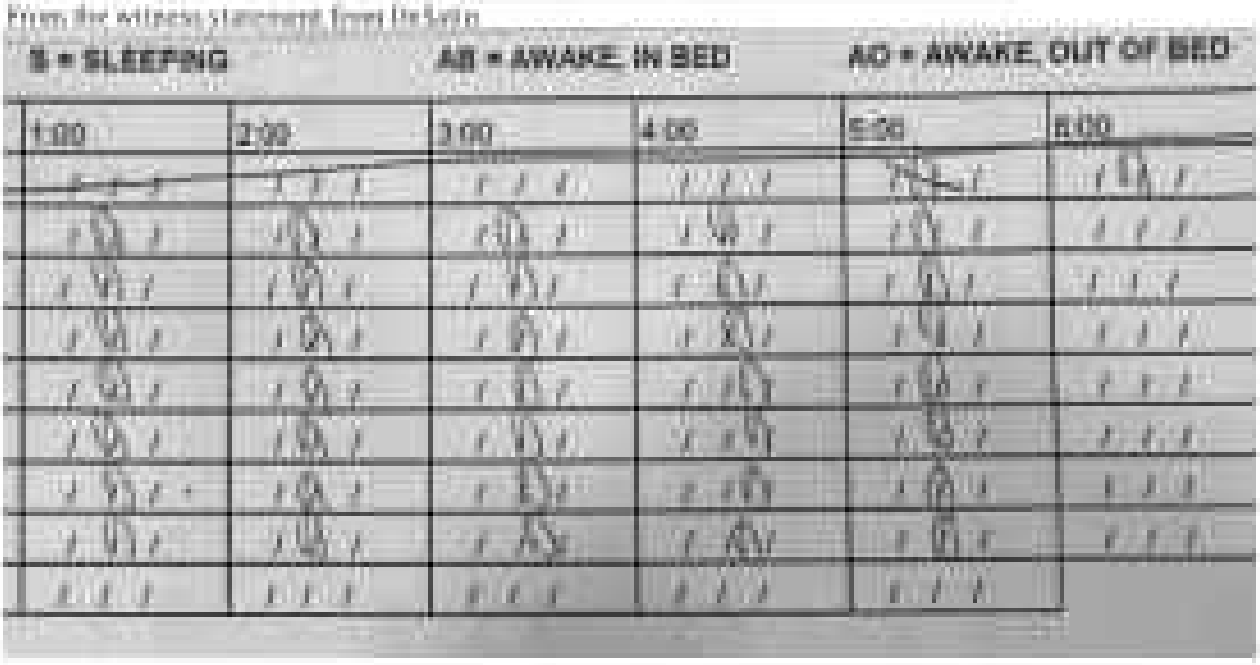
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DeSatia Curtis, DSP came to work the third shift on approximately 11/29/2021 11:00 pm – 11/30/2021 DeSatia stated that Lauren was in bed when she came on shift.
Tanya Vance indicated that at night when individuals are in bed, they are all on hourly checks.

This is documented on "Home #5 Sleep Tracker" form. The form for 11/29/21 indicated that 9:00 pm Lauren was awake and out of bed, then at 10:00 pm she is Sleeping. (They can also document awake and in bed per the key.) From 12:00 pm to 5:00 am 11/30/2021, all the documentation is consistent in it's marking of a single letter but it does not appear to match the key. Nothing is documented for the 6:00 am time frame on 11/30/2021. That is the last time frame of the documentation.
IA was not able to contact DeSatia to clarify, the Detective stated she indicated all the individuals were asleep in bed. IA did compare DeSatia's witness statement and the x's in the statement do appear to match the documentation to indicate asleep and x for awake. (see below for samples)



From the witness statement form DeSatia



From Home #5 sleep tracker, no staff signature or initials on the form.
Third shift nurse, Tracy Hacker, LPN (sole) said that she came to the home for about an hour. Approximately 1:00 am to 2:00 am. Did not see DeSatia, looked into Lauren's room and saw her in her bed sitting with her back against wall. Body asleep. Believes was in the same top. No injury was observed (verified with the Detective the same pink nightgown she showed Vikki.)

Nursing noted:
Last note prior 11/19/2021 9:07M no signs or symptoms of distress noted.

11/30/2021 7:45am - Upon entering resident's room to administer her meds and bolus, resident noted to have laceration to neck. Unable to do a full assessment to neck due to non-compliance. 911 called, tried to apply pressure unable to due to non-compliant. Minimal amount of blood noted on bed. All parties made aware. S.O. [Sandy Unterberger]

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11/30/2021 6 pm – Resident returned home with Rx of laceration at neck. 12 sutures D/I to neck. Father at bedside. Paper neck crates to keep bandage on for 24 hours however no bandage in place. Father states no bandage was applied. He also states if we place a bandage on she will not tolerate it well. Sutures are to be removed by Dr. Srivastava or in ER. TDAP given in ER today. Received No New Orders. Next sutures to be evaluated in 7 days by MD. Resident in bed at this time shows no sign symptoms of distress. S.O.

12/1/21 I am resting in bed quietly in bed eyes closed and unlabored. Airways easily to normal attitude. No signs/Symptoms of distress noted.

12/2/2021 I am Staff called nurse to inform resident has a change in condition. Nurse assessed and Resident appeared to be fine at this time. T 96.9 H/P 133/106 RR 103 this nurse administered PRN Tylenol.

12/3/2021 10:15pm Resident arrived from hospital in car with dad. She stated he want to talk to the nurse. I came out to talk to him because I was here when we sent her out. He asked me what happened and I told him that she was not able to bear weight on her Right leg and was showing pain to touch and weakness. Right hand was turned (like) but when I rubbed it, it returned to normal. Her eye were were rolling back and she was drooling excessively and blowing bubbles, not acting normal speech not cooperate with getting vitals so I called DON and told her we were going to send her out for eval and she said that was okay.

12/3/2021 12:03 am Resident is awake alert walking around, no sign/symptom of distress noted at this time ROM done. No sign symptom of pain noted at this time will cont. to monitor.

12/4/2021 8 am Resident continues to not bear weight on right leg, bruise noted to right hip and knee area. Forwarded to Dr. Srivastava received x/o x-ray Right hip and knee medides. 11am Ibuprofen given due to sign/symptoms of pain. Telemed well resident continues to not want to bear weight on right side X-ray results to MD, no dislocations/fractures noted.

[spoke to Tanya there were no reports of issues of her walking prior to 12/3/2021, and there were no observed incidents/falls.]

12/10/2021 Resident transported to hospital or return received 9:45 am. back to facility 12:25 pm/ transported by father. Laceration to neck sutures removed. Area red in color. No drainage noted.

12/13/2021 Resident room to floor right side ambulating in hallway.

Seen in podiatry clinic. 12/17/2021 with new order to apply TAO to under foot calcaleus and cover with surplus daily.

Lesions was seen by Dr. Srivastava 12/21/2021 no new orders.

Review of medical reports:

EMS report
EMS M93 AL332 emergent response to above location for a 84 y/o F with a laceration to her neck. Upon arrival, crew was met by facility staff who walked us to the Pt who presented sitting in her bed. There was very little blood noted. **Pt had a laceration approximately 4 inches long and 1.5 inches wide to the right side of her neck.** Pt is A+O x3 verbal, blind and staff was unable to tell us when the injury occurred or when it occurred. **Pt does not appear to be in any pain.** Pt is transferred to cot via EMS sl with assist arm carry. Pt secured to cot radio x2 straps x2, Vitals attempted in the best of crew ability, Pt did not comply with most of the vitals attempts. A load was unable to be obtained. **The decision was made to transport the Pt to West Chester ED.** Notification call made to West Chester ED while en route. Pt status monitored throughout transport, no changes noted. Upon arrival at ED, Pt taken to Bed 23, transferred via chair drug and secured radio x2. Verbal report given to RN, transferred

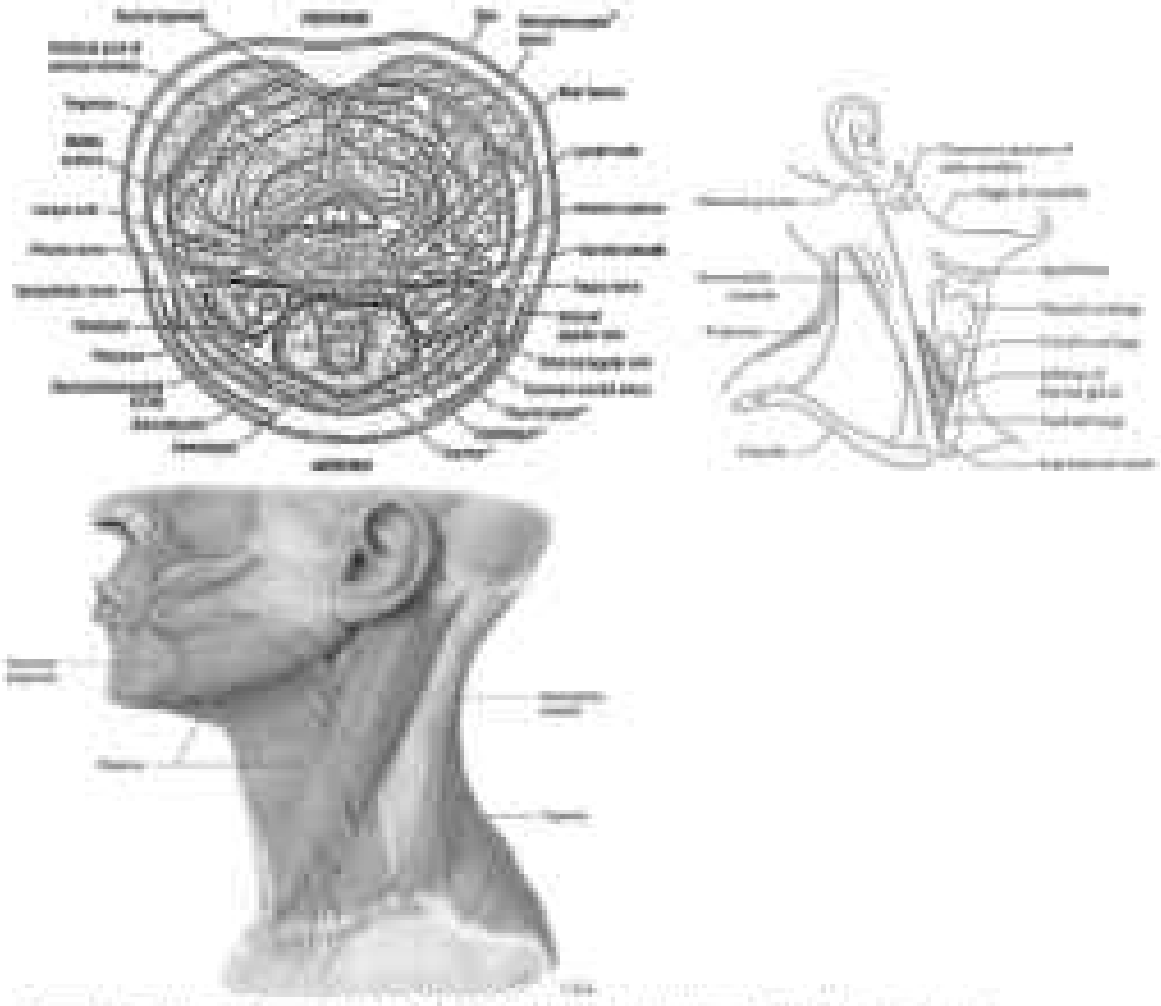
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care of PI to ER staff. Crew clear of hospital and returning to the city. Andrew Bethany Firefighter/Medic #98

[It was not able to determine why she was taken to Westchester ER instead of Mercy ER which is closer but the EMS made the determination to do so, it was suggested that if Mercy's ER was very busy they may have been directed there, but this was is not known.]

Medical records
11/30/2021 - 0:25 am Patient arrived to ER

From physical exam in ER
Constitutional: Comments: Frail appearing female with 10cm laceration noted to the right lateral/anterior neck.
Neck: Comments: 10cm laceration noted to the right lateral/anterior neck, starting at the angle of the mandible and extending anteriorly through zones 2 and 3. Does not cross platysma. Laceration appears to be a clean cut, no jagged edges noted.
Skin: Comments: 10cm laceration to the right sided neck/anterior neck. Scratch marks noted to left sided neck, and bruises in different stages of healing noted to extremities.
Patient undressed and HEAD-to-TOE assessment without other acute injuries noted.



Images form internet research, to help with location of injury and medical descriptions

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Patient presents to the Emergency room via EMS with a complaint of a laceration to her right-sided neck. Unsure the age of the wound, however given lack of active bleeding, **concern that it is at least several hours old.** No significant bleeding noted on her shirt, no active bleeding from the wound. Patient is unfortunately MRSD, nonverbal. This laceration is a zone 2 laceration of the neck, fortunately does not cross the platysma, no concern for structural injury. Patient was given Haldol and Versed IM initially prior to assessment of the laceration, we did attempt to get an IV line for further sedation as needed to facilitate repair, however were unable to obtain an ultrasound guided IV line. Patient was subsequently given another dose of IM Haldol and Versed. Patient's wound was closed as noted above, with copious irrigation, and good wound approximation. Patient did tolerate the procedure with minimal difficulty. Security, and local PD are involved due to the unclear nature of the laceration.

ED provider notes by: Jessica Hanlin, NP - Lac Repair performed by - Graduate Education
Frontier Nursing University - Hyden, KY [MP/Master of Science in Nursing, Family Nurse Practitioner]
Undergraduate Education Gallaudet University - Gallaudet, DH

Authorized by Robbin E Faulkner, MD - EDUCATION/CREDENTIALS
Residency: University of Cincinnati
Medical Degree: Emory University School of Medicine
Bachelor of Arts: Washington University in St. Louis
SPECIALTIES Emergency Medicine

Review HP's / HSIs for pages in frame:

Page on same side of frame:

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Page on other side of frame:

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[redacted]

[redacted]

Did the agency provider conduct an internal review? Yes
Did the agency submit a review within 14 days of becoming aware of the incident? No. Police were conducting investigation.

Summary of interviews:

Ellie King, Detective with Fairfield PD, completed interviews.

[redacted] Guardian
Tonya Vance, WIB investigator with Takoda Trails
Joyce Katz, DSP with Takoda Trails
Sandra "Sandy" Osterberger, LPN with Takoda Trails
Brian Patrick, ADON with Takoda Trails
Nikki Perry, DSP with Takoda Tails
DeSatta Curtis, DSP with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prospet Rizer, DSP with Takoda Trails
Lynnetta Whitaker, DHH with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Brisson, Program director with Takoda Trails

IA Spoke to the following
[redacted], individual – [redacted] is non-verbal, but is able to gesture. He did not make any indication of knowledge of the incident.
[redacted], individual – did not make any indication of knowledge of the incident.

[redacted], individual by Tanya Vance – no indication of knowledge of incident.

Other residents were in home were not reported to be on this side of the house, or were non-ambulatory [redacted].

Tanya Vance, WIB investigator with Takoda Trails – IA has spoken to Tanya several times, we met at home to review scene. And throughout the investigation. IA reviewed the summary of the police report with her and again with her and William Maynard. Notified her of DeSatta not attending a follow-up interview with the Detective.

Ellie King, Detective with Fairfield PD
Joyce Katz, DSP with Takoda Trails – IA spoke to Joyce on two occasions once in person at the facility and once on the phone, she stated her account and this was consistent with statement and police interview. IA looked for clarification on when she found Lauren in the hallway – Joyce found Lauren sat in the hallway and led her back to her room by placing hand on her back. Lauren did not want get in bed and she left her standing in her room with music playing she did not notice the injury or blood. There were a few drops of blood in the hallway approximately where she found Lauren. Joyce does state that it is possible Lauren could have been injured then and that she did not notice. At this time DeSatta was out in the area. Lauren routinely keeps her head down. Joyce brought up she thought DeSatta was acting odd, when she came to her after seeing the injury she asked did you hear a big bump? When she asked why DeSatta told her about Lauren injury and they went to see her. She also stated it was odd to have found [redacted] in the bathroom soiled and with the shower going when she went back to the wing. To her knowledge [redacted] has never done this. She stated DeSatta was acting

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said a few days after the incident, making people stay with her an extra shift. She also brought up she thought it was odd that laundry was already completed, as they normally wait until they get everyone before doing it. But she also stated she may have extra laundry from the night before to do. Joyce could not think of any causes and responded no one would have done that to Lauren. Joyce did not notice any concerns with Lauren walking or changes in her gait at the time she saw her.

Brian Petrak, SDHS with Takoda Trails – IA spoke to Brian on two occasions once in the home when he confirmed where the mirror was in [redacted] room and once on the phone, to clarify if he had seen Lauren in the hallway when Joyce stated she saw her and took her back to her room. He indicated he did not see her prior to Saturday afternoon the injury he was in home helping pass medications. He did ask Joyce for help to see where individuals were.

Vikki Perry, DSP with Takoda Tails – IA spoke to Vikki on the phone she confirmed that when she spoke to the Detective and saw the pink gown that she had told the Detective that is what she thought she put her to bed in that night. She indicated she did not see any injuries or change in Lauren's behavior before she left her shift.

Tammy Brevum, Program director with Takoda Trials: IA spoke to Tammy on the phone, to confirm if she had picked up a piece of the mirror in Lauren's room. She indicated that as she had not seen any pieces of the mirror. But the someone had moved the mirror into Lauren's room and she did try to move it as she was going to put it in office as it was broken and was a hazard. But the officer told her not to move it.

[redacted] Guardian, IA spoke to the guardian. He had requested records post MUI records. IA requested records to him. He was concerned with the number of incidents over the years and the provider never knowing what happened. He voiced concerns with the provider and her placement; he was hoping this incident would get the provider to more closely monitor Lauren. IA talked to him about being able to get a SSA assigned and they could speak to him about placement options. Greg talked about wanting to add a camera to her bedroom.

Interview medical professionals:

Michelle Truett, QA RN with BCBDD – Reviewed photos of injuries with Michelle. She did think that there would have been more bleeding than what the photos show. That the way Lauren holds her head could have naturally help put pressure on the wound. She was not sure about estimating how old the wound was. The review was mainly for any possible lifehights or cause or what to look for, mainly a sharp object.

Kathy Talbot, QA RN with BCBDD – Reviewed photos of injuries with Kathy, she confirm IA she was not sure how such a injury could occur accidently, but would have been from a sharp object the cut was very clean. IA had seen photos of late voting injuries and she reviewed them as well. She advised to check the sheets, collar and blanket. IA did check the sheet and bedding at home visit and did not find any sharp objects.

IA left messages for ER personnel at the hospital but did not receive a return call.

IA contacted Lisa K. Wernke M.D. Butler County Coroner and asked her opinion on the age of the wound. When she spoke to the Detectives. She stated she was not able to give an opinion on how old the wound was, but said she would refer me to the Pathologist that they have an contract. Dr. Gary Uts.

Dr. Gary S. Uts is a pathologist in Cincinnati, Ohio. He received his medical degree from University of Cincinnati College of Medicine and has been in practice for more than 20 years.

Dr. Gary Uts – stated that it is hard to know age, and bleeding can vary from his experience of seeing people attempt to cut themselves. Lacerations is cut in a irregular fashion, Incision is defined as a very regular cut made by sharp object. IA sent him photos of laceration and hospital records.

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His response: This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear striations above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of assault inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

IA asked to clarify if he thought there would be more bleeding after seeing the photos, and how long he thought it would take for drops of blood to dry.

His response: There does appear to be dried blood around the wound and smeared blood on her hand. It would seem that more blood would be present, suggesting that it was wiped away but I am not certain about that. As for the time for blood spots to dry, in my experience crime scene techs seem to have better handle on that. It would be easy to test. [IA did not locate sense to get a estimate of time.]

Evaluation of credibility:

PPI: Per the Detective, PPI had inconsistency in her account:

The Detective indicated that DeSatin did not schedule a follow-up interview when requested. DeSatin stated she could not because of her schedule. The Detective was going to offer a VSA in this interview but did not get a chance to. When IA was made aware of this, IA contacted the provider and they placed DeSatin on leave until she scheduled an interview with the Detective. To date, she has not scheduled the interview. The provider is moving to terminate based on not cooperating with the investigation.

One of the witnesses IA interviewed stated she thought it was odd that the PPI, after seeing the injury, came and asked her about a "big favor" before telling her Lauren was injured. [The witness stated the big favor related to DeSatin thinking someone possibly fell, but she was not aware of any residents falling.]

Reporter: Per the Detective, the reporter had a credible account
Witnesses: Per the Detective witnesses have credible accounts

Items in dispute:
PPI denies witnessing the injury until she was told about it by the nurse.

From the Detective's summary (see details above) medical opinions she obtained stated the wound would have likely occurred on the PPI shift when she was the only person on shift.

Medical opinions also stated that the wound have bled significantly at the time it occurred. Detective believed that the blood was cleaned from the scene.

PPI may not have caused the injury but would have been aware and did not seek appropriate medical attention.

Opinion from pathologist:
It is hard to determine the age of a wound and amount of bleeding can vary. This is based on her experience from seeing people attempt to cut themselves. After reviewing medical records and photos he stated it would seem that more blood would be present. He suggested it was possibly wiped away, but there was no absolute certainty.

This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear

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excoriations above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self-inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

Witness also reported the shower to be dry after the discovery of the injury and blood drops that were found at the time of discovery of the accident were dry as well. Medical has not final definite times but some research suggested a drop if blood could dry in about an hour. IA noted dry times

Witness also found [redacted] in her shower with water running. From review with witness and Tanya Vance stating a shower on for over an hour is not something she does, she normally requires help in showering. It was presumed that PPI may have started showering her and left. This was an unusual situation they had not seen [redacted] do this on her own.

A search of past MH for PPI:
No previous MH's noted.

A search of court records for PPI:
Disturbing/Passing to Left Dir – not returned – 9/22/2021
Insurance Required Convicted - 6/30/2015
Assured Clear Distance Ahead Convicted – 3/30/2013

Personnel file review:
Final written warning for use of cell phone, insubordinate behavior 7/2021

On July 9th your supervisor approached you to review an injury incident of a resident that occurred while you were on shift. During this review your supervisor was to deliver an in service and review preventative measures to ensure resident safety to you prior to you being able to work another shift. You were found in your car and reluctantly came into the home with your supervisor. Your reluctance to get off the phone in order to be in-serviced on necessary tasks for your position. Your lack of cooperation and attention necessary to obtain preventative training is a direct violation of the above noted work rule.

Incident Specific Requirements – Physical Abuse
1. Provide written statements that include a description of the amount of physical force used which may include, but is not limited to, speed of the force, range of motion, open or closed hand (fist), the sound made by impact, nature of warfare if the individual was dragged or pulled, and the distance the individual was dragged, pulled, or shoved.

No statements from witnesses indicated, the amount of physical force used.

Dr. Gary (Ex. reviewed) – This is an incised wound not a laceration. It is the result of a sharp blade being drawn across the neck. I could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it. I cannot tell for certain from the photos, but it appears there may be more faint linear excoriations above and below the wound. If I saw similar wounds on a deceased person I would be suspicious of a self-inflicted injury with "hesitation" marks. I do not think the wound that I see in the photos is more than a few hours old. It is difficult to evaluate photos of a wound that has not been cleaned.

From Detective – Although I believe DeSatnick was aware of Lauren [redacted] injury, I am unable to prove where and when the injury occurred.

PPI is unknown for the physical abuse. Though DeSatnick is the primary suspect, the Detective also lists other possibilities such as individuals or strangers.

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2. Provide a description of the individual's reaction to the physical force used (e.g., the individual fell backward or the individual's head or other body part jerked backward) and any indication of pain or discomfort experienced by the individual which may include words, vocalizations, or body movements.

No one observed an acute change in behavior.

3. Include comments made during the incident by the primary person involved.

Unknown

4. Document how the harm to the individual is linked to the physical force used by the primary person involved.

Unknown

It is still possible this incident could be caused by an accident, however, if an accident, the object/cause should have been found. If evidence has shown that the cause of the injury would most likely have been a blade like object. This object would likely have had blood on/near it, and was accessible to Lauren. If accidental. Where blood was found, in the hallway, on her bed and bandages, there was no such object/hazard found that would likely have caused the injury. The pathologist stated the injury likely occurred from a "blade-like" object. It is less likely to have been caused by a fall into a corner of a piece of furniture, or a wheelchair for example. All in those examples would likely produce tearing as a result.

Therefore, it is more likely than not, that this was a non-accidental injury, caused by an object sharp enough to cause an incised wound. It is also more likely than not, that the object was purposefully removed, or covered up, as the object was not found on the scene.

It is not likely Lauren caused the injury herself. Lauren does not routinely grasp items. She would have to have grasped a sharp object and cut herself across the throat. Due to the length of the injury this likely she would have stopped, she is not known to be self-injurious in this way.

It is not likely that the injury was caused by peers.

If she were to fall or run into a fixed blade type object, none was found. No hazards were found that would explain the cause of this injury. A mirror's frame was broken that was plastic and had some sharp edges but this was hanging on a wall and had been already noted as being broken. No loose pieces or protruding pieces were noted.

Shelving with exposed screws was found in corner of the bathroom that was blocked by shower chair, privacy screen, and piping.

Both of these hazards would have been hard for Lauren to access/fall into and would more likely produce a laceration with tearing.

Again no objects were found by police or staff that would explain the injury. With the lack of explanation of an accidental injury, the injury is more likely than not to be physical abuse.

Note injuries report from hospital - 10cm laceration to the right sided neck/anterior neck. Scratch marks noted to left sided neck, small bruises in different stages of healing noted to extremities.

On 12/8/2021 she was noted to be no bearing weight on right leg and bruising noted to right hip. X-ray completed not Fracture noted. She was not an ambulating with no sign/symptom of distress noted prior to 12/8/2021.

Reviewed preliminary findings or status within fourteen working days:

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N/A, this was a police investigation. However, IA reviewed outcome of police investigation with provider when outcome was received.

Is there evidence that a separate investigation needs to occur? Neglect was added. There was an incident mentioned related to [redacted] not cooperating with a previous incident, this was reviewed and was a III.

Incident Specific Requirements – Neglect
1. Verify and document the duty of the primary person involved to provide care to the individual.

Provider and PPI verified that she was working the night shift. She was the only staff on duty in that home. Note: there are 6 other homes on campus, each with staff. Staff should not leave their homes at night as they are typically only one staff in each home at night. No other staff, individuals from other homes or outside visitors were reported in the home.



2. Document the medical care, personal care, or other support required but not provided by the primary person involved that consequently resulted in serious injury or placed the individual or another person at risk of serious injury. Include the time period of the alleged neglect.

From police investigation based on several medical opinions, it is thought the wound was several hours old before she received treatment. That the wound most likely occurred on PPI's shift, when she was the only staff on duty. There was also a concern from medical opinions that the wound would have bled leaving more blood than was found when the wound was discovered. The lack of bleeding found after discovery leads to the blood likely having been cleaned up. Also, it was noted that the blood was dry at the time of discovery.

This leads to the PPI more likely than not having knowledge of the injury but did not seek appropriate medical treatment.

3. Verify and document the primary person involved had knowledge that the withheld medical care, personal care, or other support was needed by the individual. Such documentation might include the individual's plan of care, medical information available to the primary person involved, statements made by others to the primary person involved, statements made by the primary person involved, or training received by the primary person involved.

Police investigated and PPI denied knowledge of the injury, stating at around 6:45 am when she finished with Lauren she was not injured.

Shower was dry – this was noted witnesses, it not known for sure how long shower takes to dry, some witnesses were suspicious if a shower occurred, but it was noted by one witness that clothing was hanging outside the door of her bed room as and her top was changed at the least.

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Blood was dry – this may help confirm that the injury had not happen immediately at the time of discovery.

Very little blood was found – was a major point of the police investigation of the scene being cleaned up.

Laundry was already out - this was noted as told by one of the witnesses.

DeSalle had observed the injury when notified by the nurse, and went to tell Staff Joyce G. and she first stated did you hear a big boom, and then told Joyce that Lauren was injured.

Joyce found Lauren sat on the hallway and led her back to her room by placing hand on her back. Lauren did not want get in bed and she left her standing in her room with music playing she did not notice the injury or blood. There were a few drops of blood in the hallway approximately where she found Lauren. Joyce does state that it is possible Lauren could have been injured then and that she did not notice. At this time DeSalle was not in the area. Lauren routinely keeps her head down.

4. Verify that the action or inaction of the primary person involved resulted in serious injury or placed the individual or another person at risk of serious injury.

From the police's report finding it is more likely than not that DeSalle was aware of Lauren's injury and did not seek appropriate medical care.

5. Specifically describe the serious injury or risk of serious injury caused by the action or inaction by the primary person involved.

See description of injury above, If PPI was aware of the injury then there is reasonable risk, due to failure to provide timely medical treatment.

FINDINGS AND CONCLUSIONS

Statement of MUI rule:
Physical abuse means the use of physical force that can reasonably be expected to result in physical harm to an individual. Such physical force may include, but is not limited to:
hitting, slapping, pushing, or throwing objects at an individual.

Statement of allegation:
On 11/30/2021, it was reported to Hollie Blatz, SSA On-Call/BCBDD that a laceration was discovered to Lauren [redacted] neck at 7:45 am. Lauren was sent to the hospital and received 12 sutures. Laceration is from the side to the middle of the neck, cause unknown. [redacted] guardian informed that the SB personnel did not believe this was an "accidental" injury. He questioned why Lauren was taken to West Chester Hospital as opposed to Mercy Fairfield, which is one street over from the facility. Tukoda Trials investigator reported that police came to the facility and conducted initial investigation, but could not identify any particular cause, no person was named as a suspect. Tukoda Trials investigator believed it possibly occurred during an unreported fall, but was still conducting interviews. Intake IA spoke with, Supervisor of Investigations/Fairfield PD. He stated there is an open investigation. They are conducting interviews and do have great concern for this injury. Lauren is blind and could not have done this to herself. Additionally, there was blood in the hallway that had been cleaned up and Lauren was changed and put back to bed by someone.

Based on the information obtained, it is the findings of this investigator that the allegation of physical abuse is substantiated due to the following:

It is still possible this incident could be caused by an accident, however, if the cause was an accident, the object/cause should have been found. Evidence has shown that the cause of the injury would most likely have been a blade-like object. This object would likely have had blood on/near it, and was

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accessible to Lauren, if accidental. Where blood was found, in the hallway, on her bed and blankets, there was no such object/hazard found that would likely have caused the injury. The pathologist stated the injury likely occurred from a "blade like" object. It is less likely to have been caused by a fall into a corner of a piece of furniture, or a wheelchair for example. As in these examples would likely produce tearing as a result.

Lauren's environment is setup to reduce her risk of injury, with her bed low to the floor, padding on wall near bed, beanbag, dresser in closet, with no obvious hazards in her room to explain this injury.

Therefore, It is more likely than not, that this was a non-accidental injury, caused by an object sharp enough to cause an incised wound. It is also more likely than not, that the object was purposefully removed or covered up, as the object was not found on the scene.

It is not likely Lauren caused the injury herself, Lauren does not routinely grasp items, she would have to have grasped a sharp object and cut herself across the throat. Due to the length of the injury this likely she would have stopped, she is not known to be self injurious in this way.

It is not likely that the injury was caused by pests.

If she were to fall or run into a fixed blade type object; none was found. The police and the provider did search the day of discovery and no hazards were found that would explain the cause of this injury. A mirror's frame was broken that was plastic and had some sharp edges but this was hanging on a wall and had been already noted as being broken. No loose pieces or protruding pieces were noted.

Shelving with exposed screws was found in corner of the bathroom that was blocked by shower chair, privacy screen and piping.

Both of these hazards would have been hard for Lauren to access/fall into and would more likely produce a laceration with tearing.

Again no objects were found by police or staff that would explain the injury. With the lack of explanation of an accidental injury, the injury is more likely than not to be physical abuse.

PPI is unknown, for the physical abuse. Though a PPI was listed in the police report related to Neglect, the Detective also lists other possibilities for the cause of the injury such as individuals or strangers. The Detective stated she believed PPI Gatlin was aware of Lauren Carter's injury. I am unable to prove where and when the injury occurred.

Statement of MDI rule:
Neglect means when there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

Statement of allegation: see above

Based on the information obtained, it is the findings of this investigator that the allegation of neglect is substantiated due to the following:

Police investigated and PPI denied knowledge of the injury, stating at around 6:45 am when she touched with Lauren she was not injured.

From police investigation based on several medical opinions it is thought the wound was several hours old before she received treatment. That the wound most likely occurred on PPI's shift, when she was the only staff on duty. There was also a concern from medical opinions that the wound would have bled leaking more blood that was found when the wound was discovered. The lack of bleeding found after

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discovery leads to the blood likely having been cleaned up. Also, it was noted that the blood was dry at the time of discovery.

This leads to the PPI more likely than not, of having knowledge of the injury but did not seek appropriate medical treatment.

PPI was noted to have some credibility concerns:
Per the Detective, PPI had inconsistency in her account.

The Detective indicated that PPI did not schedule a follow up interview when requested. PPI stated he could not because of her schedule. The Detective was going to offer a VSA in this interview but did not get a chance to. When IA was made aware of this, IA contacted the provider and they placed PPI on leave until she scheduled an interview with the Detective, to date, she has not scheduled the interview the provider is moving to term her based on not cooperating with the investigation.

CAUSE AND CONTRIBUTING FACTORS
From pathologist:
The cause is likely from a sharp blade being drawn across the neck.
Could not rule out a scenario where the individual comes in contact with a fixed sharp object, such as walking into it.

PREVENTION PLAN
PPI was removed from working in the home, later PPI was placed on leave due to failure to cooperate with the investigation, she has not scheduled a follow up interview with the Detective as of the date of this report. The provider is planning to terminate based on this.

Staff trained on 12/1/2021 – Lauren is stupid range monitoring when out of her room. She is new 15-minute checks at night time. Please ensure you check and dispose of anything in Lauren's room that may be sharp or may be harmful to her.

Lauren had suture removal on 12/10/2021 at the hospital.

Lauren followed up with PCP on 12/21/2021 with no new orders.

Injury has healed

Guardian had asked for a camera to place in her bedroom, this was approved by the facility but to date has not been implemented according to the provider over how to get internet access, which Lauren or the Guardian would need to pay for.

(Official input from provider from their report.)

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DeSatin Curtis, DSP/PFI – Contacted IA after receiving PFI letter of notification. 3/14/2022 She wanted to know what they meant. I explained the letters, her copy of the alleged physical abuse, listed unsubstantiated for her, as the PFI was listed as unknown. But I had substantiated the physical abuse for the case. The alleged neglect was substantiated with her as PFI. These were based off the police investigation. I told her the detective stated she had further questions and wanted to speak to you again. She acknowledged this and said when the detective called her about setting up another interview she was not able to meet with her due to family issues. But she stated the detective never called her back to set up a time. I stated that I would help arrange another interview with the detective as she still wanted to speak to her. She was not willing to allow me to help schedule that. She stated she may attempt to contact her. DeSatin did state she didn't cause the injury and she was not aware of the injury it until Sandy told her about it. She stated she showered her and there would be no way she would have missed that. Lauren did not have that injury when she went on break. It must have happen then there were other people in the building by then. When IA started to ask more questions, she. Only wanted to talk about what the outcome meant for her. IA again encouraged her to contact the detective and that she is required to cooperate with the investigation. She did not state anything that was different from her previous statements.

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COMMON PLEAS DIVISION

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Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 4

Ohio Department of Developmental Disabilities

Division of Information Systems

EXHIBIT

64

90DD INCIDENT REPORT (ITSI)

Incident Number: 2010-009-0006			Group Name: Butler	
Client Number: [redacted]	Client Name: [redacted] LAUREN 350 WOLB DRIVE FAIRFIELD OH 45014	Gender: F	Waiver Type on Incident:	Age at Discovery: 22

Final Dat Date	Incident Date	Discovery Date	Created Date	Fax Date
02/22/2010	01/06/2010	01/07/2010	01/08/2010	

Category Type:

DD(ITSI)

Unapproved Behavioral Support — Mechanical — Locked seatbelt/vest - not during transport

Abuse

Unapproved Behavioral Support — Mechanical — Locked seatbelt/vest - not during transport

Substantiated — Was Substantiated

Injuries

Severity: None

Supervision: Other — Met

Restrained from 8 to 0 Hrs — Restrained by wheelchair/seat belt when not necessary

Behavior Support Plan: No — Type of Injury as a Result of Restraint: n/a

Location on Body: n/a

Law:

Law Enforcement Involved: No

Living Arrange:

9000293 — (ICF/ID)

Location: Non-County Operated Program — Day Program:

Incident Provider:

7001641 — Empowering People Inc. dba EW

Residential Provider:

No Residential Provider

Adult Day/Employment Provider:

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Ohio Department of Developmental Disabilities

Division of Information Systems

GOOD INCIDENT REPORT (ITSI)

No Adult Day/Employment Provider	
Notifications 9698268 Provider: 01/06/2010 Guardian: 01/06/2010 Family: 01/06/2010 County: 01/07/2010	Corrected Notified: Accepted: Actively: Res. Closure: Res. Closure By: 02/22/2010 Karen S Bennette Incident Review Status: Closed Closed Date: Investigated By: 02/22/2010 Investigative Agent Karen S Bennette Closed By: Last Change By: Daniel L Rutter Debbie McGuire

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Others
(no first name)

Initial Report	01/08/2010	1333815

Tanya Vance, Takoda Trails reported to Patrick Campbell, IA on 1-7-10 that while following up on concern from family member on 1-6-09, she discovered that CLW / workshop staff were using Lauren's wheelchair and seatbelt during meal time to keep her in place. this is not approved in her IP
<Patrick S Campbell Added on 1/8/2010>

Immediate Action	01/08/2010	1333816

No injuries were noted. Staff were re-trained on plan
<Patrick S Campbell Added on 1/8/2010>

Final Report	02/22/2010	1345396

QII at of persons interviewed and documents reviewed
AEinterviews:
[redacted] parents/guardians
Darlene Maddowe, Administrator/CLW
Josh Morris, Admin. Assistant/CLW
Brian Petrak,ADON/Takoda Trails
Tammy Holman, Program Director/Takoda Trails
Jason Bude, PT aide/CLW
Norbert Mbame, direct care staff/CLW
Jason Bode, RSI/TT
Jennifer Doughty, RSI/TT

QIIsummary of interviews and documents reviewed
At Lauren is a 21 year old white female that resides in Norwood Lauren's supervision level is 1:1 house. Mobility with checks—Assigned staff knows general whereabouts of Lauren. Supervision out of the house: Close—within visual sight at all times. Workshop: Within visual sight at all times. She utilizes a wheelchair for transportation only as stated in current Resident at a Glance. On 01/07/10 Lauren's parents and guardians [redacted] visited CLW to observe their daughter's gait. It had been reported by Takoda Trails Nursing staff that Lauren had been limping off and on for several weeks. Mr. [redacted] told this investigator while he was at CLW he observed Lauren in her wheelchair with the seatbelt buckled. He also viewed her gait and stated he saw no signs or symptoms of Lauren favoring her right leg. He spoke with CLW Administration Darlene Maddowe and discussed any changes that occurred in Lauren's daily routine in the last year, and the only one he could pinpoint was her transition to CLW from Fairfield School system. Mrs. Maddowe told Mr. [redacted] the biggest difference that she could think of was that she had an aide in her classroom at school that was able to monitor her when Lauren wanted to walk around at her discretion. Mr. [redacted] then asked what her schedule was for a typical day. She told Mr. [redacted] that she was transported to workshop, participated in activities and was given 3:1 time as well. She stated she then went to nurse's station for her tube feeding and was transported home. Mr. [redacted] then asked where she sat during the day. She showed him the bean bag in her area that, according to Mrs. Maddowe, is where Lauren preferred to sit. Mr. [redacted] then asked how much time she spent in her wheelchair. Mrs. Maddowe then told him transported to workshop to and from as well as to the nurse's station and the bathroom. Mr. [redacted] then asked her if it was about 3 hours. Mrs. Maddowe responded 'yes about that amount of time' Mr. and Mrs. [redacted] then returned to Takoda Trails and spoke with ADON Brian Petrak and PD Tammy Holman to address their concerns regarding extended amount of time that Lauren was spending in her wheelchair. It is his belief that if in fact a time was observed at Takoda Trails the most likely cause was the fact that Lauren's spending too much time in her wheelchair during the day.

Outcomes: Upon investigation Lauren was first observed according to Incident Report review the 1st week of December that she had been limping on her right side. Let it be noted that Lauren has an irregular gait and it has been confirmed by her guardian her right side is where she is the weakest. Several x-rays were obtained and all results showed no signs or symptoms of distress. PT aide Jason Bude did assessment on Lauren and spoke with ADON Brian Petrak and both were concerned there

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Others

was possibly some bone density loss and were considering a Desarcin. Let it be known the guardian do not think this is a necessary procedure at this time. And do not want their daughter to have any aversive testing that is not warranted. It was also reported by Takoda Trails direct care staff that this time that this limp was not ongoing and was only an documented occasions. Regarding allegation of Lauren spending approximately

3 hours or more in her wheelchair a day, it was confirmed that this was most likely the case and in fact her #AAG for mobility was not being followed. When this investigator asked Administrator Darlene Maddowe and Assistant Administrator Josh Morris why she was being transported to the restroom and to the nurse's station to be fed when it clearly states her criteria for wheelchair use to be only transported. They were unable to give probable cause for these actions. When Norbert Nkairne was interviewed on his routine for feeding Lauren he states he would go get Lauren, put her in her wheelchair, attach the seatbelt, administer her feeding and take her back to her area and return her to the bean bag. Administrative Assistant Josh Morris told this investigator that he (Mr. Nkairne) restrained her by buckling her seatbelt so she wouldn't get up and move around, according to Mr. Nkairne. It has been observed and confirmed by this investigator on a personal note that Takoda Trails nursing staff does not need to restrain Lauren for feeding. She is usually cooperative in this process. I also interviewed QMRP o[redacted] Andrea Adams, that audits her client several times weekly at CLW and the states she has never seen Lauren in her wheelchair at designated times. This was also confirmed by Jason Bode, Jennifer Doughty and some of Takoda Trails staff that attend meetings through the week. It is my belief that all intrems mentioned above observed Lauren prior to lunch and at lunch time as that is what their audits are focused on. It is most likely they have gone before Lauren has been fed and that why they have not seen her in her wheelchair for the second part of the day. I also have confirmed that Mrs Maddowe and Mr Morris are not knowledgeable of Lauren's plan for mobility or they allowed her to be transported in her wheelchair for other reasons at CLW other than what the plan states. In regards to allegation of Unapproved Behavior Support it has been substantiated during the interview process. Lauren is non-verbal and unable to give an accurate account of this allegation and cannot either confirm or deny it."

=Karen S Bessette Added on 2/22/2010=

Findings and Conclusions	02/21/2010	1349387

Based on the information gathered, this is an Unapproved Behavior Support without justification. It was not to ensure Lauren's or anyone else's immediate health and safety.

=Karen S Bessette Added on 2/22/2010=

Cause And Contributing Factors	02/22/2010	1349388

Plan was not followed

=Karen S Bessette Added on 2/22/2010=

Prevention Plan	02/22/2010	1349389

1. All CLW staff including Mrs. Maddowe and Mr. Morris were inserviced on Lauren's appropriate times for wheelchair use.

2. Lauren will be monitored by QMRP Andrea Adams in her visits to workshop as well as unscheduled visits from this investigator who will report all and any concerns to Ms. Adams regarding this matter.

3. CLW Administration will develop some other areas for Lauren to ambulate at the facility as well as allowing her to get up from bean bag at her discretion without staff intervention to redirect her back if in case this is the situation which has not been confirmed since no other activities were reported regarding Lauren's schedule after lunch according to Mrs. Maddowe

4. Takoda Trails Nursing and DCS will continue to monitor Lauren for any signs and symptoms of gait disturbances and report them to proper disciplines

5. STM held 01/14/10---discussed reducing Lauren's time in her wheelchair by assisting her through physical therapy on maneuvering the bus steps with assistance and encouraging Lauren to ambulate at her free will and not to inhibit her in any way

6. CLW Nurse Norbert Nkaine received disciplinary action for utilizing UBS. Mr. Nkaine was inserviced in late part of 2009 by this investigator on UBS in MLE training held at CLW

=Karen S Bessette Added on 2/22/2010=

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CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 5

Ohio Department of Developmental Disabilities

Division of Information Systems

EXHIBIT

05

DODD INCIDENT REPORT (ITSI)

Incident Number: 2011-000-0382			Group Name: Butler	
Client Number: [redacted]	Client Name: [redacted] LAUREN 350 WOLB DRIVE FAIRFIELD OH 45014	Gender: F	Waiver Type on Incident:	Age at Discovery: 23

Final Dat Date	Incident Date	Discovery Date	Created Date	Fax Date
08/15/2011	07/21/2011	07/21/2011	07/21/2011	

Category Type:
DD(ITSI)

Alleged Neglect	Supervision	Staff

Alleged

Alleged Neglect	Supervision	Staff

Substantiated		Was Substantiated
Alleged Neglect	Supervision	Substantiated

Injuries
Severity: None

Supervision: Other — Not Met — Visual range (Assigned staff can see the resident at all times) in day program

Behavior Support Plan: No — Restrained from 0 to 0 hrs — Restrained by:

Law:

Law Enforcement Involved: Yes — Outcome: Investigated — Name:

Neglect: Left in Vehicle — Risk Assessment: Substantial

Living Arrange:

9000200 — ICF/IID

Location: Non-County Operated Program — Day Program:

Incident Provider:

180900 — The Creative Learning Workshop, LLC

Residential Provider:
No Data Available

Adult Day/Employment Provider:

No Adult Day/Employment Provider

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(6000 INCIDENT REPORT SYS)

Notifications 3018260 Provider: 07/21/2011 Guardian: 07/21/2011 County: 07/21/2011	Consumer Notified: Accepted: Autopsy: Rec. Closure: Rec. Closure By: 08/15/2011 Rebekah Lyons Incident Review Status Closed Closed Date: Investigated By: 05/26/2011 Investigative Agent Owens, Lisa Closed By: Last Change By: Daniel L Butler Daniel L Butler

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Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
Cheryl Collins	FFI	Direct Care Staff	No		

Initial Report 07/21/2011 1552337

On 7/21/11, Lauren [redacted] was left on a bus without proper care and supervision from approximately 10:15am until 11:45am after the bus arrived at The Creative Learning Workshop (CLW). The FFI failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:45am when staff/individuals were leaving for an outing.
<Karen S Bessette Added on 7/21/2011>

Immediate Action 07/21/2011 1552338

Lauren was immediately observed by the nurse. Bolus fluids given per g tube. Vitals were WNL other than initial body temperature reading was 98.8. Cool compresses were applied and residential provider notified. Lauren was sent home as opposed to ER due to vitals improving. Upon arrival home, Lauren was given a cool bath, additional fluids and was closely monitored. No signs/symptoms of distress noted.
FFI placed on suspension pending the investigation.
<Karen S Bessette Added on 7/21/2011>

Question 08/14/2011 1576330

Please provide an update. thanks.
<Susan L Butler Added on 8/14/2011>

Response 08/15/2011 1576849

Ok
<Rebekah Lyons Added on 8/15/2011>

Final Report 09/15/2011 1576861

QList of persons interviewed and documents reviewed
Attorneys/Statements:
Lauren [redacted] individual- did not interview due to limited verbal/cognitive functioning
Lisa Owens, IA/BCBDD spoke with the following:
Tanya Vance, RSD-MUI/Takoda Trails
Cheryl Collins, FFI/CLW
Deleivi Farmi, driver/CLW
Alissa Muir, ATA/CLW
Crystal Fry, ATA/CLW
Mike Burgo, ATA/CLW
Karen Saylor, ATA/CLW
Floyd Swigart, driver/CLW
Anthony Ritnour, ATA/CLW
Darlene Maddow, Director/CLW
Josh Morris, PD/CLW
Lt. Rick Jones/ Forest Park PD
Detective Jackie Dwyer/Forest Park PD
[redacted] father

Documents Reviewed:
Ohio DODD ITS Report
Incident report
Past MUI involving Lauren/CLW
IDT-MR Investigation Summary- Takoda Trails
RAAG
Health Assessment
Nursing Notes

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Others
IMR
Witness Statements
Weather History
Photographs of Vehicle
CLW Policy/Procedure
In-service Record

Q5Summary of interviews and documents reviewed
A) Lauren is a 23 year old female who resides in Home 4 at Takoda Trails. She is blind and has history of seizure activity. Other diagnoses include Profound MR and CP, etc. She requires visual range supervision in the community and day program. Lauren is non verbal and ambulatory. Because Lauren lives in an ICF-MR, this investigation was completed by the facility investigator with additional information provided by Lisa Owens, IA/BCBDD and this IA. This IA is in agreement with all conclusions.
Investigation summary reviewed, which indicated that Lauren boarded the CLW bus on 7/21/11 at 8:15am to go to her day program. She rode on the first seat on the right side of the bus (her usual spot). Per CLW driver Daryl Parms, they arrived at the workshop (approximately 2 miles away) at 8:30am that day. Driver reported that he and Cheryl Collins, bus monitor/CLW were responsible for unloading and assisting the clients from the back parking lot into the program. He carried the client's bags and lunches inside to distribute to the appropriate areas. When he returned, Cheryl met him with the van keys as well as his personal keys, which were on the console. He assumed that Cheryl had unloaded everyone (including Lauren) since she secured the van by putting the lift up and locking the door, pulling the keys from ignition.
Cheryl was interviewed by investigators and law enforcement. She reported consistently that she did not see Lauren on the bus. She was visibly shaken when interviewed, but made no excuses for the fact that she left Lauren on the bus.
CLW aide Crystal Fry discovered Lauren approximately 11:45am, still sitting in her designated seat. Crystal was preparing for an outing when she made the discovery. The temperature was noted to be 91 degrees Fahrenheit, with a heat index of 101. Lauren was observed to be soaked with sweat and very hot. Several staff interviewed confirmed that Lauren's clothes were damp and she appeared hot but did not seem to be in distress. She was immediately taken to the nurse for assessment. Vitals were taken and she was given 200 ml H20 per g-tube with cool compresses to her neck and arms. Her temperature was 99.8 at 11:50am; 98.8 at 12:00pm; 98.3 at 12:18. Lauren was transported back to Takoda Trails upon request and her physician was notified. Dr. Zaken ordered Pedialyte to ensure she was hydrated, and staff gave it as ordered. No further orders or concerns were noted.
Tanya Vance, Facility Investigator/Takoda Trails and Lisa Owens, IA/BCBDD inspected the bus. Per Tanya Vance, Lauren should have been visible from the place where the aide had to stand to raise and secure the door lift. Investigators also used a small thermometer to measure temperature inside the bus. It registered approximately 88 degrees and then was placed in the bus for approximately 5 minutes at the same time of day that incident occurred 24 hours prior. The temperature rose to 103 quickly in a short amount of time.

Investigators spoke with administration from CLW regarding how they keep track of attendance, etc. Darlene Maddow, CLW Administrator stated that attendance was completed in the afternoon. It was confirmed that CLW had no previous attendance records to track clients on location. There is a driver's log in each van with a check off list, but no pre-determined format in which data is collected or who reviews it. CLW was unable to provide past records because they only retain them for one month.
Forest Park Police Department was contacted, however no charges were pressed.
No previous related incidents were found for Lauren in ITS. However, there was a previous incident in May 2010 in which another client was left unattended on a CLW vehicle. This was substantiated as neglect; the afternoon checklist was implemented as a result, which obviously did not help in this case.
PPI Cheryl Collins had a previous MUI filed for neglect, which was unsubstantiated. That allegation was unrelated in nature to the current concern.
<Rebekah Lyons Addedon 9/15/2011>

Findings and Conclusions	09/15/2011	1576862

The allegation of neglect can be substantiated. The bus monitor stated that she did not see Lauren on the bus while she

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Others

was unloading clients on the morning of 7/21/11 and failed to assist Lauren off the bus. There was no protocol in place at the time to ensure that Lauren was not missed on the bus or in the program. This resulted in Lauren being left on the bus for 2 hours with the doors and windows closed. This error placed Lauren at high risk as she has history of seizures, and is additionally unable to unbuckle her safety belt or call for assistance. Temperatures and heat index was noted to be extremely high on this date, and Lauren was observed to be in physical discomfort soaked with sweat, very hot upon discovery.
<Rebekah Lyons Addendum 9/15/2011>

Cause And Contributing Factors	09/15/2011	1576863

- Bus monitor was on a substitute route.
- Human error- Monitor did not see Lauren.
- No system in place to ensure Lauren was not missed for this time period.
- Miscommunication
<Rebekah Lyons Addendum 9/15/2011>

Prevention Plan	09/15/2011	1576864

- New orders given for Pedialyte to ensure hydration.
- Staff continued to monitor no further medical treatment was required.
- PPI was implemented due to the severity of this incident.
- New protocol for checking attendance was implemented at CLW on 7/26/11, including a new checklist for off site driver and aide responsibilities.
- CLW advised that attendance will now be completed twice daily, at 10:15 and 4:00pm.
- Team to continue monitoring for trends or issues, meet and revise plan as needed.
<Rebekah Lyons Addendum 9/15/2011>

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PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 71

EXHIBIT

06

Ohio Department of Developmental Disabilities

Division of Information Systems

DODD INCIDENT REPORT (ITR)

Incident Number: 2014-[redacted]-0023			Group Name: RUTH	
Client Number: [redacted]	Client Name: [redacted] LAWSON 1150 Kolb Drive Fairfield, OH 45014	Service: F	Waiver, Type, or Incident Opening Date	Age: 19 Gender: F
Final Close Date: 1/2/2015	Incident Date:	Discovery Date: 11/18/2014	Created Date: 11/18/2014	Fax Date:
Category: Significant Injury	Injury (Known) Fall		Subcategorized Category: Was Substantiated	
Attacks: Severity: Moderate Supervision: Minute visual checks / awake times Behavior Support Plan: No Law Enforcement Involved: No	Cause: Unintentional	Result: Bone Fracture(s) Met Restrictive Procedures: No, 0 Days	Location: Client's Home/Work Reviewed By:	
Location: Non-County Operated Program	Living Arrange: DODD Licensed Facility		Residence	ID/DD
Incident Provider: PROGRAM TRAILS Residential Provider: PROGRAM TRAILS Workshop:				
Notifications: Provider: 11/18/2014 Guardian: 11/18/2014 County: 11/18/2014	Licensor: Notified:	Accepted:	Actions:	
	Rec. Closure: 1/2/2015	Rec. Closure By: Rebekah Lyons		
	Incident Review Status: Closed			
	Closed Date: 1/2/2015	Investigated By: Investigative Agent Rebekah Lyons		
	Closed By: Rebekah Lyons	Last Changed By: Rebekah Lyons		

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PPI Witness Name	Relation

Initial Report	3851335

On 11/18/14, Lauren[redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time.
<Karen S Bennett Added on 11/19/2014>

Immediate Action	3853332

Assessed by Taboola Trails nursing staff when bruising was noted to her shoulder, neck and chest.
Sent to orthopedist for evaluation and received diagnosis of fractures.
<Karen S Bennett Added on 11/19/2014>

Final Report	3869783

Q)List of person I interviewed and documents reviewed
A)Interviews/Statements:
N/A

Documents Reviewed
Ohio DODD ITA Report
Incident reports
Past MUI involving Lauren
ISP/Health assessment
Email Correspondence
Special Team Meeting notes
MAR
Military Statements
Web research
Q1log

Q)Summary of interviews and documents reviewed
A)Lauren is a 27 year old female who resides at Tabbola Trails, an ICF-DD. This investigation was completed by Tanya Vance, Investigator/Tabbola Trails, with additional information provided by this IA. This IA is in agreement with all conclusions.
ICF summary reviewed. Lauren resides in home[redacted] at Tabbola Trails. Her level of supervision is 5 minute checks during normal waking hours in/out range while out of bedroom and walking around. She is on visual range when outside and in the community and at COM (day program). Lauren is NPO and receives all nutrition and medications through G-tube. Lauren is blind and has history of accidentally closing her fingers in doors. There are hourly audits done on Lauren in a day to ensure there are no injuries. An incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a footprint at all times. Lauren's code status is full code. Her guardian is her father[redacted]. Lauren's primary diagnosis is Profound MR. She has secondary diagnosis of CP, Seizure D/O, Cortical blindness, Multiple Cong Malfo, GP PD Lobes, History of intermittent mastitis (Surmastitis, Allergic Rhinitis, Constipation, GP Gastrostomy w/Mount, Chronic Pain/Anxiety, Arthritis/s, and Bone and/or Cartilage. On 11/18, LPN Sandy Oldefenger was preparing to administer bolus medication to Lauren when she observed bruising to her chest and right shoulder and neck area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 3cm x 1cm raised area to the right clavicle. Sandy made the investigator and COM aware of this report immediately. COTA Jason Buda was also present with nursing for this assessment. An Appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon

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Dr. Gangle). Dr. Gangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a wheelchair and wear the sling as tolerated and a follow up appointment was made for 4 weeks (1/2/15). A special team meeting was held and her level of supervision was increased.

All staff that worked with Lauren in the past week, including CIW staff were interviewed and witness statements were obtained. When interviewing staff members in the home, it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been seen or reported in the 2 weeks prior to the day it was reported. During the interview process, there was some information that was passed on to the investigator that could possibly be the cause of the injury. On 11/2, Lauren was being given her PM shower when BSI Sandy Dela Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Sandy reported she went over to secure her and Lauren fell the wall in the shower stall, striking her head as she pushed her to the floor and called for assistance. When I asked Sandy if Lauren struck the wall with enough force to cause that type of injury she replied that she thought so. I asked her during the interview if she had seen the bruise and she told me that she had, but since the incident had already been reported, she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 18th. This also is comparable to the timeline that Dr. Gangle estimated the bruise as being at least 2 weeks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 18th where Lauren was sent to the ER due to being non-compliant with treatment by the nursing department at Takoda. She received sterile band for closure of a cut above her left eye. Lauren's level of supervision was increased to 1:1 status when she returned to the facility after treatment. An in-service was implemented that morning, making staff aware of the change in supervision level as well as instructions for staff to use a gait belt at all times and to keep her in arm's reach 24/7. This is the most likely scenario of how Lauren sustained the injury.

Lauren will follow up with orthopedic surgeon Dr. Gangle for 4 week follow up. She will also be seen by Dr. Zavere (PCP) on next clinic day. Level of supervision was increased to 1:1 minute checks on third shift and a few days later increased again to 1:1 status. A SSM was held 12/5 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a bike helmet, re-training staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 15 minute checks for third shift. The team met again on 12/8 to discuss how Lauren is adjusting to the changes implemented on 12/5. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.

ITS reviewed. Lauren had a previous injury in 2010 due to her getting her hand stuck in a door.

<Rebekah Lyons Added on 1/2/2015>

Findings and Conclusions 2000764

All information given indicates that Lauren most likely diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physicians estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.

<Rebekah Lyons Added on 1/2/2015>

Cause And Contributing Factors 2000765

- Likely a fall due to seizure activity.

<Rebekah Lyons Added on 1/2/2015>

Preventive Plan 2000766

- Lauren to follow up with orthopedic surgeon Dr. Gangle and Dr. Zavere (PCP) as recommended until she has healed.

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- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A STM was held 12/3 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a bike helmet, re-assurance staff on keeping her shoes on when she is out of her room. They also reviewed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her totes bag chairs were taken out of her room and placed in the living room. The idea for grippit socks was discussed, as well as 30 minute checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/3. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.
«Rebekah Lyons Added on 1/2/2015»

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MDI Report
Individual Lauren[redacted]
Investigator: Rebekah Lyons
Incident Number: 2016-MDI-0553
Category: Significant Injury
Date: 1/2/15

INITIAL STATEMENT:
It was reported to the Office of Incident Review/ITB on 11/16/16, Lauren was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time. An MDI for significant injury was filed on behalf of Lauren.

LIST OF PERSONS INTERVIEWED AND DOCUMENTS REVIEWED
Interviews/Statements:
N/A

Documents Reviewed:
Ohio DODD ITT Report
Incident reports
Past MDI involving Lauren
ISP/Health assessment
Email Correspondence
Special Team Meeting notes
MAR
Witness Statements
Web research
UI log

SUMMARY OF INTERVIEWS/DOCUMENTS REVIEWED

Lauren is a 27 year old female who resides at Tukaide Trails, an ICF-DD. This investigation was completed by Tonya Green, Investigator/Tukaide Trails, with additional information provided by the IA. This IA is in agreement with all conclusions.

ISP summary reviewed: Lauren resides in home at Tukaide Trails. Her level of supervision is 1 minute checks during normal waking hours (visual range while out of bedroom and waking arousal). She is on visual range when outside and in the community and at DAY (day program). Lauren is NPO and receives all nutrition and medications through G tube. Lauren is blind and has history of accidentally closing her fingers in doors. There are body audits done on Lauren 3x a day to ensure there are no injuries. An Incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a bedpad at all times. Lauren's code status is full code. Her guardian is her father[redacted]. Lauren's primary diagnosis is Profound MR. She has secondary diagnoses of ICP, Seizure D/O, Corticalblindness, Multiple Gen Medic, S/P PG tubes, History of Intermittent Surgeries Traumatic, Allergic Rhinitis, Constipation, S/P Gastrostomy w/Button, Chronic Periodontitis, Amblyopia, and Hyperopia Astigmatism. On 11/16, LPN Sandy Osterhagen was preparing to administer bolus medication to Lauren when she observed bruising to her chest and right shoulder and arm area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 1 cm x 1 cm scab area to the right scapula. Sandy made this investigator and DOR aware of this report immediately. LPN/A Jamie Bode was also present with nursing for this assessment. An Appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon (Dr. Sangle). Dr. Sangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a

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ophthalmologist and went the sling as tolerated and a follow up appointment was made for 4 weeks (12/15). A special team meeting was held and her level of supervision was increased.

All staff that worked with Lauren in the past week, including CLW staff were interviewed and witness statements were obtained. When interviewing staff members in the home, it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been new or reported in the 2 weeks prior to the day it was reported. During the interview process, there was some information that was passed on to this investigator that could possibly be the cause of the injury. On 11/2, Lauren was being given her PM shower when RN Buddy Dela Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Buddy reported she went over to assist her and Lauren hit the wall in the shower stall, cutting her head as she lowered her to the floor and called for assistance. When I asked Buddy if Lauren struck the wall with enough force to cause that type of injury, she replied that she thought so. I asked her during the interview if she had seen the bruise and she said no that she had, but since the incident had already been reported, she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 10th. This also is comparable to the timeline that Dr. Gangle estimated the bruise as being at least 2 weeks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 17th where Lauren was sent to the ER due to being non-compliant with treatment by the nursing department at Takoda. She received stoma band for closure of a cut above her left eye. Lauren's level of supervision was increased to 1:1 status when she returned to the facility after treatment. An 1:1 service was implemented that morning, making staff aware of the change in supervision level as well as instructions for staff to use a gait belt at all times and to keep her in arm's reach 24/7. This is the most likely scenario of how Lauren sustained the injury.

Lauren will follow up with orthopedic surgeon Dr. Gangle for 4 week follow up. She will also be seen by Dr. Zaleski (PCP) on next clinic day. Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status. A TPM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas generated were a trial helmet, re-instruct staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her lounging chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift. The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.

ITS reviewed: Lauren had a previous injury to 2022 due to her getting her hand stuck in a door.

FINDINGS AND CONCLUSIONS

All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/10. This was based on observation the same day of bruising by the name at Takoda Youth. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.

CAUSE AND CONTRIBUTING FACTORS

- Likely to fall due to seizure activity.

PREVENTION PLAN

- Lauren followed up with orthopedic surgeon Dr. Gangle and Dr. Eskan (PCP) as recommended until she has healed.
- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas promoted were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.

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Nancy Morris

From:	Nancy Morris
Sent:	Tuesday, January 06, 2015 11:05 AM
To:	Tanya Vance
Cc:	Lola Snyder (lsnyder@lautenbd.org)
Subject:	summary 14-0553 exempt
Attachments:	[redacted] 14-0553 summary.pdf

Hi Tanya,
The summary references the incident which was discovered on 12/08/14. The guardian will also be notified.

Sincerely,
Nancy

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Office of Incident Review &
Quality Assurance
303 N. Fall Avenue
Hamilton, OH 45011

BUTLER COUNTY
Board of
DEVELOPMENTAL DISABILITIES
supporting possibilities

T: 513.785.2800
OIR Fax: 513.887.8028
QA Fax: 513.863.0987
www.butlerdd.org

WRITTEN SUMMARY OF INCIDENT

Date: 1/6/15

To: [redacted] Guardian
Tonya Ferrer, Takoda Trails
Lela Ayers, BCBDD Quality Assurance Director
From: Rebekah Lyons, IA/Butler County Board DD

Name: Lauren[redacted]
Incident Number: 2014-039-0203
Type of Incident: Significant injury

Statement of Incident: It was reported to the Office of Incident Review/OIR on 11/18/14, Lauren was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time. An MSI for significant injury was filed on behalf of Lauren.
Findings: All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to unknown activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.
Prevention Plan:

- Lauren followed up with orthopedic surgeon Dr. Gaugis and Dr. Zakem (PCP) as recommended until she has healed.
- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A TSM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when choosing her 1:1 staffing ratio. Items were presented were a vital lockout, no monitor staff on keeping her doors on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10-to-one checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 11/2. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.

This information contained in this letter is provided to you in accordance with OAC 5123:2-17-02. You may dispute the findings of this report by submitting a letter of dispute and supporting documentation to the county board superintendent or to the director of the Ohio Department of DD if the superintendent conducted the investigation. A time-limited corrective type following receipt of the summary. An individual may receive assistance from any person selected by the individual to prepare a letter and provide supporting documentation. If you have any questions, please call 513-785-2800 and ask to speak to the individual above.

cc: OIR File

RL/mm

PLEASE NOTE THAT OUR PHONE NUMBER HAS CHANGED TO 513-785-2800 & OUR FAX NO.

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Nancy Morris [redacted]

From:	DODDoNo_doNotReply@doddd.ohio.gov
Sent:	Friday, January 02, 2015 2:52 PM
To:	Karen Bennette; Rebekah Lyons; Rebekah Lyons; Nancy Morris
Subject:	IR1 Info on MSR 2014-009-0053 Sent: 1/2/2015 2:52:03 PM
Importance:	High

Incident Status Changed From (User With Information Submitted To Closed
Currently: 1/2/2015 2:52:03 PM
Incident Category: Significant Injury

This email has been auto-generated by DODD at the request of Rebekah Lyons (Nancy.Morris@dodd.ohio.gov). If you are not the intended recipient of this email you are asked to please forward this email immediately to Applications.Support@dodd.ohio.gov and then delete any further copies that you have. DO NOT REPLY TO THIS E-MAIL.

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Ohio Department of Developmental Disabilities

Division of Information Systems

[illegible] INCIDENT REPORT (ITD)

Incident Number 2014-[illegible]-0053			Group Name MUTI	
Client Number [redacted]	Client Name [redacted] AUBIN [illegible] Drive Fairfield, OH 45014	Gender F	Waiver Type on Incident(s) Credit Date	Age at Occurrence 27
Final Rpt Date 1/2/2015	Incident Date	Occurrence Date 11/18/2014	Created Date 11/18/2014	Cat. Date
Category Significant Injury	Injury (Unknown)	Subcategory	Was Substantiated	
Injuries Severity: Moderate	Cause: Undetermined	Result: Bone Fracture(s)	Location (Desk/Table/Bed)	
Location Non-County Operated Program	Living Arrangement: [illegible] Licensed Facility		Residence	[illegible]
Incident Provider: [illegible] TAKODA TRAILS Residential Provider: [illegible] TAKODA TRAILS Workshop:				
Notifications Provider: 11/18/2014 Guardian: 11/18/2014 County: 11/18/2014		Category Modified Rec. Closure	Accepted Rec. Closure By	Actions
		Incident Review Status Open with Information Pending		
		Closed Date	Investigative Agent Rebekah Lyons	
		Closed By	Last Updated By Karen Reed	

ICF Cadet.
12-17 Emailed Tanya Unick requesting follow-up + report.

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PPI Witness Name	Relation

Initial Report	2053181

On 11/18/14, Lauren [redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time.
<Karen S Bassetti Added on 11/19/2014>

Immediate Action	2053202

Assessed by Talbots Trails nursing staff when bruising was noted to her shoulder, neck and chest.
Sent to orthopedist for evaluation and received diagnosis of fracture.
<Karen S Bassetti Added on 11/19/2014>

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Karen Sexsmith

From:	Karen Sexsmith
Sent:	Thursday, November 20, 2014 9:01 AM
To:	Tanya Pence (tpence@butlerla-trails.net)
Cc:	Rebekah Lyons
Subject:	LE IVL#2014-006-0513

This is to inform you that an MOI has been filed for Lauren [redacted] for Significant Injury. This is based on her being diagnosed with a broken clavicle on 11/18/14. Rebekah Lyons has been assigned this case. Please provide your investigation report and any other information pertinent to this case to Rebekah.

Karen Sexsmith

Senior Investigative Agent
Butler County Board of Developmental Disabilities
283 N. Fair Avenue
Hamilton, OH 45011
(513) 867-3951
fax (513) 867-4038

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☐ Yes ☐ See Attached Documentation

☑ Unit: 2BA-401-1063 Lease Date: 3-2-15

PA Assigned: Brian

Individual's Name: Lauren [redacted]

Incident Date: 10/6/14 Time: _____

Reported By: Sandra Ostendorf-TT Contact #: _____

☐ Incident Report ☑ On-Call Log ☐ Phone Call ☐ E-mail ☐ In Person

Date/Time incident was reported to MCMH (either on-call or on any CS work) date: 10/15/14 time: 9:44am

Date/Time incident was reported to OA: date: 10/15/14 time: _____

Participant/Tenant: Tabitha Tomlin Any Program Provider: _____

SSN: _____ Developmental Institute: _____

Guardian: _____ Medical Waiver: _____

Description of Incident: ☑ See attached description if attached

Follow-Up/Recommendations:

☐ Requested Incident Report ☐ Requested Other Documentation: _____

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ON CALL FORM

Fill in completely and send to [redacted] by 9:00 am.

Completed By: Michelle Reed	Individual's Assigned SC (if known):
Date of Call: 11/18/14	Time of Call: 4:44 PM
Name/Title of Caller: Sandy Cunningham	Telephone Number: 330-838-2146
Individual's Name (s): Lauren [redacted]	Provider:
Incident Date/Time: 11/18/14	Location: Takeda Trails

Description of Incident: (Who, what, when and where. List any witnesses.)
Staff noticed this morning that Lauren had some bruising to her chest area and on her shoulder and neck. They consulted with their PT who felt that she needed to be seen by an orthopaedist. Sandy reported that Lauren was currently still at appt. but she had received the information that Lauren has a fractured clavicle. DIA asked if they had any idea of what happened and she said that they aren't sure. She has a seizure disorder and may have fallen or gotten up and ran into a wall.

Were there any injuries? Describe:
Fractured clavicle

Immediate Actions (What was done to ensure the immediate health and welfare of the individual?)

- ☐ Individual was assessed for injury/illness by direct care staff, name/result:
- ☒ Individual was examined by a medical professional, name/location:
- ☐ A medical professional was consulted, name/title:
- ☐ Police were called, response:
- ☐ Wellness Check Requested, result:
- ☐ Ambulance/911 was called, response:
- ☐ Individual was transported to urgent care/hospital, location:
  - Admitted? ☐ Yes ☐ No ☐ Unknown
- ☐ Mobile Crisis was called, response:
- ☐ Increased supervision, describe:
- ☐ Staff was placed on leave, name/details:
- ☐ Access to PP prevented, explain how:
- ☐ Medication/cash/property secured, describe:
- ☐ Additional staffing added to the home, describe:
- ☐ Alternative placement was arranged, describe:
- ☐ Discussed safety plan with individual or other involved party, describe:
- ☐ Other, please describe:

☐ CHECK HERE if additional information is available in a case note.

Notifications:

Person Notified	Agency/Title	How/By Who?	Date/Time
Guardian/Advocate			
Support Broker			
Provider			
Law Enforcement ANY potentially criminal	Jurisdiction:		
Children Services ANY potentially criminal <18			
Coroner: ANY death			
Superintendent ANY death			
DODD ANY ALLEGED OR SUSPECTED abuse, neglect, theft or death			
Assigned SC			
Other:			
Other:			

*The on-call report will be forwarded to designated parties by DAS office.

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Empowering People
Home Management Manual – Residential – Routine Paperwork
Unusual Incident Report

Major Unusual Incident: ☐ Yes ☐ No If yes Category: ☐ A ☐ B ☐ C
*Report Given at Desk (or dept) Major Unusual Incidents are to be called immediately to the ADC or designee

Resident Name: Kaiser [redacted] Address: 332 Lola Dr
Date: 11/17/14 Day of Week: Tuesday Time: 8am AM PM
Staff Involved: Witnesses:
Injuries: #500 Who Observed: Takeda Imoto

Must write Incident report for each person involved. Use initials for other consumers if needed to confirm in report.

TYPE OF INCIDENT – Please check all that apply
Medical (Incident Related)
- Med error – patient responsible for Med Fees: _____
- Wrong Dose
- Wrong Time
- Wrong route
- Wrong person
- Med unrefused from (check one)
- Med (pill) found
- Med documentation error
- Med refusal ☐ Staff ☐ Resident
- Med dropped
- Possible injury to resident
- Seizure
- Possible Smoking
- Minor injury to resident
- Resident to Dr. or ER
- Unwitnessed Injury
- Dietary related problem
- Accident – Resident
- Stress
- Fall
- Other (describe): _____

Behavioral (Incident Related)
- Verbal Aggression (VA)
- Self injurious Behavior (SIB)
- Theft – ☐ Under $100. ☐ Over $100.
- Property Destruction (PD)
- Peer to Peer problem
- Observed
- Physical Aggression (PA)
- Inappropriate sexual contact
- Damage to personal property
- Other (describe): _____

Environmental: ☐ Check if Work Order Written _____ Work order number
- Item broken ☐ Check if item can be repaired ☐ Check if item was discarded
- Pests observed
- Damage to Agency property
- Other (describe): _____

Other Issue(s): _____

OBJECTIVE DESCRIPTION OF INCIDENT
Describe specifically what happened BEFORE the incident: Administering Clua
& unsuccessful to resident

Describe the incident: Bruising yellow/green color noted to Right
Mid Axillary & neck area. Also Dark
Bruising area to top of shoulder

Describe the intervention(s) used and the outcome: Seen by PT. Dawn Mc
Terry of Takeda

Episode Plan Followed? ☐ Yes ☐ No ☐ Not applicable ☐ Protective Hold used? ☐ Yes ☐ No
Protective Hold in Behavior Plan? ☐ Yes ☐ No Used for medical purposes? ☐ Yes ☐ No

Duration: _____ (Minutes) Alternatives Attempted: _____

(If not in Behavior Plan and Protective Hold is used, Incident Becomes a Major Unusual Incident)

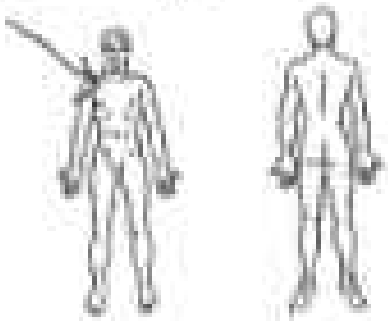
Type of Protective Hold: ☐ Lowest Figure Floor ☐ Padded Hold ☐ Limited Density Hold
☐ Full Security Hold ☐ Prone Cradle Transport ☐ Rolls Cradle Table Down ☐ Other: _____

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MEDICAL
Medical Treatment Necessary? ☐ Yes ☐ No
Explain treatment: Transported to Sta Campbell & Tri-Health for examination due to 3/5 Rated Dr Another Blunt
Who performed medical treatment: emergency
Injured's comments: Because to shoulder upper 4 inches X 4 inches yellow in color and area 1cm on Right Lower back pain.
Name's signature: [redacted] Date: 11/18/14

BODY PART AFFECTED BY THE INCIDENT:
Use left to circle injured figure way broken, cut, bruise, etc.
If no visible signs at the time, circle most likely possible type of injury:

☐ Brain	☐ Bruise/edema
☐ Possible broken	☐ Scratch
☐ Burn	☐ Swelling
☐ Bleeding	☐ Laceration
☐ Fracture	
☐ Other:	



WHO WAS NOTIFIED AT THIS OR PREVIOUS? (Include date & time)
☐ Supervisor Name: [redacted] Date: 11/18/14 Time: 9:45am
☐ Administrator Date: 11/18 Time: 9:35 Special Instructions Given:
☐ [illegible] Date: 11/18 Time: 10:00 Special Instructions Given:
☐ Tonya Date: 11/18 Time: 9:00 Special Instructions Given:
☐ Michelle Reed 11/18 5pm
☐ [illegible] Date: Time: Special Instructions Given:

DISPOSITION/FOLLOW-UP:

REPORT COMPLETED BY: Osterberger Dan 11/18/14
Name Title Date

Manager Review: Name Title (If Other Than Manager) Date

QMSP Review: Date
☐ No Additional Follow-up Needed
☐ See Behavior Plan
☐ See Attached Follow-up Report

Administrator Review: Name Date

Medical Director: Name Date

Date/Time MUI was forwarded to MUI Investigator:
Revised 9/1/01 JLAM

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Consumer Detail Report

CARTER, LAUREN

Organization: Butler County

Primary Funding Source:

Mailing Address: [redacted]

Other Address:

Phone:
Primary: ( ) -
Secondary: ( ) -

Email Address:

File Location:

Notes:

All Classifications

Classification	Start Date	End Date
Waiting List - Jobs Central	[redacted]	[redacted]
Lives in a Butler County ZIP Code	[redacted]	[redacted]
Customer	[redacted]	[redacted]

Relationship(s)

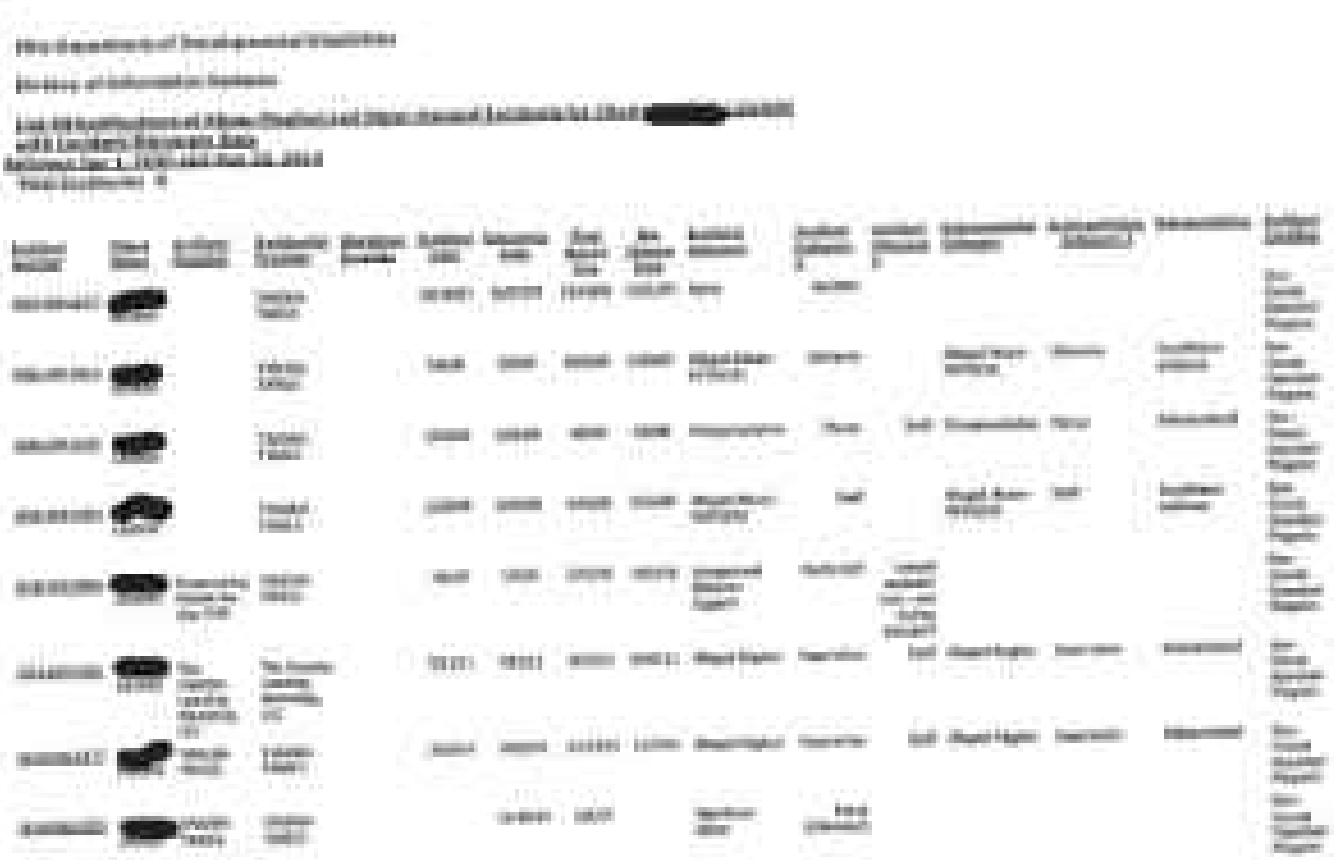
Relation	Name/Organization/Vendor	Address	Phones / Email
Parent	[redacted]	[redacted]	Phone: [redacted] Secondary: Email:

Waiting Lists

Waiting List	Status	Date On	Description	Priority	Date Off
Butler County					
45 CI Trainer	Waiting	[redacted]			

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Takoda Trails

MI/UI Investigation Form

Individuals Name: Lauren[redacted]

Date of Incident: 11-10-14

Description of Incident: Significant Injury

Immediate Action: Resident was taken to orthopedic surgeon for assessment on the day that the injury was discovered.

Trend/Pattern: No

Summary of Investigation: Lauren is a 27 yr old Caucasian female that resides in home[redacted] at Takoda Trails. Lauren's level of supervision is 5 minute checks during normal waking hours [visual range while out of bedroom and walking around. She is on visual range when outside and in the community and at CLW. Lauren is NPO and receives all nutrition and medications through via G tube. Lauren is blind and has a history of accidentally closing her fingers in doors. There are body audits done on Lauren 3 x a day to ensure there are no injuries. An Incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a bodysuit at all times. Lauren's Code Status is Full Code. Her guardian is her father[redacted] and his mailing address is[redacted] Lauren's primary diagnosis is Profound MR. She has secondary diagnoses of Cerebral Palsy, Seizure DsO, Cortical Blindness, Multiple Otitis Media, NP PE tubes, History of Intermittent Hepatic Steatosis, Allergic Rhinitis, Constipation, S/P Gastrostomy w/Version,Chronic Periodontitis, Ambliopia, and Hemianopia Cataracts. On 11-10 LPN Sandy Osterberger was preparing to administer bolus medications to Lauren when she observed bruising to her chest and right shoulder and neck area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 1cm x 1cm round area to right scapula. Sandy made this investigator as well as DON aware of this report immediately. CCTA Jamie Webb was also present with nursing for this assessment. An appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon [Dr. Gangle] Dr. Gangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a Wheelchair and wear the sling as tolerated and a follow up appointment was made for 4 wks.[12-15-14 at 10:30am.] A special team meeting was held and her level of supervision was increased.

Outcome: All staff that worked with Lauren in the past week including CLW staff were interviewed and witness statements were obtained. When interviewing staff members in the house it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been seen or reported in the 3 weeks prior to the day it was reported. During the interview process there was some information that was passed on to this investigator that could possibly be the cause

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of the injury. On 11-2 Lauren was being given her PM shower when RM Linsly Brin Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Linsly reported she went over to secure her and Lauren hit the wall in the shower stall striking her head as she lowered her to the floor and called for assistance. When I asked Linsly if Lauren struck the wall with enough force to cause that type of injury she replied that she thought so. I asked her during the interview if she had seen the bruise and she told me that she had but since the incident had already been reported she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 18th. This also is comparable to the timeline that Dr. Gaugle reported that he estimated the bruise as being at least 3 wks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 19th where Lauren was sent to the emergency room due to being unresponsive with treatment by the nursing department at Takoda. She received sutures head for closure of a cut above her left eye. Lauren's level of supervision was increased to a 1 on1 status when she returned to the facility after treatment. An inservice was implemented that morning making staff aware of the change in supervision as well as instructions for staff to use a gait belt at all times and to keep her in arms reach 24/7. This is the most likely scenario of how Lauren sustained this injury.

Recommendations/Prevention plan

Lauren will follow up with orthopedic surgeon Dr. Gaugle for 4wk follow up. She will also be seen by Dr. Zaleski [PCP] on next clinic day.

Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to a 1 on 1 status.

A STM was held 12-2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1 on 1 staffing ratio. Some of the ideas that were presented were a trial between, tomorrow staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for grippie socks was discussed as well as 10 minute checks for third shift. The team met again on 12-3 to discuss how Lauren is adjusting to the changes implemented on 12-2. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.

Completed by:
Investigator: _____ Date: 12-23-19

Reviewed by:
Administrator: _____ Date: 12-28-19

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HEALTH

FUNCTIONAL ASSESSMENT IP DATE: 4/1/2014

Resident's Name: Lauren [redacted]

Code Status: Full

DOB: [redacted]

General Medical: Lauren is seen throughout the year on a routine and as needed basis. Nurses are in contact with the physician at the point of any change in condition that warrants physician intervention. 8/7/13 Sent to Mercy Fairfield ER for noted facial laceration. An examination was completed with sutures used for closure of the wound. Lauren returned home with N.O.'s to remove sutures in 5 days complete Neurochecks per protocol and follow up with Dr. Zakem on the next clinic day. 9/23/13 Seen by Dr. Zakem in clinic for follow up from recent ER visit for a fall. An examination was completed with all discharge instruction reviewed and N.N.O.'s or concerns noted with the area noted to be healed. 9/24/13 Sent to Mercy Fairfield ER where an examination and x-rays were completed for a noted bruise to the right arm. Lauren returned home with a diagnosis of Arm Bruise, N.N.O.'s and a recommended follow up later with Dr. Zakem if problems arise. 10/3/13 Received N.O. for Milanta 15gm in 8 oz of water QD for constipation. 10/22/13 Annual Flu Vaccination was administered in the left deltoid with no adverse reactions noted. 2/14/14 Sent to Mercy Fairfield ER for noted laceration over the left eye. An examination was completed with surgical glue used for closure of the wound. Lauren returned home with N.N.O.'s and recommendations to follow up with Dr. Zakem on the next clinic day and Neurochecks completed per protocol. 2/17/14 Received N.O. for Diastat 5mg rectally for seizure activity lasting longer than 5 minutes. 3/3/14 Seen by Dr. Zakem in clinic for follow up from recent ER visit for a fall. An examination was completed with all discharge instruction reviewed and N.N.O.'s or concerns noted with the area noted to be healed.

Physical Exam: 2/4/14 Seen by Dr. Zakem in clinic where an annual physical/pre-op dental examination was completed with N.N.O.'s. All medications, labs and consultations were reviewed with no other noted concerns.

Annual TB: 2/5/14 Annual PPD was administered in the right forearm with negative results and no adverse reactions noted.

Dental: 2/20/13 Seen at Miami Valley Dental where an examination, cleaning and x-rays were all successfully completed under General Anesthesia. N.N.O.'s or concerns were noted with a recommended follow up in 1 year. Scheduled at Miami Valley Dental to be seen under general anesthesia for yearly examination and cleaning.

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Vision: 3/8/13 Seen by Dr. Sawyer in vision clinic where an examination was completed with adverse erythema noted to the left eye. Rx:Ocuwel M.D. for Tobradex to the left eye BID and a recommended follow up in 2 months for more lid views. 7/30/13 Seen by Dr. Metzger in vision clinic where an examination was completed with the previous Blepharitis noted to be better bilaterally. H.N.O.'s at cataracts were noted with a recommended follow up in 10 months.

Podiatry: 1/23/13 Seen by Dr. Kravchenkov in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up PRN.

Neurology: Lauren is currently on Keppra for seizure control. Routine labs are drawn to monitor the levels of the noted medications. Seizures are noted to be controlled within the last year with Dr. White monitoring all lab results and graphic charts as needed. 2/13/14 Seen by Dr. White in Neurology clinic where an examination was completed with all medications and seizure logs reviewed. Resolved M.D. to obtain a Keppra level on the next lab day and follow up in 6 months.

Psychiatry: Lauren is not currently on any psychotropic medications therefore psychiatric intervention is not warranted at this time.

GYN/Mammo: Guardian refuses any GYN examinations at this time. Mammograms are not indicated at this time due to Lauren's age.

Allergies: Sulfa, Reglan, Surgical Tape

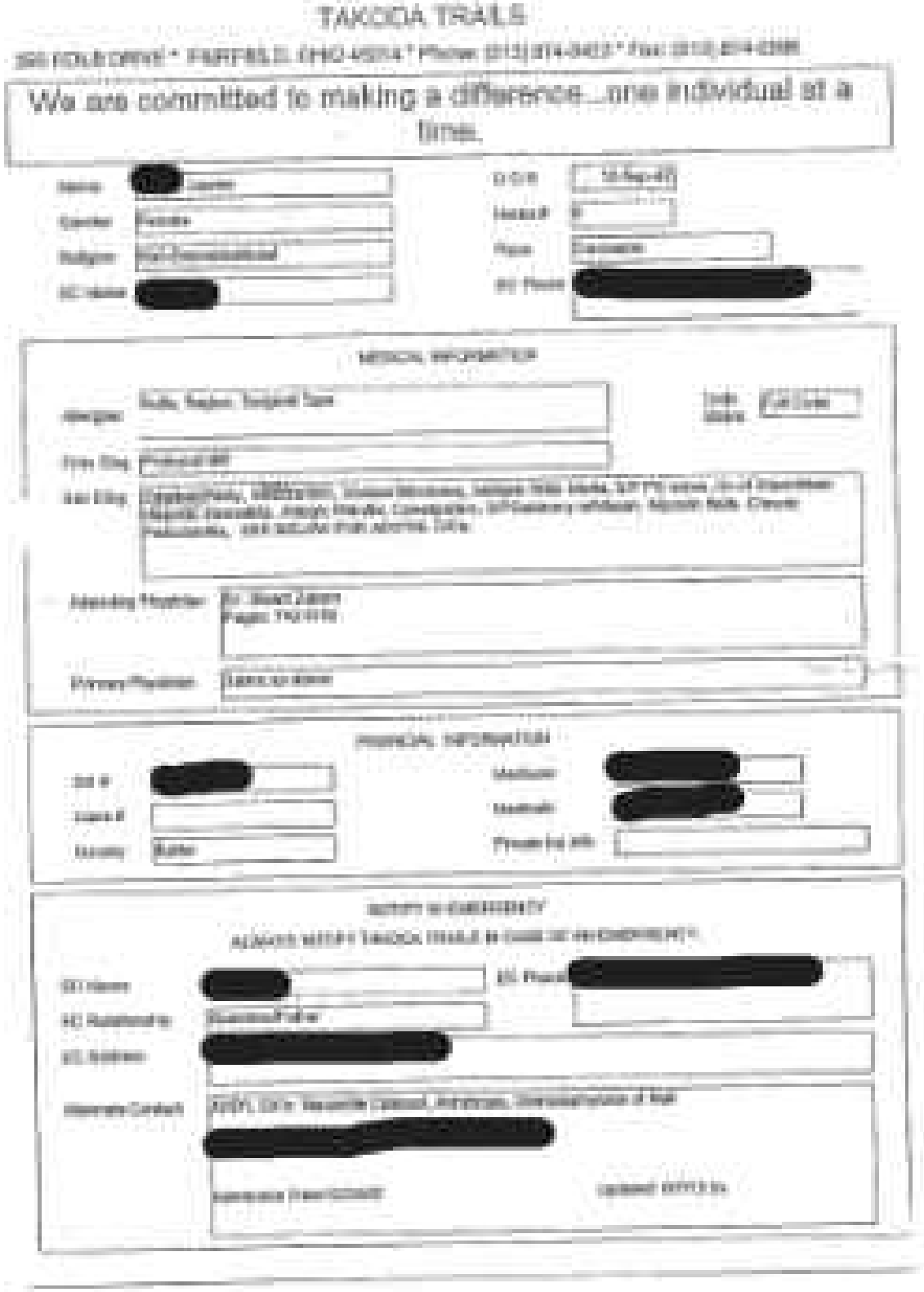
Diagnosis: Profound MR, Cerebral Palsy, Seizure Disorder, Cortical Blindness, Multiple Otitis Media, S/P PE Tubes, Hx of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastrocnemius with Nissen, Mycotic Nails, Chronic Periodontitis, Nonsenile Cataract, Anhidrosis, Dermatoglyphics of Hall, Methanethiol Penis, Blindness Both Eyes Impair Level.

Medications: Tylenol 160mg q6hrs/as elevated temperature, Diastat 5mg PRN-seizures, Claritin 10mg qd-allergic rhinitis, Keppra 1000mg bid-seizures, Flutiasone Nasal Spray 50mcg qd-allergic rhinitis, Miralax 17gm in 8oz. H2O qd-constipation, Bacitracin-Clotrimin Cream to G-Tube site bid-preventative, Lacrilube 12% bid-anhidrosis Scheral Suit.

Signature: _____ **Title:** _____ **Date:** _____

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TAKODA TRAILS

We are committed to making a difference...one individual at a time.

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Takoda Trails

Special Team Meeting

Name of Individual: Lauren [redacted] **Home/Unit:** [redacted]

Date of Meeting: 12/5/14

Discussion & Opinions:

Team met to discuss how Lauren is adjusting to her new level of supervision. Lauren has adjusted fine thus far with no problems. Team agrees to continue level of supervision and plan.

Kimberly Cundiff-Case Mgr 12-5-14

Signatures/Title/Date

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TAKODA TRAILS

DATE: 12-2-14 Time: hrs: _____ min: _____

TITLE OF IN-SERVICE: STM Lawyer [redacted]

Verification/Presenter(s) Signature: Print Last Name

Attendance: Signature indicative that person(s) in attendance will be responsible for this in-service information and will perform their job duties accordingly.

PRINT NAME FACILITY

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Takoda Trails

Special Team Meeting

Name of Individual: Lauren [redacted] **Home/Unit:** [redacted]

Date of Meeting: 12/2014

Discussion & Opinions:

Team met to discuss Lauren's supervision level and ways to keep her safe. Remove 1:1 supervision

- Arrival Protocol
- Re-assurance on shoes
- plastic furniture?
- put dresser in closet
- Person might Stand
- Remove Lauren bags put in living room
- Grip socks?
- Lauren morning and night
- to make checks for Mood
- Out of room watch Warning or Isolation

Kimberly Brookshire 12/2/14

Signature/Title/Date

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Special Team Meeting

Student

Lorain [redacted]

12/2014

The following people were invited and served on this Individuals Team:

Signature and Title:

[signature] [signature]

[signature] [signature]

[signature] [signature]

[signature] [signature]

[signature] [signature]

☐ Individual was not in attendance at today's meeting because: _____

_____

_____

As a result of missing his/her special team meeting, the IP was reviewed with him/her by:

_____

Signature/Title/Date of Review

☐ The guardian was not in attendance at today's meeting because: _____

_____

_____

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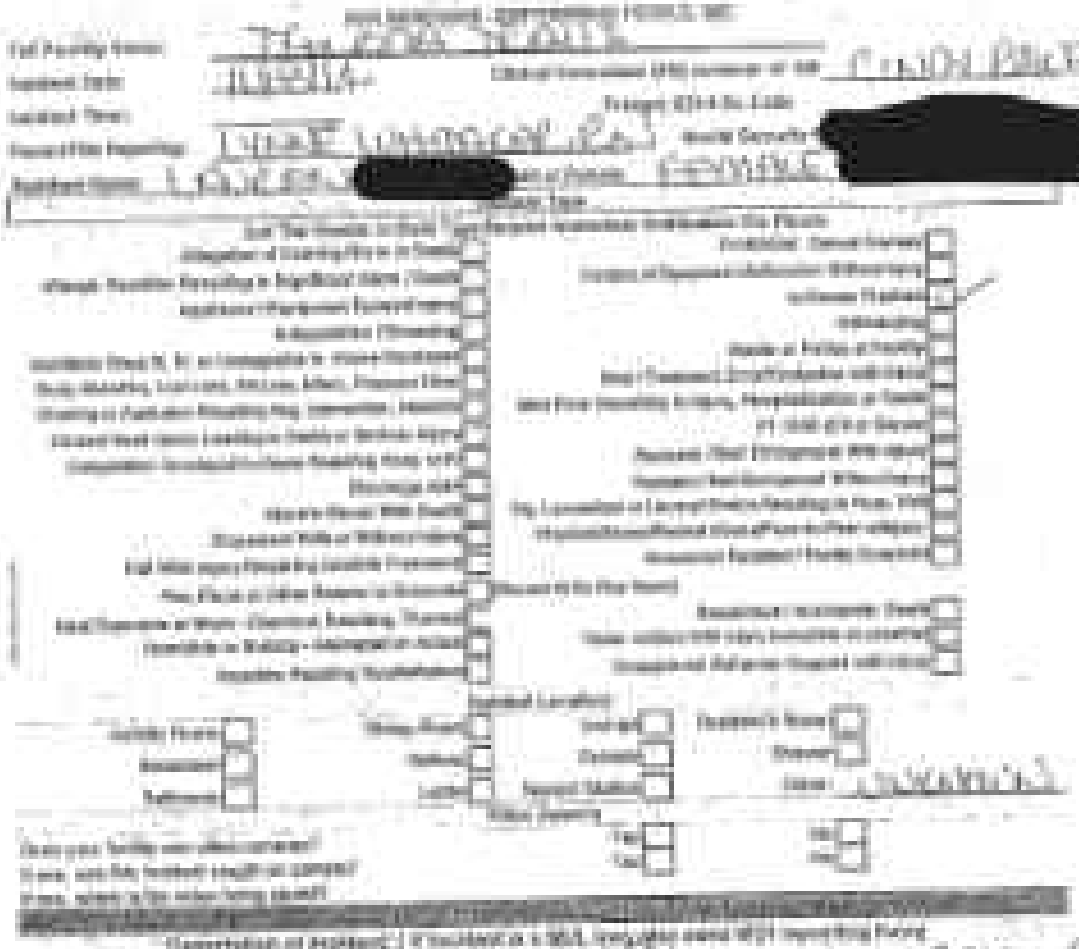
Special Team Meeting Consent

Name of Child: [redacted]

Date of Meeting

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UNCLE WOULD REQUIRE WORD TO CHASE, KICK + BALL. AREA APPROX 4 INCHES - 6 INCHES - FLEXIBLE IN SHAPE - RANGE FROM END OF KNEE TO TOP OF RIGHT SHOULDER - TWO AREAS W/ INFLAMMATION SPREADING. PT'S LOOKED AT AREA WITH WOUNDS + DOCUMENT SEEN BY DR. GRACE, DEMO PART OF

CLOSED FRACTURE OF R. CLAVICLE WORD ON XRAY. MD DECIDED TO KEEP IN SLING + USAGE PAIN TOLERATED. F/U IN 4 WEEKS - 12 WEEKS & WOMEN MD FEEL WHEN 1-2 WEEKS OLD PT COMPLAINED OF BACK ACHE

FEMORAL DEVOTH FRACTURE - FEELS THAT HE MIGHT BE ABLE TO KEEP WEIGHT OFF

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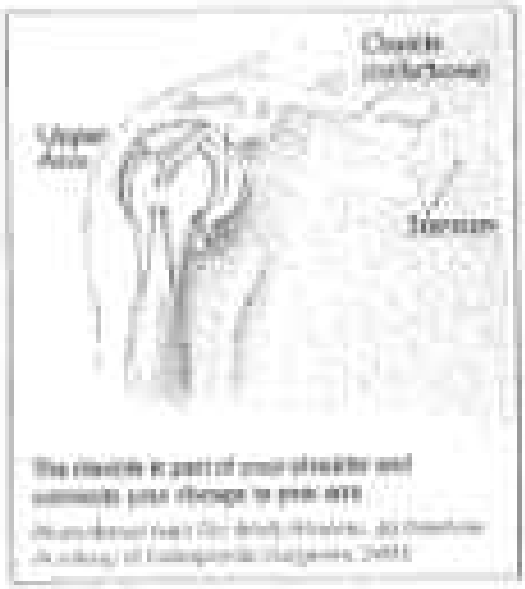
Clavicle Fracture (Broken Collarbone)

A broken collarbone is also known as a clavicle fracture. This is a very common fracture that occurs in people of all ages.

Anatomy

The collarbone (clavicle) is located between the ribcage (sternum) and the shoulder blade (scapula), and it connects the arm to the body.

The clavicle lies above several important nerves and blood vessels. However, these vital structures are rarely injured when the clavicle breaks, even though the bone ends can shift when they are fractured.



The clavicle is part of your shoulder and connects your ribcage to your arm.

Was this article he

Description

The clavicle is a long bone and most breaks occur in the middle of it. Occasionally, the bone will break where it attaches at the ribcage or shoulder blade.

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There are many types of shoul... injuries:

- Fractures are broken bones. Fractures commonly involve the clavicle (collar bone), proximal humerus (top of the upper arm bone), and scapula (shoulder blade).
- Dislocations occur when the bones on opposite sides of a joint do not line up. Dislocations can involve any of three different joints.
  - A dislocation of the acromioclavicular joint (collar bone joint) is called a "separated shoulder."
  - A dislocation of the sternoclavicular joint interrupts the connection between the clavicle and the breastbone (sternum).
  - The glenohumeral joint (the ball and socket joint of the shoulder) can be dislocated toward the front (anteriorly) or toward the back (posteriorly).
- Soft-tissue injuries are tears of the ligaments, tendons, muscles, and joint capsule of the shoulder, such as rotator cuff tears and labral tears.

The following discussion will focus on fractures and dislocations.

Causes

Fractures

Fractures of the clavicle or the proximal humerus can be caused by a direct blow to the area from a fall, collision, or motor vehicle accident.

Because the scapula is protected by the chest and surrounding muscles, it is not easily fractured. Therefore, fractures of the scapula are usually caused by high-energy trauma, such as a high speed motor vehicle accident. Scapula fractures are often associated with injuries to the chest.

Shoulder Dislocations

- Anterior dislocations of the shoulder are caused by the arm being forcefully twisted outward (external rotation) when the arm is above the level of the shoulder. These injuries can occur from many different causes, including a fall or a direct blow to the shoulder.
- Posterior dislocations of the shoulder are much less common than anterior dislocations of the shoulder. Posterior dislocations often occur from seizures or electric shocks when the muscles in the front of the shoulder contract and forcefully tighten.

Shoulder Separations

Dislocations of the acromioclavicular joint can be caused by a fall onto the shoulder or by striking objects. The term "shoulder separation" is not really correct, because the joint injured is not the shoulder joint.

Watch this article for updates when new content is added

Symptoms of Fractures

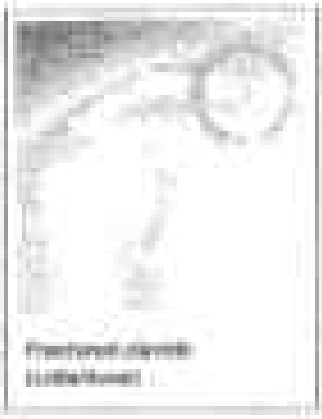
Symptoms of fractures about the shoulder are related to the specific type of fracture.

Clavicle Fractures

- Pain
- Swelling and bruising
- Inability to move the shoulder
- A grinding sensation when the shoulder is moved
- Deformity – "It does not look right"

Specific Findings: Clavicle Fracture

- Swelling about the middle of the collarbone area
- An area that may have a "bump," which is actually the prominent ends of the fracture under the skin
- Shoulder range of motion is limited, although not as much as with fractures of the proximal humerus



Fractured clavicle (collarbone)

Specific Findings: Proximal Humerus Fracture

- A severely swollen shoulder
- Very limited movement of the shoulder
- Severe pain



Fractured head of the humerus

Specific Findings: Scapular Fracture

- Pain
- Swelling
- Severe bruising about the shoulder blade



Fracture patterns in the scapula

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[illegible] Reproduced with permission from Lippincott Williams & Wilkins: Rockwood CA Jr, Green DP, Bucholz RW, Heckman JD (eds): Rockwood and Green's Fractures in Adults, 4th ed. Philadelphia, PA, Lippincott-Raven Publishers, 1996, vol 1, p 1013.

Specific Findings: Shoulder Separation (Acromioclavicular Joint Separation)

- Pain over the top of the shoulder
- A prominence or bump about the top of the shoulder
- The sensation of something sticking up on the shoulder



An acromioclavicular joint dislocation with the external shoulder of the clavicle.

Reproduced with permission from Rockwood CA Jr, Green DP, Bucholz RW, Heckman JD (eds): Rockwood and Green's Fractures in Adults, 4th ed. Philadelphia, PA, Lippincott-Raven Publishers, 1996, vol 1, p 1013.

Specific Findings: Shoulder Dislocation (Glenohumeral Joint Dislocation)

- A prominence about the front of the shoulder
- Inability to move the arm
- An arm rotated outward
- The sensation of a "dead arm"



Shoulder instability

Diagnosis

Most fractures are diagnosed with X rays of the area and by physical examination. Sometimes, additional imaging techniques, such as computed tomography, are necessary.

Treatment Options

Clavicle Fractures

Most clavicle fractures can be treated without surgery. Surgery is necessary when there is a compound fracture that has broken through the skin or the bone is severely out of place. Surgery typically involves fixing of the fracture with plates and screws or rods inside the bone.

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Proximal Humerus Fracture
Most fractures of the proximal humerus can be treated without surgery if the bone fragments are not shifted out of position (displaced). If the fragments are shifted out of position, surgery is usually required. Surgery usually involves fixation of the fracture fragments with plates, screws, or pins or it involves shoulder replacement.

Scapula Fractures
Most fractures of the scapula can be treated without surgery. Treatment involves immobilization with a sling or shoulder immobilizer, icing, and pain medications. The patient will be examined for additional injuries.

About 10% to 20% of scapula fractures need surgery. Fractures that need surgery usually have fracture fragments involving the shoulder joint or there is an additional fracture of the clavicle. Surgery involves fixation of the fracture fragments with plates and screws.

Shoulder Separations (Acromioclavicular Joint)
Treatment of shoulder separations is based on the severity of the injury as well as the direction of the separation and the physical requirements of the patient.

Less severe shoulder separations are usually treated without surgery.

Severe separations in an upward direction or dislocations in the backward or downward directions often require surgery. Surgery involves repair of the ligaments.

Professional athletes and manual laborers are often treated with surgery, but the results are often unpredictable.

Shoulder Dislocations (Glenohumeral Joint)
The initial treatment of a shoulder dislocation involves reducing the dislocation ("putting it back in the socket"). This usually involves treatment in the emergency room.

The patient is given some mild sedation and pain medicine, usually through an intravenous line. Often, the physician will pull on the shoulder until the joint is realigned. Reduction is confirmed on an X-ray and the shoulder is then placed in a sling or special brace.

Additional treatment at a later date is based on the patient's age, evidence of persistent problems with the shoulder going out of place, and the underlying associated soft-tissue injury (either to the rotator cuff or the capsuloligamentous complex).

Patients who are 25 years of age or younger generally require surgery. Persistent instability (repeat dislocations) of the shoulder usually requires surgery. Surgery involves repair of the torn soft tissues.

Life After a Shoulder Injury

Life after a shoulder fracture, separation, or dislocation can be greatly affected for several weeks or even months. Most shoulder injuries whether treated surgically or nonsurgically require a period of immobilization followed by rehabilitation.

If the injury was not severe, there is fairly rapid improvement and return of function after the first 4 to 6 weeks. Shoulder exercises, usually as part of a supervised physical therapy program, are usually necessary. Exercises decrease stiffness, improve range of motion, and help the patient regain muscle strength.

What Should You Discuss With Your Orthopaedic Surgeon?

Some of the information you should discuss with your orthopaedic surgeon includes the following:

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AAOS

OrthoInfo

Your connection to expert orthopaedic information

Shoulder Trauma (Fractures and Dislocations)

Trauma to the shoulder is common. Injuries range from a separated shoulder resulting from a fall onto the shoulder to a high-speed car accident that fractures the shoulder blade (scapula) or collar bone (clavicle). One thing is certain: everyone injures his or her shoulder at some point in life.

Anatomy

The shoulder is made up of three bones:

- Scapula (shoulder blade)
- Clavicle (collar bone)
- Humerus (arm bone)

These bones are joined together by soft tissues (ligaments, tendons, muscles, and joint capsule) to form a platform for the arm to work.



Shoulder Anatomy

The shoulder is made up of three joints:

- Glenohumeral joint
- Acromioclavicular joint
- Sternoclavicular joint

The shoulder also has one articulation, which is the relationship between the scapula (shoulder blade) and the chest wall.

The main joint of the shoulder is the glenohumeral joint. This joint comprises a ball (the humeral head) on a golf-tee-shaped joint (the glenoid of the scapula).

The bones of the shoulder are covered by several layers of soft tissues.

- The top layer is the deltoid muscle, a muscle just beneath the skin, which gives the shoulder a rounded appearance. The deltoid muscle helps to bring the arm overhead.
- Directly beneath the deltoid muscle is sub-deltoid bursa, a fluid-filled sac, analogous to a water balloon.

Types of Shoulder Injuries

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- The exact type of your injury
- The severity of the injury
- The treatment plan
- The possible complications
- Whether surgery will be necessary
- When it is expected that you will be mentally improved
- What is the expected outcome will be both in the short term and in the long term

Last reviewed: September 2007



Co-developed by the Orthopaedic Trauma Association

AAOS does not endorse any treatments, procedures, products, or physicians referenced herein. This information is provided as an educational service and is not intended to serve as medical advice. Anyone seeking specific orthopaedic advice or assistance should consult his or her orthopaedic surgeon, or doctor near you through the AAOS Find an Orthopaedic Surgeon on this web site.

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Related Articles

Cervical Fracture (Broken Collarbone) in the Newborn (Beyond the Basics)
Dislocated Shoulder (Beyond the Basics)
Fractured (Broken) Hand (Beyond the Basics)
Hospital (Emergency Room) Fractures (Beyond the Basics)
Shoulder Separation (Beyond the Basics)

OrthoInfo
The American Academy of Orthopaedic Surgeons
6300 N. River Road
Rosemont, IL 60018
Phone: 847.823.7186
Email: orthoinfo@aaos.org

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Takoda Trails - Unusual Incidents

Includes all IIIs and MUIs for [redacted] Learner From 1-1-14 to 11-1-14

Date	Time	Name	MUI Incident Type	Incident Summary	Prevention Plan
[redacted]			☐ Theft Arrest	during per hygiene staff reported 1-1 car a 4.20 car taken area by vehicle right hand/ taken	safe parking to feel there and dark
[redacted]			☐ Injury Overdose/Seizure	Staff observed to take her client resting bathroom observing done	resident observed to driving room when attempted to get up had fell
[redacted]			☐ Injury Minor Cut	during am hygiene she ran into the corner of her dresser and resulted in a cut under her left eye	assisting applied to corners of dresser
[redacted]			☐ Injury Minor Cut	resident was in her room when staff heard her scream/ing upon upon investing saw her sitting on a couch on floor in left side of face and mouth/cut and bruise noted to top of left shoulder	incident was to Henry Ford ER for follow up. plan is to get shoe inside and shower. Ex Lauren's protection
[redacted]			☐ Injury Accidental Injury	during pm hygiene lavatory she stood to leave a bruise/cut on left hand/arm on Fri/ hours	hand body audits implemented
[redacted]			☐ Injury	1 hour +/- Lucia came area as he hindered she was up old wound and had registered	monitor body audits
[redacted]			☐ Injury Overdose/Seizure	staff observed on negative sessions on Lawson left wrist	finger patients pin on all lingers areas
[redacted]			☐ Injury Overdose/Seizure	Resident noted to have swollen ear finished	attempt to see a healthcare and medical supervision level
[redacted]			☐ Injury Accidental Injury	Resident noted to have 1 bruised knot minutes on right wrist	take nurse participant's protect home hig and
[redacted]			☐ Illness	resident said home from workshop with stomach complications and nausea	a care order for possession obtained (Order was take) ESI daily the 9 level. Ex ben hing tab 1-2 take per side nutri ed 5 tea pot
[redacted]			☐ Injury Accidental Injury	While staff was changing Lawsons shirt they noticed scratch on upper arm.	Med light prescribed tested to 1 apply/ area. Applied. 0.25cm Area checked with prop and noted. Tech again. B.D. 5.4.D 0.0 1 1 days. Staff trained on body audits and reviewed and SSP for incorporation follow-ins

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Date	Time	Name	YES	Incident Type	Incident Summary	Preventive Plan
[redacted]	[redacted]	[redacted]	☐	Injury: Bruising	Staff was assisting resident with changing. Resident refuse [illegible] resident a bruise and scratch on mid-back left thigh.	DEP Interdisciplinary staff to determine if they can be modified about for having bed objects in the house.
[redacted]	[redacted]	[redacted]	☐	Injury: Bruising	Resident was left side of forehead, bruise and DEP both checked. Lasers neither was sure a blocks on her forhead.	DEP Informed staff that it was a issue on her forhead.
[redacted]	[redacted]	[redacted]	☐	Illness: Infection	Resident was walking to the hallway when staff noticed her left eye watering.	Resident diagnosed with pink eye. Started prescribed antibiotic drops 3xday for 7 days.
[redacted]	[redacted]	[redacted]	☐	Injury: Other ER	Lasers was observed when receiving morning hygiene a bare bleed and her elbow. Left pinky was noticed to have some pain with it on dressings. Area cleansed with soap and water. CALL applied.	Staff been told to keep Lasers arm [illegible] to minimizing arm/all injury. This may she will harm areas on and avoid further injury.
[redacted]	[redacted]	[redacted]	☐			
[redacted]	[redacted]	[redacted]	☐	Injury: Abdominal Area	Was walking through kitchen staff noted L eye was red. Eyelid appeared L eyelid red no discharge or pain noted.	Staff will continue current level of supervision, no possible reason inside house found.
[redacted]	[redacted]	[redacted]	☐			
[redacted]	[redacted]	[redacted]	☐	Safety Concern	resident observed leaning her head when she was into the wall	continue to report situation as they are addressed in a timely manner and monitor. Lasers if you see these might be a potential danger
[redacted]	[redacted]	[redacted]	☐	Injury: Scratch/Scrape	Staff went to get Lasers from her room and could she was crying and screaming and had a scrape on her arm. Abrasion is still clear red in color noted.	Staff to address to 3 and assess in areas Lasers does not get hurt while she is in her room.
[redacted]	[redacted]	[redacted]	☐	Injury: Scratch/Scrape	resident was seen to have an abrasion to her left elbow and lip area	Staff will observe and report any changes while resident is in her room.
[redacted]	[redacted]	[redacted]	☐			
[redacted]	[redacted]	[redacted]	☐	Injury: Scratch/Scrape	Staff reported a Lasers was found on the right side of hip and a Green Hemangiolo to her left elbow.	Staff will continue to continue observe

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Date	Time	Name	MEU Incident Type	Incident Summary	Preventive Plan
25-Sep-14	0:40 AM	[redacted]	☐ Indoor Sidewalk/Ramps	resident exited w bare foot on downhill direction on NS glider loc	plant bamboo under to form padding and thorns on the footdrop

FILED 04/22/2015 04:59 PM / CONFIRMATION 1525597 / A 2205597 / MONA BRADEN / ADM

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WITNESS STATEMENT

Witness Name: Victoria Harris

Witness Position:

Witness Date of Hire: 10/22/19

DESCRIPTION OF INCIDENT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Summary: I wasn't assign to Lauren the last two week I didn't see her Call

Victoria Harris
Signature

10/20/20
Date this statement is completed

Rev: 1/2/14

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WITNESS STATEMENT

Witness Name: [illegible]

Witness Position:

Witness Date of Hire:

DESCRIPTION OF INCIDENT

Date of Incident: 11-2-21 Time of Incident: 3Pm

Location of Incident: Street S

Summary: I did notice some burning odor however, didn't actual, but because I live a retired fire officer I did not think I needed to report the burning there was burning on buses left South and a little down by 25th Ave

Signature

11-3-21
Date this statement is completed

Rev. 2/2014

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MAR CLOSURE FORM

Must be completed for all MARs

INTAKE SECTION	
Incident Number: 521	Individual's Name: [redacted]
Category: Neglect or Exploitation	Date: 11/20/2024
Investigator's name: [illegible]	DDSD Due Date: N/A
Does the MAR involve a county board unit staff or the PPI?	Yes or (NO)
If Yes, the IA must complete all fields typically completed by the Program Manager	

IA SECTION
Include the complete name/address (physical or mail) for each person below. Mark N/A if does not apply. If a letter should not be sent, indicate that below and explain reason.
Individual or Individual's Guardian/Advocate: [redacted]
Provider(s): McKinley Hall
Provider(s) at the time of incident (if different than above):
Support Coordinator: N/A
Primary Person Involved: RECEIVED PPI LETTER ONLY, NO SUMMARY LETTER
N/A
Date Determined for Closure: 12/

PROGRAM SECRETARY SECTION
List the date each task was completed below. Mark N/A if the task does not apply
Date Summary Letters Sent: 12/
Date of Closure: 12/
Date Closure Notification Sent:
Date PPI Letter Sent:
Date Death Certificate Sent:

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EXHIBIT

07

Prehospital Care Report Summary

City of Fairfield FD

315 Nilan Rd Hall, Fairfield, OH 45014

Date: [redacted] Call #: [redacted] Booked: [redacted] Time Zone: America/New_York

Call Information:

Billing Disposition: Treated/Transported
Initial Patient Acuity: Lower Acuity (Green)
Unit #: M30 - Medic 30, Ground Ambulance - ALS2 Trip Type: Initial Trip
Run Type by Scene: Emergency Response (Primary Response Area); Emergent (Immediate Response)

Service Requested: Emergency Response (Primary Response Area)
Incident Facility: Twinsta Trails (Assisted Living) (Assisted Living Center) - 350 Kolb DR - Fairfield, OH 45014
Incident Location: 350 Kolb DR - Fairfield, OH 45014 (Butler County)
Incident Location Type: Res. Custodial Facility

Receiving Facility: Mercy Health - Fairfield Hospital - 3000 Mack Road - Fairfield, OH 45014
Facility Address: 3000 Mack Road - Fairfield, OH 45014
Destination Type: Hospital Emergency Department
Dest. Reason: Nearest/Most Accessible Facility
Hospital Capability: Hospital (General)
Condition of Patient At Destination: Unchanged
Registration #: N/A

Loaded Mileage: 1.1 (Total Mileage: 1.1)
Crew Members: Jennifer Rhodeberry, Paramedic(DOC); Ben Stoeppel, EMT(SS/DH); Joe Byers, Paramedic

Moved to Amb By: Stretcher Transport Position: Semi/Full Fowlers Push Amb By: Stretcher

Other Units On Scene: A31 - ALS2

Call Origin: N/A Lights/Siren: Scene Lights and Siren, Destination - Lights and Sirens

# Patients Transported to My Unit:	1
# Patients at Scene:	1
Call Received:	18:27:20
Dispatched:	18:30:33
En Route:	18:30:40
At Staging Area:	
On Scene:	18:45:07
Patient Contact:	18:50:03
Transfer of EMS Patient Care:	
Left Scene:	19:02:20
At Destination:	19:05:42
Destination Patient Transfer of Care:	19:20:03
In Service:	19:36:33
Time On Scene:	7 Min
Time to Destination:	17 Min
Total Time of Run:	49 Min

Patient Information:

Name: Lauren Carter
Address: 350 KOLB DR - FAIRFIELD, OH 45014
County: Butler
Phone:
Email:
SSN: [redacted]
Driver License:
Local Resident: Yes
Veteran: No

DOB: [redacted]
Gender: Female
Age: 31 Years
Weight: [redacted] kg (Approx.)
Breadbox:

Current Meds:
Env Allergies:
Med Allergies:
Patient Physician:
Advance Directives:
PMH:
Comment:
Patient Physical Limitations:
Comment:

Comments:
Comments:
Comments:

Payer Information:

Medicare Beneficiary Notice
Was a Medical Necessity: No
Always Request Closest Appropriate Facility: No
Requested Service:

Non Covered Service: No
Preferred Physician: No

[redacted]

Clinical:

[redacted]

Assessments:

Time	Employee	Type	Summary
[redacted]	[redacted]	ABC	Airway: General: Patent: Yes Breathing: Rate: Normal: Yes Quality: Unlabored: Yes Lung Sounds: Left: Clear: Yes Lung Sounds: Right: Clear: Yes Circulation: General: Normal: Yes Skin Capillary Refill: Normal Skin Color: Normal: Yes Skin Temperature: Normal: Yes Skin Condition: Normal: Yes
[redacted]	[redacted]	Neurological	AOPV: Alert Mental Status: Normal: Yes Neurological: All Flaccid: Normal

Vitals:

Time	Employee	Summary
[redacted]	[redacted]	Patient Position: Sitting BP: Systolic Unable to Complete Diastolic Unable to Complete Pulse: Unable to Complete Resp: 16 SPO2: Unable to Complete Pain: 0 Pain Scale: Numeric (0-10) Glasgow Coma Score: E (4) + V (5) + M (6) = 15 - Adult

Treatments/Medications:

Time	Employee	Summary

Supply:

Qty: Supply

EMS Device (Incident Number):

Narrative (History Text):

[redacted]

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Unable to sign because: (If Yes) (Patient unable to sign because of comments)
Authorized Representative: No authorized representative is available or willing
Authorized Representative Signature: No
Secondary Documentation: Patient Care Report (signed by representative of facility)
Secondary Documentation Signature: No
Comments:
Pt is MR

Auth Signature: No **Privacy Sig:** No **Unable to Sign:** Yes **Refused to Sign:** No

Signature Image(s)

Authorization Signature

Privacy Notice Signature

Receiving RN / MD Signature - Megan - 08/25/2019 10:26



Technician Signature - Raspberry Jennifer - 08/25/2019 10:16



Technician 2 Signature - Snapper Ben - 08/25/2019 10:16



Recommended Service Level: BLS / Dispatch Service Level: BLS

PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 3

EXHIBIT

07

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315 Nilan Rd Hall, Fairfield, OH 45014

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Service Requested: Emergency Response (Primary Response Area)
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Registration #: N/A

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Call Origin: N/A Lights/Siren: Scene Lights and Siren, Destination - Lights and Sirens

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On Scene:	18:45:07
Patient Contact:	18:50:03
Transfer of EMS Patient Care:	
Left Scene:	19:02:20
At Destination:	19:05:42
Destination Patient Transfer of Care:	19:20:03
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Time to Destination:	17 Min
Total Time of Run:	49 Min

Patient Information:

Name: Lauren Carter
Address: 350 KOLB DR - FAIRFIELD, OH 45014
County: Butler
Phone:
Email:
SSN: [redacted]
Driver License:
Local Resident: Yes
Veteran: No

DOB: [redacted]
Gender: Female
Age: 31 Years
Weight: [redacted] kg (Approx.)
Breadbox:

Current Meds:
Env Allergies:
Med Allergies:
Patient Physician:
Advance Directives:
PMH:
Comment:
Patient Physical Limitations:
Comment:

Comments:
Comments:
Comments:

Payer Information:

Medicare Beneficiary Notice
Was a Medical Necessity: No
Always Request Closest Appropriate Facility: No
Requested Service:

Non Covered Service: No
Preferred Physician: No

[redacted]

Clinical:

[redacted]

Assessments:

Time	Employee	Type	Summary
[redacted]	[redacted]	ABC	Airway: General: Patent: Yes Breathing: Rate: Normal: Yes Quality: Unlabored: Yes Lung Sounds: Left: Clear: Yes Lung Sounds: Right: Clear: Yes Circulation: General: Normal: Yes Skin Capillary Refill: Normal Skin Color: Normal: Yes Skin Temperature: Normal: Yes Skin Condition: Normal: Yes
[redacted]	[redacted]	Neurological	AOPV: Alert Mental Status: Normal: Yes Neurological: All Flaccid: Normal

Vitals:

Time	Employee	Summary
[redacted]	[redacted]	Patient Position: Sitting BP: Systolic Unable to Complete Diastolic Unable to Complete Pulse: Unable to Complete Resp: 16 SPO2: Unable to Complete Pain: 0 Pain Scale: Numeric (0-10) Glasgow Coma Score: E (4) + V (5) + M (6) = 15 - Adult

Treatments/Medications:

Time	Employee	Summary

Supply:

Qty: Supply

EMS Device (Incident Number):

Narrative (History Text):

[redacted]

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Unable to sign because: (If Yes) (Patient unable to sign because of comments)
Authorized Representative: No authorized representative is available or willing
Authorized Representative Signature: No
Secondary Documentation: Patient Care Report (signed by representative of facility)
Secondary Documentation Signature: No
Comments:
Pt is MR

Auth Signature: No **Privacy Sig:** No **Unable to Sign:** Yes **Refused to Sign:** No

Signature Image(s)

Authorization Signature

Privacy Notice Signature

Receiving RN / MD Signature - Megan - 08/25/2019 10:26



Technician Signature - Raspberry Jennifer - 08/25/2019 10:16



Technician 2 Signature - Snapper Ben - 08/25/2019 10:16



Recommended Service Level: BLS / Dispatch Service Level: BLS

PAVAN PARIKH
HAMILTON COUNTY CLERK OF COURTS

COMMON PLEAS DIVISION

ELECTRONICALLY FILED
April 22, 2025 03:54 PM
PAVAN PARIKH
Clerk of Courts
Hamilton County, Ohio
CONFIRMATION 1623394

LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 56

EXHIBIT

08

Ohio Department of Developmental Disabilities

Division of Information Systems

[redacted]

Incident Number: 2019-009-0038			Group Home: Butler	
Client Number: [redacted]	Client Name: [redacted] LAUREN 350 NOLD DRIVE FAIRFIELD, OH 45014	Gender: F	Waiver Type on Incident:	Age at Occurrence: 31
Final Due Date: 10/08/2019	Incident Date: 08/25/2019	Discovery Date: 08/25/2019	Created Date: 08/25/2019	Rev Code:
Category Type: Enrolled				
Unanticipated Hospitalization:	Medical:		Bowel Obstruction	
Alleged:				
Unanticipated Hospitalization	Medical		Bowel Obstruction	
Substantiated:			Rep Substantiated:	
Injuries: Severity: N/A				
Law: Law Enforcement Involved: No				
Living Address: [redacted]	ID#: [redacted]			
Location: Non-County Operated Program			Residence: ICF/DD	
Incident Provider: [redacted]	ALEXSON SERVICES/FAIRFIELD			
Residential Provider: [redacted]	ALEXSON SERVICES/FAIRFIELD			
Adult Day/Employment Provider: No Adult Day/Employment Provider				
Notifications: [redacted] Guardian: 08/25/2019		Caregiver Notified: Rep. Closure: 09/23/2019	Accepted: Rep. Closure By: Joan Omar	Autopsy:

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Ohio Department of Developmental Disabilities

Division of Information Systems

ROOM INCIDENT REPORT (ISR)

Incident Number: 2019-055-5339	Group Name: Butler
Notifications County: 08/29/2019 Administrator: 08/29/2019	Incident Review Status: Closed Closed Date 09/23/2019 Investigated By: Investigative Agent Joan Orlyn Closed By: Joan Orlyn Last Change By: Joan Orlyn

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Others

Initial Report	08/26/2019	3813749

It was reported to Elizabeth Grove, SIA On-Call/BCBDD on 8/26/19 that Laura[redacted] was admitted to the hospital with diagnosis of bowel obstruction.
<Rebekah Lyons Added on 8/26/2019>

Immediate Action	08/26/2019	3813179

Lauren remains in the hospital at this time.
<Rebekah Lyons Added on 8/26/2019>

Final Report	09/03/2019	3823009

Q1(a) List persons interviewed and documents reviewed:
A)Interviews/Statements:
Lyons Rebekah, Takoda Trails IA – completed this MUI with review from Wb IA.

Documents Reviewed:
DODD Incident Report
Incident report
On call report
Consumer detail report
Net MAR's
IP
Email correspondence
Prevention Plan
Medical records
Nurses notes
Bowel charts
Providers report

Q1(a) Summary of interviews and documents reviewed:
A)
The administrative investigation commenced by Rebekah Lyons on 8/26/19 by gathering and reviewing relevant documents, incident report. This IA received and reviewed case assignment on 8/26/19.

Level of supervision: Met. Would range at home when out of bedroom, 15 minute checks in bedroom.

Review of past MUI's – 6 past MUI's filed since 2015. No past UH filed.

Background information:
Laura[redacted] is a 15-year-old female who resides at Takoda Trails[redacted] father, serves as her guardian. Supervision level: is would range at home when out of her bedroom. 15 minute checks while in her bedroom. Diagnosis Includes: Profound ID, Cerebral Palsy, Seizure disorder, Cortical Blindness, Multiple Cysts kidneys,G/P PE Tubes, Hx of intussusception, Hernia Surgeries, Allergic Rhinitis, Constipation, G/P Gastromy with Nissen fundoplic Hiatal, Chronic Pancreatitis, Juvenile Cataract, Arthritis, Dermatoglyphics of Hall, Mechanical Pleural, Blindness both eye Impair Vision.

Medical history (e.g., recent similar illnesses or chronic/acute conditions):
N/A

Health status during prior seventy-two hours:
No reported issues. Bowel records show that she was having regular BM's.
Date and reason for most recent prior hospitalization:

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Others

s/s

Description of the Incident:

Staff noted multiple skin discolorations on all 4 extremities and coffee ground emesis. Nursing checked Lauren and assessed the area to be bruising. They also noted the coffee ground colored emesis and the same residual in her stomach. 911 called and she was sent to Mercy Fairfield ER for further evaluation.

Review of diagnosis, discharge summary, and follow up appointment:

If the individual had the flu or pneumonia, indicate whether he or she received a flu shot or pneumonia vaccine: n/a

<Quan. Other Added on 9/23/2019>

Findings and Conclusions	09/23/2019	3823991

Lauren was sent to the hospital on 9/23/19 due to multiple skin discolorations on all four extremities and coffee ground emesis.

Lauren was evaluated in the ER and admitted with a diagnosis of Blindness, CP, Profound DD, Constipation and small bowel obstruction. She was started on IV fluids and no findings were given that her tube fix a while. They thought that she might require surgery, but her bowels started working again. Her tube feedings were restarted and she was able to return home. She had new orders for Potassium 20meq 3 times daily x 9 days and increase her Miralax to daily.

Lauren was discharged from the hospital on 9/29/19.

Appropriate and timely treatment was sought for Lauren.

<Quan. Other Added on 9/23/2019>

Cause And Contributing Factors	09/23/2019	3823993

- Multiple skin discolorations on all four extremities and coffee ground emesis.
- Bowel obstruction and constipation and history/diagnosis of constipation.

<Quan. Other Added on 9/23/2019>

Prevention Plan	09/23/2019	3823995

Lauren will complete the potassium supplements as prescribed.

Her Miralax was increased to daily.

Staff will monitor bowel movements and document them and will report any issues with vomiting to nursing.

Nurses will monitor bowel movements to ensure that the increased dose of Miralax is effective and also not too much for Lauren.

Follow up with Dr. Zakem in clinic.

<Quan. Other Added on 9/23/2019>

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MIT Report
Individual: Lauren [redacted]
Investigator: Jean O'Neill
Incident Number: 2019-009-0136
Category: Unauthorized Departure/Elopement
Date: 8/25/19

INITIAL STATEMENT:
It was reported to DCDD on call staff that on 8/25/19 Lauren was admitted to the hospital with a diagnosis of bowel obstruction.

IMMEDIATE ACTION:
Lauren was taken to the hospital and admitted for treatment.

LIST OF PERSONS INTERVIEWED AND DOCUMENTS REVIEWED
Interviews/Statements:
Lyssa Webster, Tabatha Trails III – completed this MIT with review from this IA

Documents Reviewed:
DODD Incident Report
Incident report
On call report
Consumer detail report
Past MIT's
IP
Email correspondence
Prevention Plan
Medical records
Nurses notes
Bowel charts
Frontlines report

SUMMARY OF INTERVIEWS/DOCUMENTS REVIEWED

The administrative investigation commenced by Rebekah Lyons on 8/26/19 by gathering and reviewing relevant documents, incident report. This IA received and reviewed case assignment 8/29/19.

Level of supervision: Min, Visual range at home when out of bedroom, 15 minute checks in bedroom

Review of past MIT's – 0 past MIT's filed since 2015. No past UR filed.

Background Information:
Lauren [redacted] is a 23 year old female who resides at Tabatha Trails [redacted], father, serves as her guardian. Supervision level is visual range at home when out of her bedroom, 15 minutes checks while in her bedroom. Diagnosis includes Profound ID, Cerebral Palsy, Seizure disorder, Cortical Blindness, Multiple DDDs, Medically F/P PE Tubes, Hx of Laryngotracheal Laryngitis Stenosis, Allergic Rhinitis, Constipation, G/T Gastrostomy with Mitrofanoff Stoma, Chronic Periodontitis, Traumatic Cataract, Astigmatism, Dermatophytosis of Nail, Mechanical Ptosis, Blindness both eye (right/left)

Medical History (e.g., recent similar illnesses or chronic/acute conditions):
n/a

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Health status during prior seventy-two hours:
No reported issues. Bowel sounds show that she was having regular BM's.
Date and reason for most recent prior hospitalization:
n/a
Description of the incident:
Staff noted multiple skin discoloration on all 4 extremities and coffee ground emesis. Nursing checked Lauren and removed the items to be testing. They also noted the coffee ground colored emesis and the same residual in her stomach. 911 called and she was sent to Mercy Fairfield ER for further evaluation.

Review of diagnosis, discharge summary, and follow-up appointment:

If the individual had the flu or pneumonia, indicate whether he or she received a flu shot or pneumonia vaccine n/a

FINDINGS AND CONCLUSIONS
Lauren was sent to the hospital on 8/21/19 due to multiple skin discolorations on all four extremities and coffee ground emesis.

Lauren was evaluated in the ER and admitted with a diagnosis of Blindness, CP, Profound ID, Constipation and small bowel obstruction. She was started on IV fluids and no feedings were given then but rate for a while. They thought that she might require surgery, but her bowels started working again. Her tube feedings were restarted and she was able to return home. She had new orders for Potassium 20meq 3 times daily x 9 doses and increase her Miralax to daily.

Lauren was discharged from the hospital on 8/25/19.

Appropriate and timely treatment was sought for Lauren.
CAUSE AND CONTRIBUTING FACTORS
- Multiple skin discolorations on all four extremities and coffee ground emesis
- Bowel obstruction and constipation and History/diagnosis of constipation.

PREVENTIVE PLAN
Lauren will complete the potassium supplements as prescribed.
Her Miralax was increased to daily.
Staff will monitor bowel movements and document them and will report any issues with vomiting to nursing.
Nurses will monitor bowel movements to ensure that the increased dose of Miralax is effective and also not too much for Lauren.
Follow up with Dr. Sakers in clinic.

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Ohio Department of Developmental Disabilities

Division of Information Systems

INCIDENT REPORT REPORTED

Incident Number: 2019-009-0236			Group Name: Butler	
Client Number: [redacted]	Client Name: [redacted] LAUREN 300 KOLB DRIVE FAIRFIELD, OH 45014	Gender: F	Witness Taken on Incident:	Age at Occurrence: 31

First Due Date: 10/08/2019	Incident Date: 08/25/2019	Discovery Date: 08/25/2019	Created Date: 08/26/2019	Sys Date:

Category Type:

Alleged:

Unanticipated Hospitalization | Medical | Missed Medication

Substantiated: | Was Substantiated

Injuries:
Severity: N/A

Living Arrangement:

[redacted] | HOME

Location: Non-County Operated Program | Residence | HOME

Incident Provider:

[redacted] | AUDITION SERVICES 6480 BLVD

Residential Provider:

[redacted] | AUDITION SERVICES 6480 BLVD

Adult Day/Employment Provider:

Non Adult Day/Employment Provider

Notifications:

[redacted]

Guardian: 08/25/2019
County: 08/25/2019
Administrator: 08/25/2019

Caused:
Verified: Accepted: Autopsy:
Rec. Closure: Rec. Closure By:

Incident's Review Status:
Open with Information Pending

Verified. 8-28-19

Tuesday, August 27, 2019

Page 1 of 1

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Ohio Department of Developmental Disabilities

Division of Information Systems

DIDD INCIDENT REPORT (IIR)

	Closed Date	Investigated By Investigative Agent Jean Ohlair
	Closed By	Last Changed By Rebekah Tanen

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Others

Initial Report	08/26/2019	3813189

It was reported to Elizabeth Gross, RN On-Call/LCBDD on 8/23/19 that Lauren [redacted] was admitted to the hospital with diagnosis of bowel obstruction.
<Elizabeth Lipsey Added on 8/26/2019>

Immediate Action	08/26/2019	3813719

Lauren remains in the hospital at this time.
<Elizabeth Lipsey Added on 8/26/2019>

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Rebekah Lyons

From:	Rebekah Lyons
Sent:	Monday, August 26, 2019 9:56 PM
To:	Lynnette Whitaker; [redacted]@butlerbhdd.net; Joan O'Neill
Subject:	UC MUI 2019-[redacted]-0338

Please be advised that an MUI for unanticipated hospitalization has been filed on behalf of Laure[redacted]. This is based on report that she was admitted to the hospital due to bowel obstruction on 8/23/19. Joan O'Neill has been assigned to review this MUI.

Lyons, please submit your investigation summary/form, along with the discharge summary, nursing notes, and any pertinent follow up to Joan by 9/5/19.

Rebekah Lyons | Intake Investigative Agent
Butler County Board of Developmental Disabilities
phone: 513-867-5882 | fax: 513-867-5928 | [redacted]@butlerbhdd.com

BUTLER COUNTY
Board of
DEVELOPMENTAL
DISABILITIES

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ISR CALL FORM

ISR is completely and sent in via filing portal no later than 9:00 am.	
Completed By: Elizabeth Stone	Individual's Assigned SC (if known): N/A
Date of Call: 8/28/19	Time of Call: in 9:00pm Start 9:00pm Total Time of Call: 4 minutes
Name/Title of Caller: Frank Ophrah	Telephone Number: 513-518-2316
Individual's Name (if Known): Lauren [redacted]	Provider: Tabitha Trails
Age: 31	
Incident Date/Time: Around 6:00pm	Location: Tabitha Trails

Description of Incident: (Who, what, when and where. List any witnesses.)
Lauren was experiencing pain and vomiting bowel vibs. Tabitha Trails staff called 911, ambulance arrived around 6:40pm, Lauren was admitted to Mercy Fairfield Hospital for bowel obstruction.

Were there any injuries? Describe:
Bowel obstruction

Immediate Actions (What was done to ensure the immediate health and welfare of the individual?)

- [x] Individual was assessed for injury/illness by direct care staff, name/results: Witnessed bowels vomit
- [ ] Individual was assessed by a medical professional, name/function: Mercy Fairfield Hospital
- [ ] A medical professional was consulted, name/title:
- [ ] Police were called, response:
- [ ] Wellness Check Requested, result:
- [ ] Ambulance/911 was called, response:
- [x] Individual was transported to urgent care/hospital, location: Mercy Fairfield Hospital
  - Admitted? [x] Yes [ ] No [ ] Unknown
- [ ] Mobile Crisis was called, response:
- [ ] Increased supervision, describe:
- [ ] Staff was placed on leave, name/details:
- [ ] Access to PPI prevented, explain how:
- [ ] Medications/personal property secured, describe:
- [ ] Additional staffing added to the home, describe:
- [ ] Alternative placement was arranged, describe:
- [ ] Discussed safety plan with individual or other involved party, describe:
- [ ] Other, please describe:

[ ] CHECK HERE if additional information is available in a case note.

Notifications

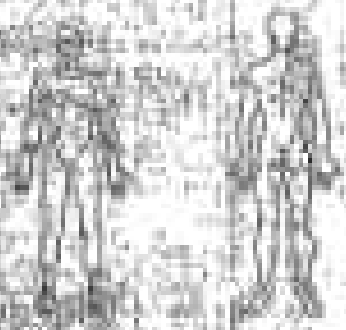
Person Notified	Name/Title	Done/By What?	Date/Time
Guardian/Advocate	[redacted]	Frank Ophrah	Around 6:45pm on 8/28
Support Broker			
Provider			
Law Enforcement ANY potentially involved	In Institution		
Children Services ANY potentially involved			
Coroner ANY death			
Signet Member ANY death			
In ANY SITUATION OR SUSPECTED abuse, neglect, theft or death			
Assigned SC	N/A		
Other:			
Other:			

*The on-call report will be forwarded to designated parties by ISR office.

Revised: 10/10/18

E-FILED 04/22/2020 3:54 PM / CONFIRMATION 1023284 / A 2002007 / COMMON PLEAS DIVISION / ICON





E-FILED 08/26/2019 05:17:04 PM CDT FILED DATE: 8/26/2019 5:17 PM 2019CH06555

Consumer Detail Report

[redacted] LAUREN

Organization: Butler County

Primary Funding Source:

Plan Year Start:	Early Voter Host:	Locale ID:	SSN:	Resident Num:	Verification Num:	DPN:	Section:
		3764	[redacted]	[redacted]	[redacted]	[redacted]	2

Resident Address: [redacted]

Mailing Address: [redacted]

Phone:
Primary: ( ) -
Cell: ( ) -

Other Addresses:

Email Address:

File Location:

All Classifications:

Classification	Start Date	End Date
Lives in a Butler County VOP/BI	[redacted]	[redacted]
Consumer	[redacted]	[redacted]

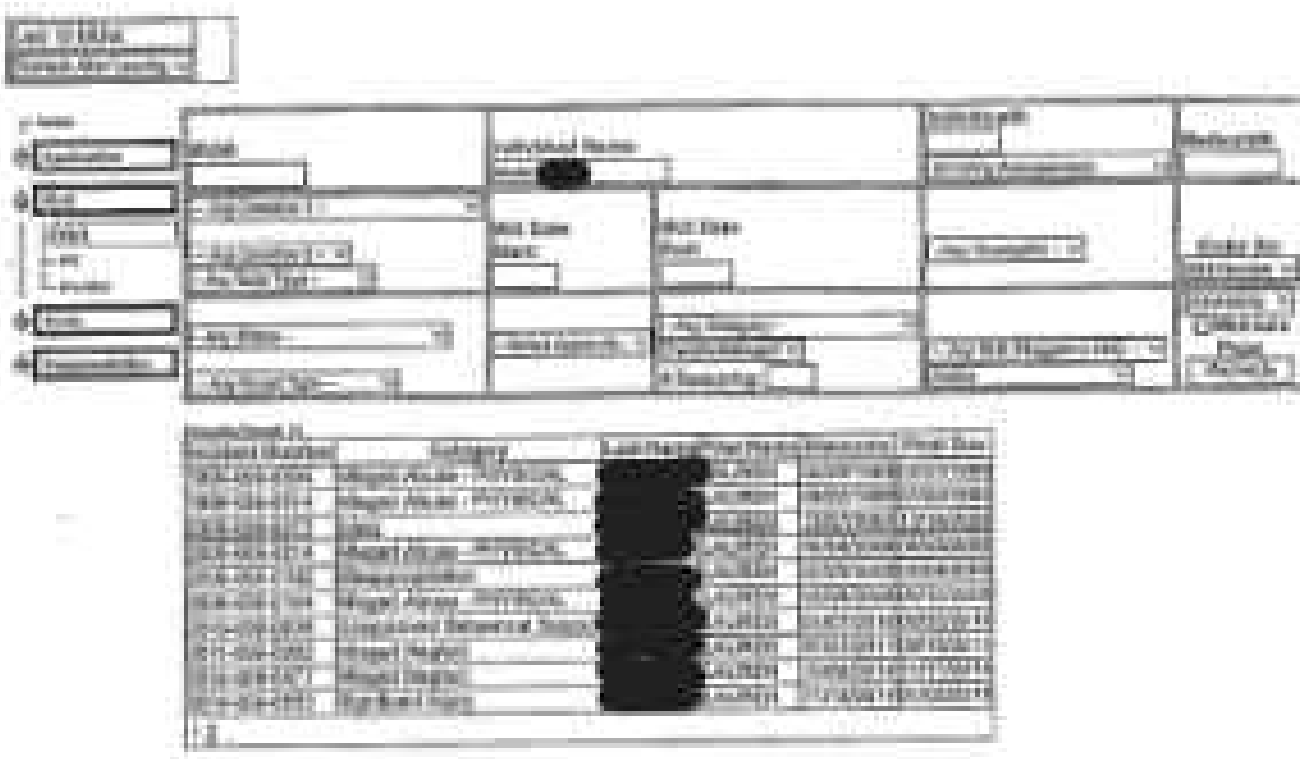
Relationships:

Relation	Name/Organization/Vendor	Address	Phones / Email
Parent	[redacted]	[redacted]	Primary: ( ) - Pager: ( ) - Secondary: ( ) - Children: ( ) - Pref: ( ) - Email:

Waiting Lists:

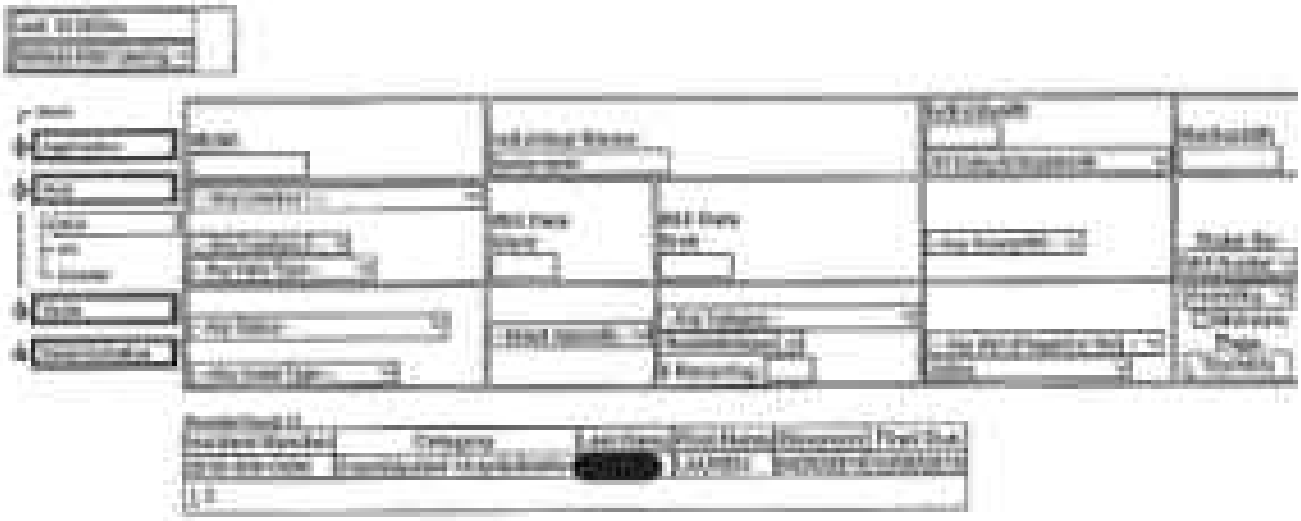
Butler County	Status	Date On	Emergency	Priority	Date Off
20.10 Kitchen Waiting		[redacted]			

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E-FILED 04/05/2019 3:54 PM - CONFIRMATION 1455811 / 2019-CV-[redacted] / COMMON PLEAS DIVISION / ICON

6/10/2019



Joan O'Hair

From:	Lynnette Whitaker <LWhitaker@fishcole-trailb.net>
Sent:	Monday, September 9, 2019 10:24 AM
To:	Joan O'Hair
Cc:	Bill Maynard
Subject:	FW: Scanned image from MX-M565N
Attachments:	IM0Scan_20190909_084806.pdf

Joan - Please see attached MUI report for Lauren [redacted] recently updated hospitalization from 8-23-19. If you have any questions, please let me know. Thank you.

Lynne Whitaker, RN,

Director Of Nursing

Takoda Trails

350 Rolls Drive

Fairfield, OH 45014

Phone: 513-874-0420 x337

Fax 513-874-0598

From: copier@fts-is.com [copier@fts-is.com] on behalf of copier@ [fts-is.com copier@fts-is.com]
Sent: Monday, September 09, 2019 9:48 AM
To: Lynnette Whitaker
Subject: Scanned image from MX-M565N

This message contains confidential information and is intended only for the addressee of the message. If you are not that person you should not disseminate, distribute or copy this e-mail. If you have received this message by mistake please notify the sender immediately and delete this e-mail from your system.

PROVIDE DATE AND CAUSE OF MOST RECENT HOSPITALIZATION BEFORE THIS ONE?
Lauren has had as recent hospitalizations
INDIVIDUAL'S DIAGNOSIS AND MEDICAL HISTORY FROM THE DP:
Profound MR, Cerebral Palsy, Seizure Disorder, Cortical Blindness, Multiple Otitis Media, S/P PE Tubes, Hx of Intermittent Hepatic Steatosis, Allergic Rhinitis, Constipation, S/P Gastrocy with Knees, Myositis Nails, Chronic Periodontitis, Nuclear Cataract, Anhidrosis, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes Legal Level.
HOSPITAL DIAGNOSIS: *ATTACH HOSPITAL DISCHARGE PAPERWORK
Lauren was evaluated in the ER and admitted with diagnosis of Blindness, CP, Profound MR, Constipation and small bowel obstruction. She was started on IV fluids and no feedings were given thru her tube for a while. They thought that she might require surgery, but her bowels started working again. Her tube feedings were restarted and she was able to return home. She had new orders for Potassium 30meq 3 times daily x 9 doses and increase her Miralax to daily.
WAS HOSPITALIZATION DUE TO FLU OR PNEUMONIA OR ASPIRATION PNEUMONIA? If yes, did the individual receive the flu shot or pneumonia vaccine?
N/A
PREVENTION PLAN: • Please include any changes • Follow up appointments • Continuing needs of the individual • Person responsible for each
Lauren will complete the potassium supplements as prescribed. Her Miralax was increased to daily. Staff will continue to monitor for bowel movements and document them. They will report any issues with vomiting to nursing. Nursing will monitor her bowel movements to ensure that the increased dose of Miralax is effective and also not too much for her. Dr Zakem reviewed her paperwork at the ER/IP clinic and had no new orders. She will follow up with Dr Zakem on an as needed basis.
SIGNED: [signature] Dictated (continuation from 3-8-18)

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Unscheduled Hospitalization Form

Please complete this form and send electronically (via email when possible) to the County Board as directed.

NAME OF INDIVIDUAL/MUSH:
Lauren [redacted]
NAME AND TITLE OF PERSON COMPLETING FORM:
Lynne Wildaher, RN
CONTACT INFORMATION OF REPORTER/AGENCY:
Takoda Trails 813-974-0423 x331
DATE AND TIME OF HOSPITALIZATION:
8/30/19 8pm
NUMBER OF DAYS IN HOSPITAL: Consider the day of admission as first day and the day of release as the last day
5 days
TYPE OF HOSPITALIZATION (MEDICAL OR PSYCHIATRIC):
Medical
NAME OF HOSPITAL
Mercy Fairfield Hospital
REASON(S) FOR HOSPITALIZATION: Please include symptoms, issues and/or concerns that lead to hospitalization; description of incident; if symptoms were addressed in a timely manner and if not why
Staff noted multiple skin discolorations on all 4 extremities and coffee ground emesis. Nursing checked her and assessed the areas to be bruising. They also noted the coffee ground colored emesis and the stool residual in her stomach. 911 called and she was sent to Mercy Fairfield ER for further evaluation.
DESCRIPTION OF INDIVIDUAL'S HEALTH FOR 72 HOURS PRIOR TO HOSPITALIZATION:
No reported issues. Bowel records show that she had been having regular BM's.
HAS THE INDIVIDUAL EXPERIENCED ANY RECENT SIMILAR ILLNESSES? If so, please explain
Lauren has not had any issues with coffee ground emesis.

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DOC 07/7187

Empowering People
Universal Incident Report

Major Unusual Incident: ☒ Yes ☐ No If yes Category: ☐ A ☐ B ☐ C

Regardless of time or day, Major Unusual Incidents are to be called immediately to the ADC.

Resident Name: Lavon [redacted] Address: _____

Date: 8/24/19 Day of Week: Saturday Time: 6:40 pm AM PM

Staff Involved: _____ Witnesses: _____

Home: [redacted] Site Director: _____

Must write incident report for each person involved. Use initials for other consumers if needed to mention in report.

TYPE OF INCIDENT – Please check all that apply

Medical (Healthcare Related)

___ Med error - person responsible for Med Pass: _____

___ Wrong time ___ Wrong dose ___ Wrong person ___ Med exposure

___ Wrong med ___ Wrong route ___ Med omitted from (check one)

___ Med (pill) found ___ Med documentation error ___ Med refusal ☐ Staff

___ Med dropped ___ Possible injury to resident ___ Seizure ☐ Resident

___ Possible bruising ___ Minor injury to resident ___ Referred to Dr. or ER

___ Undiscovered injury ___ Dietary related problem ___ Accident – Resident

X Other (describe) Client found on floor in room ___ Illness ___ Fall

Behavioral (Resident Related)

___ Verbal Aggression (VA) ___ Self Injurious Behavior (SIB) ___ Theft – ☐ Under $100 ☐ Over $100

___ Property Destruction (PD) ___ Peer to Peer Incident ___ Elopement

___ Physical Aggression (PA) ___ Inappropriate sexual contact ___ Damage to personal property

___ Neglect ___ Program implementation ___ Law Enforcement

___ Other (describe) _____

Ownership/Maintenance ☐ Check if Work Order Written _____ Work order number

___ Item broken ☐ Check if item can be repaired ☐ Check if item was Unfamiliar

___ Auto accident ___ Damage to Agency property

___ Other (describe) _____

Other describe: _____

OBJECTIVE DESCRIPTION OF INCIDENT

Describe specifically what happened, BEFORE the incident: Client was discharged from Covid Clinical Site where client tested positive for Covid. Client was transported via Medical Transport Van to client's home. Client was then escorted into client's home.

Describe the intervention(s) used and effectiveness: Assessment completed

ISP Followed? ☐ Yes ☐ No ☐ Not applicable Protective Hold Used? ☐ Yes ☐ No

Protective Hold in ISP? ☐ Yes ☐ No Used for medical purposes? ☐ Yes ☐ No

Duration: _____ (Minutes) Alternatives attempted: _____

(If not in ISP and Protective Hold is used, Incident becomes a Major Unusual Incident)

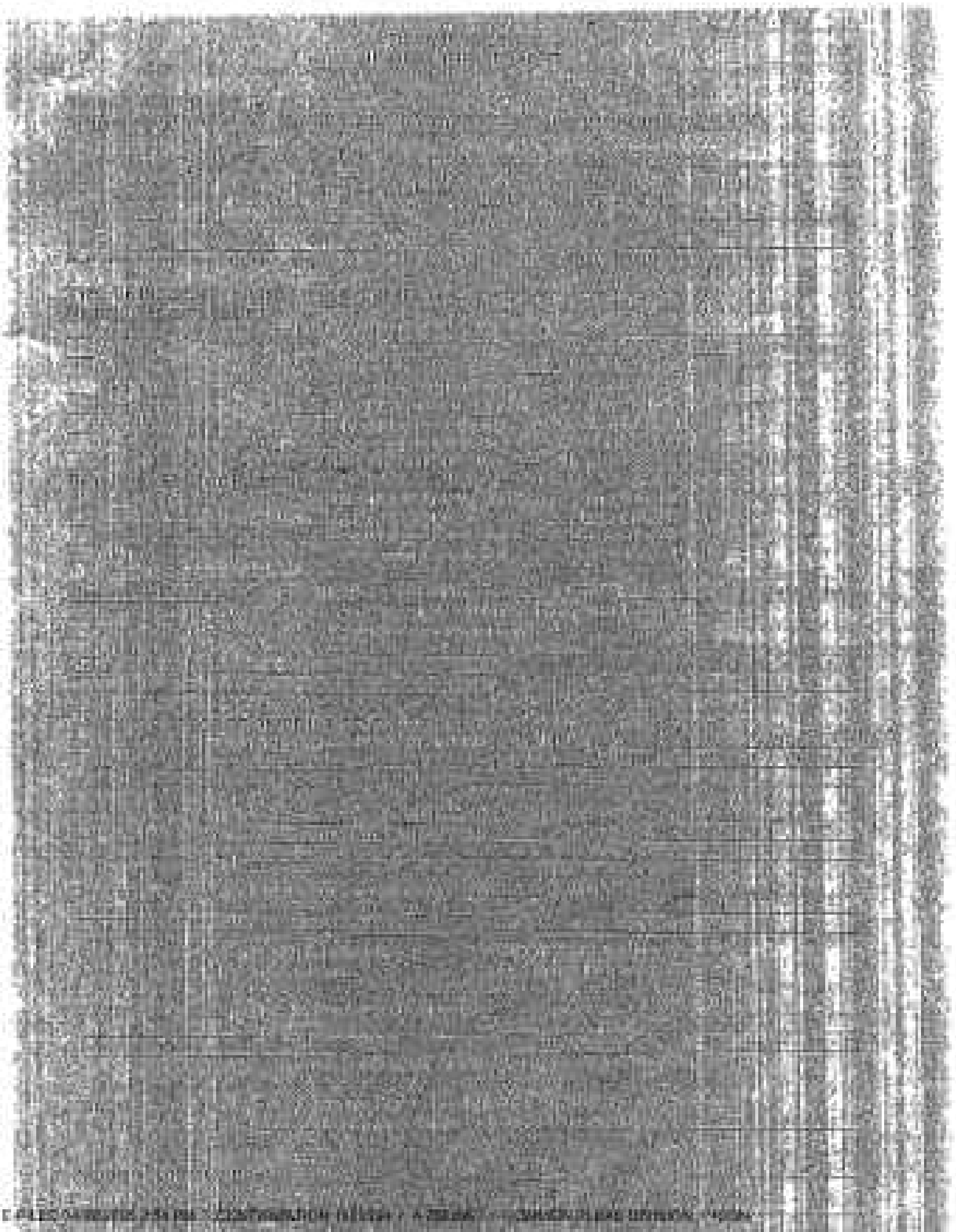
Type of Protective Hold: ☐ Lower Figure Four ☐ Parallel Hold ☐ Limited Security Hold

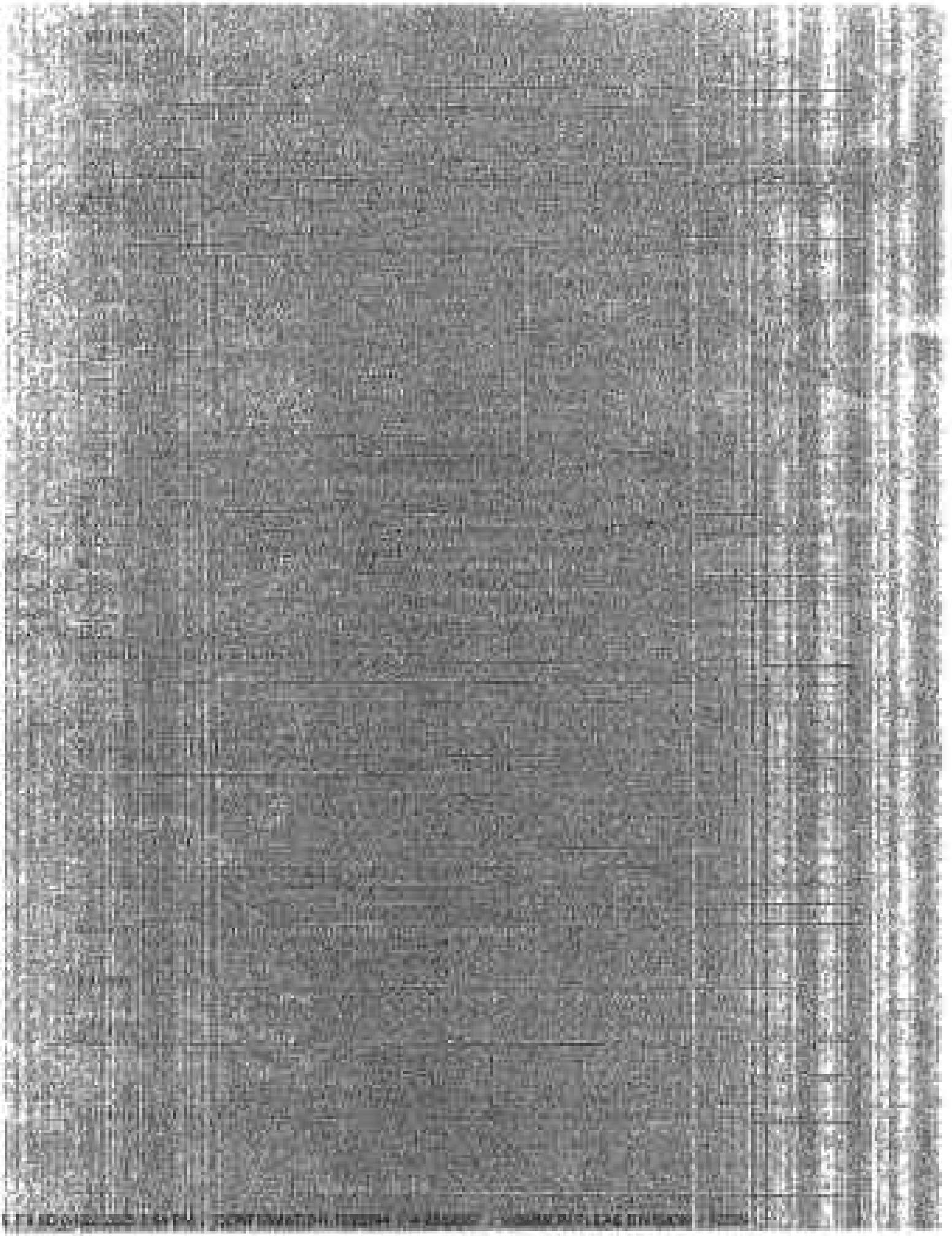
☐ Full Security Hold ☐ Rose Chaffe Transport ☐ Rose Chaffe Take Down ☐ Other: _____

Signature of person completing report: _____ Date: 8/25/19

Print Name: REGINA ORTEGA Position: LPN

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Transmission Log

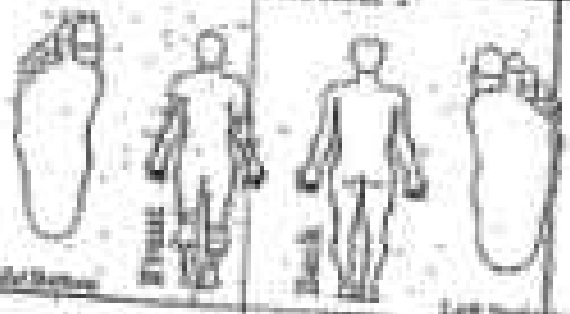
Dakota Trails Rdlo Monday, 2019-08-26 08:16 9198736755

Date	Time	Type	Job #	Length	Speed	Pgs	Status
2019-08-26	08:12	RCSD	0611	4:33	14400	3	OK -- 9,17 5811



E-FILED 04/22/2025 3:54 PM / CONFIRMATION 192334 / A 2502007 / COMMON PLEAS DIVISION / IGSN

SKIN GRID - OTHER



E-FILED 04/22/2025 3:54 PM / CONFIRMATION 102334 / A 25000

TAKODA TRAILS

860 HOLB DRIVE * FAIRFIELD, OHIO 45014 * Phone: (513) 874-0403 * Fax: (513) 874-0366

We are committed to making a difference...one individual at a time.

Name	[redacted]	D O B	[redacted]
Gender	Female	Height	[redacted]
Religion	Non-Denominational	Race	Caucasian
EC Name	[redacted]	EC Phone	[redacted]

MEDICAL INFORMATION

Allergies	Nuts, Aspirin, Surgical Tape
Rx's (Drg)	Proliviol MFI
Rec'd by	[redacted]
Attending Physician	Dr. Basil Salem Phone: 745-8787
Primary Physician	[redacted]

Code Status: [redacted]

FINANCIAL INFORMATION

SS #	[redacted]	Medicare	[redacted]
Case #		Medicaid	[redacted]
County	Butler	Private Ins Info	None

NOTIFY IN EMERGENCY

ALWAYS NOTIFY TAKODA TRAILS IN CASE OF AN EMERGENCY

EC Name	[redacted]	EC Phone	[redacted]
EC Relationship	Guardian/Father		
EC Address	[redacted]		

Alternate Contact: [redacted]

Admission Date 10/20/09 Updated: 10/20/16 jm

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TAKODA TRAILS
INDIVIDUAL PROGRAM PLAN
MONTHLY/SPECIAL/QUARTERLY TEAM MEETING MINUTES

NAME: Lauren [redacted]

DATE: 8-28-19

SLDO: [redacted]

The Interdisciplinary Team met to discuss the following:

The IP team met to discuss Lauren. Lauren was just released from the hospital after a multi day admission. She was diagnosed with bowel obstruction. She returned home with a new order for potassium chloride.

TRANSLATION DATE

[illegible]

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HEALTH

FUNCTIONAL ASSESSMENT IP DATE: 5/22/2019

Resident's Name: Lauren [redacted]
Code Status: Full
DOB: [redacted]

General Medical: Lauren is seen throughout the year on a routine and as needed basis. Nurses are in contact with the physician at the point of any change in condition that warrants physician intervention. 8/7/18 Received N.O.'s for Bacitracin Ointment BID x 5 days and Augmentin 875mg BID x 5 days for noted reddened area to her nose. 8/9/18 Received N.O. to continue Augmentin 875mg BID x 7 more days. 9/9/18 Annual Flu Vaccination was administered in the right deltoid with no adverse reactions noted.

Physical Exam: 8/6/18 Seen by Dr. Zaken in clinic where an annual physical and pre-op dental PE was completed with all medications, labs and consultations reviewed. N.S.O.'s or concerns were noted with recommendations to follow up with any needed dental treatment under GA.

Annual TB: 3/21/19 Annual PPD was administered in the left forearm with negative results and no adverse reactions noted.

Dental: Lauren is an established patient at Miami Valley Dental where she receives all needed dental treatment under GA yearly. This need is due to historical issues with non-compliance which resulted in the inability to do a thorough examination and or any needed treatment. 8/30/18 Seen at Miami Valley Dental under GA where an examination, x-rays and cleaning was all completed with N.N.O.'s and a recommended follow up in 1 year.

Vision: 12/14/18 Seen by Dr. Landrum in vision clinic where an examination was completed with moderate cataracts noted bilaterally. N.N.O.'s or concerns were noted with a recommended follow up in 9 months for more critical views.

Podiatry: 9/13/18 Seen by Dr. Beatty in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up in 3 months. 11/16/18 Seen by Dr. Beatty in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up in 3 months. 1/17/19 Seen by Dr. Beatty in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up in 3 months. 3/21/19 Seen by Dr. Beatty in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up in 3 months.

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Neurology: Lauren is currently on Keppra and Lamictal for seizure control. Routine labs are drawn to monitor the levels of the saint medications. Seizures are noted to be controlled while she last year with Dr. Callow combining all lab results and graphic sheets as needed. 9/18/18 Seen by Dr. Callow in Neurology clinic where an examination was completed with all medications and seizure logs reviewed. N.O.C.'s or concerns were noted with a recommended follow up in 1 year.

Psychiatry: Lauren is not currently on any psychotropic medications therefore psychiatric intervention is not warranted at this time.

GYN Memmo: Guardian refuses any GYN examinations at this time. Mammograms are not indicated at this time due to Lauren's age.

Allergies: Bells, Reglan, Surgical Tape

Diagnosis: Profound MR, Cerebral Palsy, Seizure Disorder, Cortical Blindness, McGhee Otitis Media, S/P PE Tubes, Hx of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastromy with Nissen, Myrtle Nails, Chronic Periodontitis, Nasocaile Cataract, Astigmatism, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes Impair Level.

Medications: Tylenol 160mg q4h/prn-elevated temperature, Diastat 10mg PRN-seizures, Miralax 17gm q4-constipation, Claritin 10mg q8-allergic rhinitis, Keppra 1000mg bid-seizures, Fluticasone Nasal Spray 50mcg q8-allergic rhinitis, Lamictal 150mg q6-seizures, Betadine-Clotrimin Cream to G-Tube site bid-preventative, Lactulose 12% bid-achalasia blistered feet.

Signature: _____ **Title:** _____ **Date:** _____

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AFTER VISIT SUMMARY

MERCYHEALTH

Lauren [redacted] DOB: [redacted]

[redacted] - [redacted] Mercy Health Fairfield Hospital [redacted]

Instructions

Need Help?

After Visit Summary

(Discharge Instructions)

This summary was created for you.

Thank you for entrusting your care to us. The following information includes details about your hospital/visit stay along with steps you should take to help with your recovery once you leave the hospital. Follow up with your Primary Care Provider when condition worsens. In the event of an emergency, call 911 or go to the nearest Emergency Department. At your follow-up appointment, ask your physician about any tests or studies they were not available at discharge. In this packet, you will find information about the topics listed below:

- Instructions about your medications including a list of your home medications
- A summary of your hospital visit
- Follow-up appointments now you have left the hospital.
- Your care plan at home

You may receive a survey regarding the care you received during your stay. Your input is valuable to us. We encourage you to complete and return your survey in the envelope provided.
We hope you will choose us in the future for your healthcare needs.

No changes were made to your medications.

Care Plan Once You Return Home

Destination

CM Takoda Trails
Assisted Living
300 Kelb Drive
Fairfield OH 45014
513-874-0433

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Your Visit

Here you will find information about your visit, including the reason for your visit. Please take this sheet with you when you visit your doctor or other health care provider in the future. It will help determine the best possible medical care for you at that time. If you have any questions once you leave the hospital, please call the department phone number listed below. In the event of an emergency, call 911 or go to the nearest Emergency Department.

Preventive Care

	Date Due
Varicella Vaccine (1 of 2 - 13+ 2-dose series)	09/14/2009
HIV screening is recommended for all people regardless of risk factors; ages 15-65 years at least once (Optional) who have never been HIV tested.	09/10/2002
Pap Smear	09/16/2008
Yearly Flu Vaccine (1)	08/01/2015
Tetanus Combination Vaccine (2 - Td)	11/06/2022

Follow Up Information and Future Appointments

Follow up with STUART ALAN ZAXBY
Specialty: Internal Medicine, Hospitalist
As needed

Continuing Care

Discharge Destination

CM Takoda Trails
Assisted Living
333 Falls Drive, Fairfield OH 45014
Phone: 513-829-0933

Follow up

You are allergic to the following

Allergies	Reactions
Metoclopramide Pt Unable to explain	Other See Comments
Sulfa Antibiotics Pt Unable to explain	Other See Comments
Adhesive Tape	Rash
Keflex (Cefadroxil monohydrate)	Rash

Your Latest Vitals

Blood Pressure 138/87	BMI 18.21	Weight 74 lb	Height 5' 4"
Temperature (Temporal) 98.5 °F	Pulse 98	Respiration 16	Oxygen Saturation 96%
BSA 1.16 m²			

Daily Medication List (This medication list can be shared with any healthcare provider who is helping you manage your medications)

These are medications you told us you were taking at home, CONTINUE taking them after you leave the hospital

	Start Stop Date	AM	MOSH	PM	NIGHT
acetaminophen 160 MG/5ML solution Commonly known as: TYLENOL 15 mg/kg by Per G Tube route every 4 hours as needed.	Per needed				
CLARITIN 10 MG capsule Generic drug: loratadine 1 tablet by Per G Tube route daily.	9 am 8/30				
clotrimazole 1 % cream Commonly known as: LOTRIMIN Apply topically 2 times daily Apply topically 2 times daily	9 pm 8/29				
diazepam 2.5 MG Gel Commonly known as: DIASTAT Place 0.2 mg/kg rectally once as needed. 5-7.5-10mg per rectum for seizure	As needed				
Budesonide 118 MCG/ACT inhaler Commonly known as: FLOVENT HFA Inhale 2 puffs into the lungs daily.	9 am 8/30				
LACLOTION EX Apply topically, TO BOTH FEET TWICE DAY	9 pm 8/29				
lamoTRIgine 25 MG tablet Commonly known as: LAMICTAL Take 100 mg by mouth daily	9 am 8/30				
levETIRAcetam 100 MG/ML solution Commonly known as: KEPPRA 16 mg/kg by Per G Tube route See Admin Instructions 1000 mg bid	9 pm 8/29				

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	Start: Dose Date	AM	NOON	PM	NIGHT
ondansetron 4 MG disintegrating tablet Commonly known as: ZOFRAN-ODT 1-1 tablets by Per G Take route every 12 hours as needed for nausea for 12 doses.	Per marked				
polyethylene glycol packet Commonly known as: GLYCOLAX 17 g by Per G Take route daily.	9 am 8/10				
potassium chloride 20 MEQ/15ML (10%) solution Commonly known as: KAYCIEL Take 15 mls by mouth 3 times daily for 9 doses.	9 pm 8/10				
RA ALPHA HYDROXY FACE LOTION EX Apply topically See Admin Instructions DAILY TO DRY SKIN	9 am 8/10				

COC Instructions

Continuity of Care Form

Patient Name: Lauren [redacted]
DOB: [redacted] MRN: [redacted]

Admit date: 8/23/2018 Discharge date: 8/29/18

Code Status Orders: Full Code
Advance Directives:
Advance Care Planning/Goals of Treatment:

[redacted]

08/23/18 1615	No, patient does not have an advance directive for healthcare treatment

Admitting Physician: Siddarth K Mukhi, MD
PCP: STUART ALAN ZAGNI

Discharging Nurse (Author Not Rn)
Discharging Hospital Unit/Room#: 4TH 4465/4467-01
Discharging Unit Phone Number: 513-585-5101

Emergency Contact:
Intended Emergency Contact Information
Primary Emergency Contact: [redacted]
Address: [redacted]
Home Phone: [redacted]
Work Phone: [redacted]
Relation: Parent

Past Surgical History

Past Surgical History

- GASTROSTOMY TUBE PLACEMENT
  with vision

Immunization History

[redacted]

- Tdap (Boostrix, Adacel) 11/08/2013

Active Problems:

Patient Active Problem List

[redacted]

- Blindness H54.7
- CP (cerebral palsy) (HCC) G80.9
- Profoundly mentally retarded F73
- Constipation K59.09
- SBO (small bowel obstruction) (HCC) K56.609

Isolation/Infections:

Isolation

[redacted]

No Isolation

Vital Assessment:

Last Vital Signs BP 103/78 | Pulse 130 | Temp 98.6 °F (37.0 °C) (Oral) | Resp 14 | 5'6.9" (1.698 m) | Wt 74 lb (33.6 kg) | SpO2 99% | BMI 16.65 kg/m²

Last documented pain score (0-10 scale) Pain Level: 0

Last Weights

Wt Readings from Last 1 Encounters:

08/25/16 74 lb (33.6 kg)

Mental Status: Alert/oriented

IV Access:

- None

Nursing Mobility/ADLs:

Walking	Dependent
Transfer	Dependent
Bathing	Dependent
Dressing	Dependent
Toileting	Dependent
Feeding	Dependent
Med Admin	Dependent
Med Delivery	per G Tube

Wound Care Documentation and Therapy:

[redacted]

Number of days: 1058

Elimination:

Continence:
- Bowel: No
- Bladder: No

Urinary Catheter Removal Date 6/28/19
Colostomy/Ileostomy/Ileal Conduit: No

Date of Last BM: 6/28/19

Intake/Output Summary (Last 24 hours) at 6/30/2019 0903
Last data filed at 6/26/2019 0945

	Gross per 24 hour
Intake	---
Output	330 ml
Net	-330 ml

(0) last 3 completed shifts
Ins -
Out: 330 [Drains/NG output:330]

Safety Concerns:
At Risk for Falls and History of Seizures

Impairments/Disabilities:
Speech, Vision and MRDD

Nutritional Therapy:
Current Nutrition Therapy:
- Tube Feedings: Standard with fiber and 240 ml 4 times per day

Routes of Feedings: Gastrostomy Tube
Liquids: No Liquids
Daily Fluid Restriction: no
Last Modified Sodium Bentiromide with Valve (Video Swallowing Test): not done

Treatments at the Time of Hospital Discharge:
Respiratory Treatments:
Oxygen Therapy: is not on home oxygen therapy.
Ventilator:
- No ventilator support

Rehab Therapies:
Weight Bearing Status/Restrictions: No weight bearing restrictions
Other Medical Equipment (for information only, NOT a DME order):
Other Treatments:

Patient's personal belongings (please select all that are sent with patient):
None

RN SIGNATURE: Electronically signed by HAYNES A Hall, RN on 6/30/19 at 9:40 AM

CASE MANAGEMENT/SOCIAL WORK SECTION

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Inpatient Status Date: 8-29-19

Readmission Risk Assessment Score
Readmission Risk

Risk of Unplanned Readmission:
9

Discharging to Facility/ Agency
- Name: Talimar Hall

Address:
800 Hall Drive, Fairfield OH 45014
Phone: 513-874-0503
Fax: 513-874-0599

Dialysis Facility (If applicable)
- Name:

Case Manager/Social Worker signature Electronically signed by Nancy S Schooler, LSW on 8/29/19 at 9:29 AM

PHYSICIAN DISCHARGE

Prognosis: Good

Conditions at Discharge: Stable

Rehab Potential (If transferring to Rehab): Good

Recommended Labs or Other Treatments After Discharge: SNF physician

Physician Certification: I certify the above information and transfer of Laure[redacted]e necessary for the continuing treatment of the diagnosis listed and that she requires Skilled Nursing Facility for less 30 days.

Update Admission H&P: No change in H&P

PHYSICIAN SIGNATURE: Electronically signed by Dhyanesh Saksena, MD on 8/30/19 at 10:20 AM

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TAKODA TRAILS
Individual Program Plan (IPP)

GENERAL INFORMATION

Name: Lauren [redacted]

IPP Date :5/23-18
Implementation Date:

Living Area: A[redacted]

CLIENT INFORMATION

Date of Birth: [redacted]

SSN #[redacted]

Gender:F

Medicaid #[redacted]

Race:Caucasian

Medicare [redacted]

Guardian: [redacted]

DD Level: Profound

[redacted]

Adaptive Behavior: Impaired
Next of Kin: [redacted]

Religion: non denom
Weight: 85 lbs

Height: 4'4

Meds/Purpose:
Tylenol-elevated temperature, Diastat-seizures, Miralax -constipation, Claritin -allergic rhinitis, Keppra-seizures, Nebulizer Nasal Spray-allergic rhinitis, Lamictal-seizures, Bactroban-Cuticles. Cream to G-Tube-preventative, Lactation-antihistamine historical list.

Seizure type

Adaptive Equipment:
gait belt, swim suit, wedged under the head of her bed to reduce risk of aspiration.

Supervision Level:
Inside the home at Takoda Trails-Visual range (when out of her bedroom) Lauren in eyesight of staff when outside her room. 15 minute checks while in her room.
Outside the home at Takoda Trails-Visual range, Assigned staff can see Lauren at all times.

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CLW- Visual Range. Learns to eyesight of staff at all times

REVIEW OF PREVIOUS IPP

SERVICES
1.Medical to monitor health status (provided).
2. NPO diet monitored by dietary (provided).
3. Offer regular opportunities to participate in community outings as well as CLW by ATC's and RSI's (provided).
4. Medical to provide Vision exam within 1 year (provided)..
5.Supervision for my safety (provided).
6.Medical staff to monitor Learns medications and overall health provided by nursing (provided).
7.To have personal needs monitored by QIDP (provided).
8..Fire safety training provided by ATC(provided).
9.Resident rights training by ATC (provided).
10. Ensure my rights are maintained and advocacy (provided).
11. To continue to have [redacted] as Learns guardian (provided).

ACTIVE TREATMENT PROGRAMS
1Communication-Make a choice between 3 items with 1 PP 10% of sessions. Has progressed. Will continue.
2.Grooming – brush 1 stroke of hair with 1 PP 10% of sessions. Has regressed. Will continue.
3.Oral Hygiene- Hold tube of toothpaste for 5 seconds before oral hygiene with 1 PP 10% of sessions. Has progressed. Will continue.
4.Showering- Wash her arms with 1 PP 10% of sessions . Has progressed. Will continue.
5.Dressing-Pull down shirt with 1 PP5% of sessions. Has progressed. Will continue.
6.Toileting- Hold clean utensil while staff changes soiled one with HOH 75% of sessions. Has progressed. Will continue.
7.Self Medication- Cooperate and accept meds from nurse when fed with 1 VP 75% of sessions. Has progressed. Will continue.
8.Handwashing/Handwipe- Wipe hands with handwipe with HOH assistance 50% of sessions. Has progressed. Will continue.
9.Money Management- Drop coin in container with 1 PP 10% of sessions. Has progressed. Will continue.
10.Privacy- Close door before changing clothes with 1 PP 5% of sessions. Has progressed. Will continue.
11.Vocational- participate in group activity with HOH 65% of sessions. Has progressed. Will continue..
12. Behavior- Have 20 or less episode a month of SIB. Has progressed. Will be modified to 10 episodes..

UNUSUAL INCIDENTS/INJURIES REVIEW
I had very few incidents over this past IP year. I had 5 incidents with injuries of unknown origin. None were serious and all were resolved.

RESTRAINTS REVIEW

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NONE

COMPREHENSIVE FUNCTIONAL ASSESSMENT SUMMARY
HEALTH MANAGEMENT – PHYSICAL HEALTH

I am seen throughout the year on a routine and as needed basis. Nurses are in contact with the physician at the point of any change in condition that warrants physician intervention. 8/9/18 Received N.O.'s for Bacitracin Ointment BID x 5 days and Augmentin 875mg BID x 5 days for noted reddened area to my nose. 8/9/18 Received N.O. to continue Augmentin 875mg BID x 7 more days. 9/9/18 Annual Flu Vaccination was administered in the right deltoid with no adverse reactions noted.

AUDITORY

My audiological was conducted 12-23-18. I was unable to complete pure tone screening due to low cognitive status. Will reassess annually.

HEALTH SKILLS

Nursing did a self medication assessment on me. There are several areas I was assessed with inability to perform in self medication tasks. I am unable to recognize med by size, color, and shape along with telling what any of my medication is for. I have a program to cooperate and accept meds from the nurse which I do with VP's . I cannot get my medication from storage. My overall assessment shows I need certified staff to administer my medication and am in need of DN services per state rules.

VISUAL

12/14/18 Seen by Dr. Landrum in vision clinic where an examination was completed with moderate cataracts noted bilaterally. N.N.O.'s or concerns were noted with a recommended follow up in 6 months for more retinal views.

HEALTH MGMT – MENTAL HEALTH/EMOTIONAL DEVELOPMENT

MENTAL HEALTH/EMOTIONAL DEVELOPMENT

I function within profound range of mental retardation. I scored a 1 year 2month old in the communication domain of the Vineland Adaptive Behavior Scales development. My daily living was 3 months old while my socialization skills were 6 month old. My adaptive behavior composite was 8 months. I have Behavior strategies that address my disruptive (non compliance) and my SIB (biting, pinching, scrubbing). Over the last 6 months my SIB numbers have increased. In Nov, Dec, and Jan I averaged 1.3 for my SIB. For Feb, Mar and Apr my SIB decreased to less than 1 episode per month..

DEFINITION OF BEHAVIOR(S)

DATA

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	BASE
Disruptive (non compliance)	4	1	0	0									
SIB (biting, pinching,	2	1	0	1									

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scratching													

HEALTH MANAGEMENT – PSYCHOTROPIC MEDICATION PLAN

PSYCHOTROPIC MEDICATION REVIEW (HISTORY/CHANGES IN REVIEW PERIOD)
None

PSYCHOTROPIC MEDICATIONS (INCLUDE SIDE/BENEFITS)
none

PSYCIATRIC DIAGNOSIS/SYMPTOMS
none

INTERDISCIPLINARY DISCUSSION
I have behavior strategies that address my non compliance, hitting, pinching, and scratching self. I have to have my dental appointments under GA due to non compliance. Over the last 3 months I have had 2 instances of SIB. I wear a swim suit that does not restrict me but does delay me getting to and possible pulling out my tube. Team will continue tracking the behaviors of non compliance and SIB.

BEHAVIORAL STRATEGIES
Disruptive Behavior (non compliance)
-If I am non compliant with a request
1. Let me know what you are doing (hygiene, medication, etc).
2. Let me know you will be done as quickly as possible
3. Ensure that security music is playing in the background as this tends to calm me.
4. Give her over exaggerated praise as she may or may not be more compliant with praise

SIB
-Redirect me from any SIB.
-Intervene if redirection is not accepted.

TITRATION PLAN
None. No Psych meds

HEALTH MANAGEMENT – NUTRITIONAL/DIMING

NUTRITIONAL/DIMING
Lauren is a 31-yr-old female who is NPO. Via mic-tube she receives 400 ml Pfeiffer's RN QD, 125ml water flushes QID, & 200ml cranberry juice daily. She is tolerating all nutrition without difficulty and has no known food allergies. No changes to nutrition in the past year. TF and flushes provide a total of 1920 kcal, 2305ml fluids, 1795ml free water, and 85g protein on a daily basis. This more than meets her estimated needs of 1100-1300 kcal, 1305-1500ml fluids, and 27-34g protein. Lauren requires assistance with monitoring her nutritional status.

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HEALTH MANAGEMENT – ORAL HYGIENE/DENTAL CARE

CURRENT ORAL HYGIENE STATUS
Lauren is an established patient at Miami Valley Dental where she receives all needed dental treatment under GA yearly. This need is due to historical issues with non-compliance which resulted in the inability to do a thorough examination and or any needed treatment. 8/30/18 Seen at Miami Valley Dental under GA where an examination, x-rays and cleaning was all completed with WNL's and a recommended follow up in 1 year.

MOTOR DEVELOPMENT

GROSS MOTOR
I have good gross motor skills. I am able to grasp items and manipulate them from hand to hand. I am able to utilize all my major muscle groups without any difficulty. I exhibit decent posture and balance. I am able to lift, bend, and carry light objects without any difficulty. I show dominance with my right hand.

FINE MOTOR
I am able to reach grasp and manipulate items from hand to hand. I am able to carry items. I would have some difficulty opening containers of various types such as milk cartons. I can hold a pen but do not have legible handwriting.

MOBILITY SKILLS
I ambulate independently within the home and other familiar areas. I may occasionally sustain minor injuries while doing so due to visual impairment. A gait belt is used for me in unfamiliar environments and on wheelchair lift. The Team felt that as the injuries are almost always very minor, it is not appropriate to limit my independence while ambulating within familiar areas. Only acceptable when staff note that obstacles or other hazards make injury imminent. Whenever I am ambulating outside of my home or other familiar areas (i.e. My group's room at CLW) staff should use one-person assistance with a gait belt. When getting on or off of a bus I should be accompanied by staff on the bus lift with the use of a gait belt.

COMMUNICATION

RECEPTIVE COMMUNICATIONS
I recognize familiar voices and am able to localize sound. I respond to environmental noise/speech at conversational levels. I recognize my name. I am able to follow routine one step commands with verbal or physical prompts and additional processing time. I am unable to follow more complex directions. I am also unable to respond verbally or nonverbally to yes/no/wh questions. I'm not able to identify objects by label or function.I cannot comprehend basic concepts of size, shape, position or body parts. I cannot point to named objects and do not exhibit object manipulation skills which is likely limited by tactile defensiveness.

EXPRESSIVE COMMUNICATION
I am non-verbal. I communicates via vocalizations and avoidance. I make requests by reaching for or touching a desired object. I show rejection by recoiling and moving/pushing away. I do not typically offer any sort of greeting, nor will I initiate communication with consistency.

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COMMUNICATION MODE
I am non-verbal. I have a communication program to make a choice between 2 items.

PERSONAL MANAGEMENT

TOILETING
I am incontinent. I wear medium utensils. I will not indicate a need to be toileted, and may offer resistance during toileting/changing. I need total assistance with all aspects of toileting and changing. I have a program to hold a clean utensil while staff changes the soiled one. I wear a body suit to prevent me from removing fecal matter.

BECWTR[NG]
I demonstrate limited insight and functional ability regarding bathing. I need assistance with all bathing-related tasks. I do enjoy occasional baths as opposed to showers at times. I have a program to wash my torso.

DRESSING
I demonstrate limited insight regarding appropriate dressing procedures. I cannot dress myself without total staff support. I do not understand weather-appropriate dressing. I am not able to undress myself without assistance. Quite frequently, I choose to remove my shoes and/or socks, regardless of the time or place. I have a dressing program to pull down my shirt.

PERSONAL HYGIENE
I demonstrate limited insight and ability regarding personal hygiene tasks. I have a handwashing/handwipe program to wipe my hands with a handwipe. I also have a grooming program to brush my hair. I require intensive staff assistance and hands-on prompting to complete all such tasks. I have tactile defensiveness which interferes with my cooperation during oral hygiene, nail care, and regular haircuts. My father continues to desire to cut my hair and is the only one to do this.

DOMESTIC LIVING SKILLS
I do not demonstrate adequate insight or functional ability to independently initiate and complete most tasks of domestic living. While I may cooperate briefly to assist staff with performing these tasks, I will more often offer resistance due to tactile defensiveness. Additionally, I rely on staff to do laundry, clean the home, and maintain my own personal belongings. I should not be involved in meal prep, due to my NPO status.

SAFETY/SURVIVAL SKILLS
I lack many safety/survival skills. This makes me more likely to put myself in potentially dangerous situations when not appropriately supervised. I do not fully understand that precautionary measures must be taken in order to avoid chemical poisoning, burns, and other injuries. Regarding fire drills, I require staff to lead me out of the building. I tend to become very agitated due to the noise and urgency. I do not understand what to do in the case of a tornado. Annual fire/safety training is provided to me by the Active Treatment Coordinator. I like to spin and close doors.

SOCIAL DEVELOPMENT/LEISURE

INTERACTION WITH OTHERS

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My interaction with both peers and staff is very limited. I prefer to avoid other people and engage in individual activities (e.g. music, rolling ball.). I am very tactile-defensive. This interferes with most attempts at physical interaction with me. When agitated, I may scratch or hit others around me. I typically do not go out of my way to aggress toward other people.

SEXUAL AWARENESS
I demonstrate very limited insight into human sexuality and related issues. I do not appear to recognize myself as female. I do not appear to understand the purpose of sexuality. I do not understand societal boundaries pertaining to nudity. I do not engage in any inappropriate behaviors that are sexual in nature at this time. Sexuality training does not seem appropriate at this time, given low need and low likelihood of efficacy.

RECREATIONAL/LEISURE INTEREST
My favorite thing to do is listen to music (especially country music). I will often seek out the sources of music in my environment. While listening to music I appreciate sitting and rocking for self-stimulation. I also enjoy going for walks.

COMMUNITY ACCESS SKILLS
I do not understand public transportation. It is all done by Tabatha Trails and CLW for me. I also do not know how to use a phone in an emergency or how to dial 911. I require close supervision while in the community for safety and to access safe routing and emergency assistance. I am provided opportunities for community access.

EMPLOYMENT-PATH TO EMPLOYMENT

WORK INTERESTS
I attend Creative Life and Work Services. I enjoy getting up and attending. I enjoy participating in activities at CLW. I enjoy participating in arts and crafts, TV, games, and magazines at CLW. I am in CLW #2 which is more sensory based.

WORK SKILLS
My attention span is very short. Staff encourage me to participate. Depending on my mood, I will stick to activities sometimes longer than others. I enjoy running around the room and listening to music.

WORK ATTITUDES
I enjoy workshop. I should be encouraged to participate in activities and praised for all attempts. I should also be encouraged to make choices throughout the day to construct/personalize my day. I am not able to comprehend the concept of work equals money or/a from employer relationship.

WORK-RELATED BEHAVIORS
I do at times have work related behaviors. I exhibit disruptive behaviors (non compliance) and at times SIB (hitting, pinching, scratching). I do recognize my own needs. I am not able to carry on verbal exchanges with staff and peers. I had a vocational program to participate in a sensory activity. At CLW my vocational and behavior data is implemented with documentation. My handwashing and toileting goals are implemented informally without document.

MONEY MANAGEMENT

MONEY CONCEPT
I do not have a concept of money. I am dependent on staff for handling or carrying my money and purchasing any items for me. I do not correlate the exchange of money for goods. I have a money management program to drop coin in a container.

MONEY USAGE
I do not have any idea for the usage of money. I am dependent on staff for handling or carrying my money and purchasing items. I do not correlate the exchange of money for goods. I would not know how to locate a cashier or give the denomination to give them without staff assistance.

MONEY BUDGETING
I do not know how to budget my money nor do I understand the concept. I have a money management goal to drop coin in container. I am dependent on staff for saving and budgeting my money. Team feels it is in my best interest to have Takoda walk as my payee. I cannot carry any money on my person responsibly. My guardian allows for any amount of money to be spent on me for my needs.

CLIENT RIGHTS

EXERCISING OF RIGHTS
I express my rights to the best of my ability. I have guardianship to assist me in the understanding. I have exercised the ability to choose what I want to do and right of refusal most often. I have full access to my personal belongings and can have private time my data I choose.

COMPREHENSION
I cannot comprehend most of my rights. I seem to be aware that my father Greg Carter is my guardian. My guardian is very active in my life and assist me with the comprehension of my rights.

RESTRICTIONS
None

SUPPORTS
1. Guardianship
2. ambulatory
3. family support

CLIENT'S INPUT

PREFERENCES AND OPTIONS
I chose to attend CLW and stick with my normal routine. My father/guardian chose not to come or be conference called to my IP. Several disciplines showed up and discussed my progress over the past 1p year.

INTERDISCIPLINARY TEAM RECOMMENDATIONS

ADOPTED IDT RECOMMENDATIONS

PROGRAMS

E-FILED 04/22/2025 3:54 PM / CONFIRMATION 102334 / A 2522307 / COMMON PLEAS DIVISION / ICON

1. Communication
2. Oral hygiene
3. Dressing
4. Grooming
5. Showering
6. Handwashing/bathtype
7. Money Management
8. Self Medication
9. Toileting
10. Privacy
11. Vocational
12 Behavior

SERVICES
1.Medical to monitor health status.
2. NPO diet monitored by dietary.
3. Offer regular opportunities to participate in community outings as well as CLW by ATC's and RSI's.
4. Medical to provide Vision exam within 1 year..
5. Medical to provide Dental exam within 1 year of last appointment.
6. Improve hygiene skills (Showering and Handwashing). Formal programs implemented by RSI's.
7.Improve Oral Hygiene skills (toothbrushing). Formal program implemented by RSI's..
8 Improve Money Management skills. Formal program implemented by RSI's.
9.Increase independence in Self-Medication. Formal program implemented by LPN.
10.Supervision for my safety.
11.Medical staff to monitor Lauren medications and overall health provided by nursing.
12.To have personal needs monitored by QDDP.
13.Increase in vocational skills. Formal program implemented by CLW staff.
14.Fire safety training provided by ATC.
15.Resident rights training by ATC.
16. Ensure my rights are maintained and advocacy.
17. To continue to have [redacted] as Laurens guardian.

PLACEMENT GOAL

SHORT-TERM PLACEMENT GOAL

IDT'S GOAL (WITHIN NEXT 1-3 YEARS)
Team would like to see me to excel at programming while at Takoda Trails. Team wants me working towards independence. Would also like for improved social skills. I also needs 24 hour supervision.

LONG-TERM PLACEMENT GOAL
IDT'S GOAL (WITHIN 3-5 YEARS)
Team would like me to continue with 24 hour supervision . Team would like for me to continue to excel at programming and working towards independence

_____

QDDP DATE

NURSE'S NOTES

Name Lauren [redacted] Date Zakem Room No. [redacted]

Date/Time	Subjective
	Resident in Podiatry Clinic. Vitals Entered under
8/5/19 9a	Res assisted to Clinic. Vital Signs obtained BP 116/62, P 78, R 18, T 97.4 per oral site. Diabetes noted. — SLM
8/15/19 9:15a	Res alert and awake, all Safety measures in place. Mickey tube placement verified by aspiration and fx patency. Pt Stable all parameters noted. — SLM
8/25/19 9:45a	Pt is alert, resting comfortably. Placement verified by aspiration. Tolerated feedings and flushes well. No acute distress noted. — SLM
8/26/19 6:25a	Res Right upper arm multiple bruises. Pale pink in color. Drainage noted, skin warm to touch. NAD. Vitals obtained. — SLM
8/25/19 6:45p	Staff reported multiple skin discolorations on resident during assessment. Mickey button noted open c moderate amount of dark (coffee) drainage c a foul smell. Some drainage also noted from mouth. Also multiple dark or bruise-like discolorations noted on bil lower and bil upper extremities. Skin felt cold to touch. VS T 96 Or. 97% RA T 95.8 R 18 B/P WTD. MD notified Guardian notified. Individual sent out to ER for eval via 911 on stretcher. KJ Jones

NURSE'S NOTES

Name Lauren [redacted] Doctor Zaccour Room No. [redacted]

Date and Time	Notes
8/26/19 @ 10pm	Pt please call to Mercy Hospital ER — Charge Nurse Andrea contacted about pt being admitted for renal abscess — and all requested pt papers have been gathered.
8/26/19 10p	Spoke to Steven RN — Stated pt needs to change — She will be transferred to 2 Jen Room 2 and Dr. Scheduled for the morning.
8/27/19 9a	Kelly RN — State Lauren is awake + has been NPO with an order for Renal Consult — MRI abdomen w. IV. + bowels are starting to move — had urgent abdominal X-ray — results are pending. No documentation of discharge plan @ this writing.
8/29/19	Rec'd back to room from MRI via stretcher and accompanied by Mercy Hospital employee. Alert, GCS — oriented x4 Skin color and temperature WNL. Abdomen soft and non-tender. Vitals stable. Left [illegible] Lauren [illegible]

NURSE'S NOTES

Name [redacted] Room Parkview Floor/Unit

Date/Time	Notes	Initials
8/29/19 2p	Pt was transferred to Parkview, approx 2pm by Transport staff and Stretcher. Pt was received: N.O. Pt resides in Childrens Choices Solutions. Tele Swl per Protocol. Skin was dark (Black). Pt was oriented to unit. Pt's previous vitals: WNL noted.	
8/30/19 2p	Admission Vital Signs: BP 138/76. P 68. R 16. T 98. O2 Sat 96% RA. Pt's skin assessed and noted to be dry with scattered ecchymosis. Pt's skin was cleansed and dressed as per orders. Pt's skin was noted to be intact. Pt's skin was noted to be dry with scattered ecchymosis

[redacted]

Month: 4 Year: 19

Room: [redacted] Shift: [redacted]

Document title on appropriate shift record, initial each entry and sign in at the bottom. Write name of any abbreviations.

Duties: Attend Reflection Lounge. Ensure students [illegible] Initial the documents [illegible]

Individual	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																

Staff Signature: [redacted]

Parent Signature: [redacted]

TUSCOLA TRAILS (WOMEN) GROUP

Month: ___ Year: ___

Name: ___ Shift: ___

Document RNs on appropriate shift record. Initial each entry and sign in at the bottom. Inform nurse of any abnormalities.

Individual	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															

Initials Signature: Anna

Nurse Sign: Elizabeth Nightingale, RN

TEXAS TRACK-DOWN RECORD

Month: 6 Year: 19

Room: 8 Date:

Document DMs on appropriate shift record. Initial each entry and sign in on this bottom. Indicate names of any abbreviations.

D=No DB D=Dead R=Re-Dun L=Large L=Loose (Example: John has documents a medium DB "M / JC")

Individual	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
[redacted]																
Person Initials																

Will Sign In: Ronald

Kevin

Person Signing: John S

TAHOMA TRAILS – SCHOOL DISTRICT

Record your time on appropriate shift record. Initial each entry and sign-in at the bottom. Inform owner of any discrepancies.

SUBMISSAL	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
[redacted]															
Hours Worked					04	04		10	10	10	04				

Mgr Sign-in: [redacted]

Owner Sign-in: [redacted]

FILED 04/22/2024 1:34 PM / CASE #2024-1-CV-[redacted] / [redacted] / [redacted] / [

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LAUREN CARTER **A 2502067**

vs.

TAKODA TRAILS AKA
MILLER HOLDINGS TAKODA
INC

FILING TYPE: INITIAL FILING (ADDITIONAL PAGES)

PAGES FILED: 3

EXHIBIT

28

Billing Review

City of Fairfield FD

370 Nilles Rd, null, Fairfield, OH 45014

Date: [redacted] Call #: [redacted] Booklet: [redacted] Shift Lvl: 1 Bill Status: [redacted] Time Zone: America/New_York

Call Information:

Billing Disposition: Treated/Transported
Initial Patient Acuity: Emergent (Yellow)
Unit #: M20 - Medic 20, Closed Ambulance (81) Trip Type: Initial Trip
Run Type To Scene: Emergency Response (Primary Response Area) Emergent (Immediate Response)
Service Requested: Emergency Response (Primary Response Area)
Incident Facility: Takoda Trails (Assisted Living) (Assisted Living Center) – [redacted] - Fairfield, OH 45014
Incident Location: [redacted]
Incident Location Type: Res. Custodial Facility

Receiving Facility: UC West Chester Hospital (Hospital) - 7700 University Drive - West Chester, OH 45069
Facility Address: 7700 University Drive - West Chester, OH 45069 NPI: [redacted]
Destination Type: Hospital Emergency Department
Dest. Reason: Medical Protocol
Hospital Capability: Trauma Center Level II
Condition of Patient At Destination: Unchanged
Registration #: N/A

Loaded Mileage: 12.0 (ADDED) (Total Mileage 12.0)

Crew Members: Evan Miller, Paramedic (CIC); Andrew Dunham, EMT (DECEASED); Mark Bitner, Paramedic

Personal Protective Equipment Used:
Evan Miller - Eye Protection, Gloves, Mask-N95
Andrew Dunham - Eye Protection, Gloves, Mask-N95
Mark Bitner - Eye Protection, Gloves, Mask-N95

Moved to Amb By: Stretcher Transport Position: Semi/Full Fowlers From Amb By: Stretcher

Call Origin: N/A Lights/Sirens: Siren - Lights and Siren, Destination - Lights and Siren

Patients Transported In By Unit:
Patients at Scene:

Call Received:	[redacted]
Dispatched:	[redacted]
En Route:	[redacted]
At Staging Area:	
On Scene:	[redacted]
Patient Contact:	[redacted]
Transfer of EMS Patient Care:	
Left Scene:	[redacted]
At Destination:	[redacted]
Destination Patient Transfer of Care:	[redacted]
In Service:	[redacted]

Time On Scene:	15:56
Time to Destination:	33:56
Total Time of Run:	54:56

Patient Information:

Name: Lauren Carter
Address: [redacted]
County: Butler
Phone:
Email:
SSN: [redacted]
Driver License:
Local Resident: Yes
Veteran: No

DOB: [redacted]
Gender: Female
Age: 34 Years
Weight: [redacted] lb kg
Donation:

Current Meds:
Env Allergies:
Med Allergies:
Patient Physician:
Advance Directives:
PMH:
Comments:
Patient Physical Limitations:
Comment:

Comments:
Comments:
Comments:

Payer Information:

Advanced Beneficiary Notice
Did a Medical Necessity: No
Was Closest Appropriate Facility: No
Requested Service:
Representative Relation:

Non Covered Service: No
Preferred Physician: No

Clinical:

Onset Date/Time:
Dispatch Reason (EMD): 33001 - POSSIBLY DANGEROUS body area
Special Conditions:
Chief Complaint (Primary): Trauma Injury **Duration:**
Organ System: Musculoskeletal/Skin
Anatomic Location: Neck
Provider Impression: S16.2XXA (Penetrating injury of
Mechanism of Injury: Y33.0XXA (Unknown)
Injuries: S11.82XA (Deep open wound of unspecified part of neck, init encntr)
Protocol 1: **Other:** **Protocol 2:**

Assessments:

Time	Employee	Type	Summary
07:48:14		Injury	Injury - Neck Location Modifier: Injury: Laceration Injury Modifier: PTA: Yes
08:17:47	Dechert, Andrew	ABC	Airway: General: Patent: Yes Breathing: Circulation:
08:17:59	Dechert, Andrew	Neurological	Mental Status: Combative: Yes, Combative: Yes, Combative - Normal for Patient: Yes

Vitals:

Time	Employee	Summary
08:12:54	Dechert, Andrew	Patient Position: Sitting BP: 121/ 86 Associated Type: Size Cuff - Automated - Dbc Cuff - Automated Pulse: 80 Pulse Type: Regular Pulse Measurement Method: Electronic Monitor - Cardiac Resp: 20 Effort: Normal SPO2: 96 Environment: Room Air/Nasal Glasgow Coma Score: 3 (E) + 5 (V) + 6 (M) = 14 - Alert

Treatments/Medications:

Time	Employee	Summary

Supply:

Qty	Supply

ECG Device Incident Number:

Narrative History Text:
CPFD M53 ALS32 emergent welcome to above location for a 54 y/o F with a laceration to her neck. Upon arrival crew was met by facility staff who walked us to the Pt who presented sitting in her bed. There was very little blood noted. Pt had a laceration approximately 4 inches long and 1.5 inches wide to the right side of her neck. Pt is non verbal, alert and [illegible] accurate to all answers the majority occurred at which it occurred. Pt does not appear to be in any pain. Pt is transferred to cot via DMS x1 with a under arm carry. Pt secured to cot via x2 straps x3. Vitals attempted to the best of crew ability. Pt did not comply with most of the vitals attempts. A [illegible] to be obtained. The decision was made to transport the Pt to West Chester ED. Notification call made to West Chester ED while enroute. Pt stable, monitored throughout transport, no changes noted. Upon arrival at ED, Pt taken to Bed 23, transferred via sheet drag and secured with x2. Verbal report given to RN, transferred care of Pt to ED staff. Crew clear of hospital and returning to the city.

Andrew Dechert
Firefighter/Medic 468

Addendum: Redacted font from all caps of patient name to proper format. Changed during station check. (E. Dyppel 10-5-2021

Addendum: Changed Incident Location Type to Res. Custodial Facility. (Stallman 10/21/21

Unable to Sign:
Unable to Sign Reason: Verbally unable (must describe in comments)
Authorized Representative: No authorized representative is available or willing
Authorized Representative Signature: No
Secondary Documentation: Patient Medical Record
Secondary Documentation Signature: No
Comment:
Pt is HPQE very verbal and timid

Auth Signature: No **Primary Sig:** No **Unable to Sign:** Yes **Refused to Sign:** No

Signature Image(s):
Authorization Signature

Privacy Notice Signature

Receiving RN / MD Signature - Jun Ho - 11/26/2021 08:20



Technician 2 Signature - Miller, Ryan - 11/26/2021 08:36



Termination Signature - Dechert, Andrew - 11/26/2021 09:13



Recommended Service Level: BLS (A0429) / Dispatch Service Level: ALS
Run Type: Emergency
Calculated Mileage: 16.43
Medically Necessary: Yes (0)

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MILLER HOLDINGS TAKODA
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WRITTEN SUMMARY OF INCIDENT

EXHIBIT

10

BUTLER COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Date: 08/27/2022

To: [redacted] Guardian
Bill Napeard, Administrator w/ Takoda Trails
Carye Painter, President of CLW
Kara Frederick, Quality Assurance Director with BCBDD

From: Mike Sweetin, Butler County Board DD

Name: Lauren [redacted]
Incident Number: 2022-BBS-0248
Type of Incident: Alleged Neglect

Statement of Incident/Findings:
Statement of SIR rule: Neglect means when there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

Statement of allegation: On 7/13/2022, it was reported to the Office of Incident Review that Lauren [redacted] was accidentally left unattended on the van at CLW for several hours approximately 8:30am-1:30pm. The Administrator for CLW was driving the van. Fortunately, the weather was very nice. The doors and windows to the van were open, and there were no adverse effects/outcomes. IP/RAG was reviewed: Lauren requires visual supervision while in the community and at day program. She has a seizure disorder and is blind; she has no safety skills.

Lauren was checked by nursing and monitored through the night at home by nursing staff. No adverse outcomes were reported, no injuries or changes to vitals, etc.
CLW implemented a new bus checklist audit to be done to ensure all individuals have been assisted off the van. All staff at CLW were in serviced on this.

In reviewing this case, it was determined by the IA through video footage from CLW that Lauren was left on the bus for 5 hours, arriving at 9:30am and being discovered on the bus at 2:30pm. The weather on this day had a high of 83° and a low of 69° with an average temperature of 74°. The high was from around 3pm and the low was from around 8am. Two reports of the weather from this day show it was cloudy with the report from the Columbus airport showing there was light rain in the morning, with fog and cloud coverage until 8:52pm when there were scattered clouds. This weather report shows that it was partly sunny from 1:51pm to 2:51pm with cloud coverage still in place. During this time, it was reported to be 77°. The LWA Airport report shows there was light rain in the morning with cloud coverage until 4:52pm when it was partly cloudy.

Upon discovering Lauren at 2:30pm, the PN took Lauren to the CLW nurse, where an objective assessment was performed. The nurse attempted to do current vital signs; however, it was noted that Lauren was non-cooperative, they were able to obtain a temperature of 97.9° and noted there was no change in Lauren's gait or her demeanor, with her skin being warm and dry. At this time the nurse continued with Lauren's scheduled feed via her tube and noted that Lauren tolerated this well.

Upon arrival back to Takoda Trails Lauren was assessed again, after being informed by the nurse/s at CLW of what had happened. Lauren was monitored for s/s of change in status. Zero s/s of distress. Lauren was sitting on her bed. Zero s/s of distress noted at this time. Her temperature was again taken at 97.8° and new feeds were given per tube and she tolerated well.
07/18/22 @ 11:43pm: Lauren was resting quietly in bed easily aroused by tactile stimuli.

Vital signs and head to toe assessments continue to remain within the normal limits. Zero s/s of any distress or discomfort noted at this time.

07/20/2022 @ 4:30pm Resident up in her room walking around. Shows zero s/s of distress at this time. Skin warm and dry color natural. Tolerated meds/ fluids well.

Lauren's Dad/Guardian asked Tukenda Trails to keep Lauren at Tukenda from now on and she will no longer be attending CLW day programming moving forward. Lauren's Dad/Guardian has contacted the Police and Sgt DeSalvo with the Forest Park Criminal Investigations Unit is looking at this case for patient endangerment. As of 08/23/2022 Sgt. DeSalvo was speaking to a prosecutor about this case. As of 09/21/22 Lauren's Dad/ Guardian notified IA that he had spoken with Sgt. DeSalvo today [09/21/2022] and it sounds like any criminal charges will be unlikely. This does not negate the risk of serious injury from a DD standpoint.

Based on the information obtained, it is the findings of this investigator that the allegation of neglect is **substantiated** due to the following:

Supervision levels were not met, and Lauren was left alone on the bus for 5 hours, (not around 3 hours as originally reported)
Lauren has no safety skills and needs to be in view of staff in the community and at CLW
Lauren has a history of seizures and the lack of vertical blindness with supervision not in place, this placed Lauren at risk for serious injury, should a seizure occur, or the attempt to unbuck from the bus. Being left in a vehicle, even although oversized, in mid 70s weather places Lauren at risk for Serious injury. The doors and windows were closed. (not open as originally reported)

Prevention Plan:

1. A letter to notify PPI that effective immediately he was placed on administrative suspension pending further investigation. As of 07/20/2022.
2. Transportation Policy/Procedure Manual update with VIII and IX being added, which state: VIII. The CLW driver is responsible for checking the bus after unloading to ensure all individuals have exited the bus/van and no one is left on the vehicle. IX. Each CLW bus will be equipped with a binder and check off sheet of each individual that is riding the bus that day: both AM and PM or anytime individuals are on the bus including outings. The driver is responsible for documenting who is on the bus and checking off when they exit the bus. The Administrator or their designee is responsible for monitoring these forms weekly by initialing the bottom of the page.
3. New checklist showing new columns added with 'Clear clear from bus' columns for AM and PM. Previous checklist in place had a check box for AM and PM for pick up and drop off, but no column specific to clearing clients from bus.
4. In-Service sheet from 07/19/2022 by Administrator/PPI on the new bus sheets 'Clear from bus', signed by staff at CLW Forest Park location.
5. In-Service sheet from 07/20/2022 by Assistant Administrator on Transportation Policy updates, signed by staff at CLW Forest Park location.
6. IA received training for PPI on IP's dated 09/08/2022, training completed by CLW Assistant Admin.
7. IA received CLW training for staff on MUI's/IP's, Health and Wellness skills and Client Rights, dated 09/05/2022, training completed by Administrator/PPI.

8. Lauren's Dad/Guardian asked that Lauren no longer attend CLW day programming, and an active plan be put in place for Lauren at Takoda Trails, to keep her active while she spends her days at Takoda.
9. Lauren's team met to update her IP as of 07/22/22 to discuss her new needs, health and wellness and add in an active plan for staying at Takoda moving forward.

Cc: Will Pike

The information contained in this letter is provided to you in accordance with OAC 5123:17-01. You may dispute the findings of this report by submitting a letter of dispute and supporting documentation to the county board superintendent or to the director of the Ohio Department of DD if the department has conducted the investigation, within fifteen calendar days following receipt of this summary. An individual may receive assistance from any person selected by the individual to prepare a letter and provide supporting documentation. If you have any questions, please call 513.789.9979 and ask to speak to Dan Hibbard about

2323 N. Fair Avenue
Hamilton, OH 45011
www.butlerdd.org
info@butlerdd.org
(513) 785-2800

8/4/2022 3:54 PM / CONFIRMATION 168284 / A 2200307 / COMMON PLEAS DIVISION / 4020