

Incident Statement: (Describe the incident completely, e.g., the circumstances and cause of incident, and the nature and extent of physical harm, etc, identifying interventions attempted, outcome for the individual with MR/DD, and responsible party(ies). Attach additional sheets, if necessary)

CONSUMER NAME: LAUREN [REDACTED] DATE OF INCIDENT: 6/22/99

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.

Incident Statement: (Describe the incident completely, e.g., the circumstances and cause of incident, and the nature and extent of physical harm, etc, identifying interventions attempted, outcome for the individual with MR/DD, and responsible party(ies). Attach additional sheets, if necessary)

CONSUMER NAME: LAUREN [REDACTED] DATE OF INCIDENT: 6/22/99

THE NURSE ACCUSED OF PHYSICAL AND VERBAL ABUSE TO LAUREN, WAS
DISCHARGED FROM HER POSITION. SHE ALSO IS NOT ELIGIBLE FOR
RE-HIRE. MIDDLETOWN POLICE COULD NOT SUBSTANTIATE THIS CASE AND
THEREFORE, THIS CASE HAS BEEN CLOSED.

James Herbin 10-20-99
Signature of MUI Reviewer Date

Martha Ungell 10-20-99
Supervisor, Signature of MUI Reviewer Date

Ohio Department of Mental Retardation and Developmental Disabilities
County Board of Mental Retardation and Developmental Disabilities

CBMR/DD INCIDENT REPORT (ITS)

Incident No.	County BUTLER	Client No. [REDACTED]	Client Name (Last, First, Middle, Surname) [REDACTED] LAUREN		Gender M / (F)
Client Social Security No. [REDACTED]		Client Date of Birth (mm/dd/yyyy) [REDACTED]		Facility No.	
Facility Name ABILITIES FIRST FOUNDATION		City Middletown		State OH	Zip Code 45044
Street Address 4710 Timber Trail Drive		Incident Type (Check One) <input checked="" type="checkbox"/> A - Individual <input type="checkbox"/> B - Group		Incident Date (mm/dd/yyyy) 6/22/99	
Incident Time Known? Y / (N)		Incident Time (00:00) (Circle One) : AM / PM		MUI Reviewer Assigned JIMMIE HARDIN	
Victim? (Y) N		Alleged Perpetrator? Y / N		Alleged Perpetrator Name CAROL J. SCHAUER	
Is the Alleged Perpetrator SL Service Provider? (Y) N		Alleged Perpetrator's Soc. Sec. No. (If SL Provider) [REDACTED]		Neglect? <input type="checkbox"/> Yes	Attempted Suicide? <input type="checkbox"/> Yes
Rights Code Violations? <input type="checkbox"/> Yes					
Type of Incident Location: (Check One) <input type="checkbox"/> A - Early Intervention <input type="checkbox"/> B - School <input type="checkbox"/> C - Adult Program <input type="checkbox"/> D - Community Employment <input checked="" type="checkbox"/> E - Residence <input type="checkbox"/> F - Other: _____		Perpetrator's Relationship to Victim: (Check One) <input type="checkbox"/> A - Family <input checked="" type="checkbox"/> B - Staff <input type="checkbox"/> C - Volunteer <input type="checkbox"/> D - Peer <input type="checkbox"/> E - Client <input type="checkbox"/> F - Unknown		Abuse Category: (Check All Applicable) <input checked="" type="checkbox"/> A - Physical <input type="checkbox"/> B - Sexual <input type="checkbox"/> C - Theft <input type="checkbox"/> D - Fraud	
Notification: (Check All Applicable) <input checked="" type="checkbox"/> A - Local Law Enforcement Agency <input checked="" type="checkbox"/> B - ODMR/DD Office of Licensure <input type="checkbox"/> C - CDHS Children's Protective Services/ Children's Services Bureau <input checked="" type="checkbox"/> D - Relative <input type="checkbox"/> E - Legal Guardian <input type="checkbox"/> F - Other: _____		Health Treatment: (Check One) <input type="checkbox"/> A - Hospitalization/Medical Treatment Facility <input type="checkbox"/> B - Mental Health Institution <input type="checkbox"/> C - Hospital Emergency Room		Death Category: (Check One) <input type="checkbox"/> A - Natural <input type="checkbox"/> B - Suicide <input type="checkbox"/> C - Homicide <input type="checkbox"/> D - Accident	
Origin of Life Threatening Reaction: (Check One) <input type="checkbox"/> A - Adverse reaction to medication <input type="checkbox"/> B - Failure to take medication <input type="checkbox"/> C - Failure to follow prescribed dietary plans <input type="checkbox"/> D - Failure to follow medical treatment plans <input type="checkbox"/> E - Pattern of Medication Errors		Fire or Damage Results: (Check All Applicable) <input type="checkbox"/> A - Injury to the individual (s) <input type="checkbox"/> B - Relocation of the individual (s) <input type="checkbox"/> C - Inability to provide services		Law Enforcement Action: (Check One) <input type="checkbox"/> A - Arrest <input type="checkbox"/> B - Charges pressed <input type="checkbox"/> C - Criminal conviction <input type="checkbox"/> D - Incarceration	
Administrative Action Taken: (Check All Applicable) <input type="checkbox"/> A - Staff suspended <input checked="" type="checkbox"/> B - Staff terminated <input type="checkbox"/> C - Other administrative actions taken <input type="checkbox"/> D - No administrative actions taken		Incident Review Status: <input checked="" type="checkbox"/> OI - Open - Information Pending <input type="checkbox"/> OC - Open - Information Complete <input type="checkbox"/> CL - Incident Case Closed		Date Case Closed (mm/dd/yyyy)	
Signature of MUI Reviewer <i>Jimmie Hardin</i>		Date 7/15/99		Is the incident substantiated: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Supervisor of MUI Reviewer <i>Mark Angelo</i>		Date 7/15/99			

Incident Statement: (Describe the incident completely, e.g., the circumstances and cause of incident, and the nature and extent of physical harm, etc, identifying interventions attempted, outcome for the individual with MR/DD, and responsible party(ies). Attach additional sheets, if necessary)

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INCIDENT REPORT

✓ MAJOR UNUSUAL (check appropriate line)

Resident Name: Lauren ✓ for reportHome Facility: Doty House

Incident Information

Date: 6/22/99 TuesdayTime: 7-9

a.m.

(p.m.)

Shift: 2NDLocation: ✓ HomeSchoolWorkshopOutingOther:

Describe nature and extent of the incident in detail: Heaven Cassidy reported that
ATS's reported both verbal & physical abuse occurred
to Lauren Tuesday night when the nurse Carol Schaefer
worked, see attached witness statements.

Signature of Person Witnessing the Incident/Title _____

Supervisor Staff Use

Incident Reported

Date: 6/24/99Time: 8:30

a.m.

(p.m.)

Reported By: Heaven Cassidy

Emergency Information

911 Called Yes ✓ No

If yes, what time? _____

a.m. p.m.

Was resident transported? Yes ✓ No

If yes: Location _____

Time _____

a.m. p.m.

Was resident admitted to the Hospital? Yes ✓ No

Reported to (or N/A)

911 Operator Name or No. No

Date/Time _____

Attending Physician (As needed) He

Date/Time _____

Parent/Guardian _____

Date/Time 6/24/999:30pAdministrator on Call Den EiseeDate/Time 6/24/998:30pSocial Services Debbie EwersDate/Time 6/24/999:00pCase Management (only if MUI) Miss. Wright to Michelle with Room this morningDate/Time 6/24/999:00p

Physician's Response

Date: _____

Time: _____

a.m. p.m.

Orders given: _____

Describe any additional pertinent information: _____

Supervisor's Signature/Title Heaven RDate 6/24/99

Routing (Initial/Date)

Nursing Manager DE6/24/99Residential Director DE6/25/99

Executive Director _____

Social Services DE6/25/99

Human Rights Comm. _____

Medical Director _____

Comments _____

WITNESS STATEMENT

M11 Tuesday 22nd, 1999

At about 8:30 9:00 pm I was helping Brenda with Lauren [REDACTED] the nurse Carol Shover could feed her and while Brenda & I was why - holding her Lauren was grinding her teeth and Carol would take the feeding syringe and poke Lauren in her mouth. So she would stop. She would yell at Lauren and tell her to stop grinding her teeth.

and for the reason I didn't tell the next shift nurse was because Carol was still there at 11:00 pm so I waited to report the next day which was on 6-23-99.

6-24-99
Chapman
9:15 pm

Signature

Date

Time

WITNESS STATEMENT ✓

I Brenda Bailey was working on Tuesday 6-22-99 when Carol the nurse was passing med's on boys side. At 7:00^h Lauren [redacted] was grinding her teeth. Carol went over to her and took her head and shook it hard. She did that 2 times. Then she went to girls side and was feeding Lauren. Lauren started grinding her teeth again. Carol took the feed tube syring and tried to shove it in her mouth. She did that about 7 or 8 times. She told her if she didn't stop she would put her in room & close door on her. She also said Derrick Lucas was her papa. The reason I did not say anything that night was because Carol was on that night till 11:00 when I left.

June 24, 1999
Brenda Bailey

This was written at 9:15 pm

Signature

Date

Time

On 22 June, The nurse on duty.
Had the little girl about head.
SCREAMING, Hitting the table.
Saying call papa Derrick. She said
call papa Derrick over and over
again.

Observed around 900 ✓

Althea Turner

Signature

6-24-99

Date

9:20

Time

on June 22, 1999 ✓
I Donna Bust Don't Remember if
I helped out on Lauren feeding
I couldve Been doing something
else that night. When Steve and
Lori + Gwelly Lauren grine's their
teeth she screams at them,
or tells us to put them in
their Room. she tells them
to stop. They keep on grinding
their theeth. she tells
Lauren she is a Devil Baby that
she is mean. I told her that
*wasnt nice. she is so mean
to Lauren. Lauren cant help
it how she acts. she acts like
that when feeding comes. One
day she told her that she
dont need to Be Fed. I heard
her say that, that wasnt
very nice. I told her that
she needs her Food.

Donna Bust
7-16-99

Ohio Department of Mental Retardation and Developmental Disabilities
County Board of Mental Retardation and Developmental Disabilities

CBMR/DD INCIDENT REPORT (ITS)

1099-009-0014

Incident No.	County BUTLER	Client No. [REDACTED]	Client Name (Last, First, Middle, Surname) [REDACTED] LAUREN	Gender M / <input checked="" type="radio"/> F
Client Social Security No. [REDACTED]	Client Date of Birth (mm/dd/yyyy) [REDACTED]	Facility No.	Facility Name ABILITIES FIRST FOUNDATION	
Street Address 4710 Timber Trail Drive		City Middletown	State OH	Zip Code 45044
Incident Type (Check One) <input checked="" type="checkbox"/> A - Individual <input type="checkbox"/> B - Group	Incident Date (mm/dd/yyyy) 6/22/99	Incident Time Known? Y / <input checked="" type="radio"/> N	Incident Time (00:00) (Circle One) : AM / PM	
MUI Reviewer Assigned JIMMIE HARDIN	Victim? <input checked="" type="radio"/> Y <input type="radio"/> N	Alleged Perpetrator? Y / N	Alleged Perpetrator Name (STAFF/NURSE) [REDACTED] CAROL J. SCHAUER	
Is the Alleged Perpetrator SL Service Provider? <input checked="" type="radio"/> Y <input type="radio"/> N	Alleged Perpetrator's Soc. Sec. No. (If SL Provider) [REDACTED]	Neglect? <input type="checkbox"/> Yes	Attempted Suicide? <input type="checkbox"/> Yes	Rights Code Violations? <input type="checkbox"/> Yes
Type of Incident Location: (Check One) <input type="checkbox"/> A - Early Intervention <input type="checkbox"/> B - School <input type="checkbox"/> C - Adult Program <input type="checkbox"/> D - Community Employment <input checked="" type="checkbox"/> E - Residence <input type="checkbox"/> F - Other: _____		Perpetrator's Relationship to Victim: (Check One) <input type="checkbox"/> A - Family <input checked="" type="checkbox"/> B - Staff <input type="checkbox"/> C - Volunteer <input type="checkbox"/> D - Peer <input type="checkbox"/> E - Client <input type="checkbox"/> F - Unknown Health Treatment: (Check One) <input type="checkbox"/> A - Hospitalization/Medical Treatment Facility <input type="checkbox"/> B - Mental Health Institution <input type="checkbox"/> C - Hospital Emergency Room Origin of Life Threatening Reaction: (Check One) <input type="checkbox"/> A - Adverse reaction to medication <input type="checkbox"/> B - Failure to take medication <input type="checkbox"/> C - Failure to follow prescribed dietary follow medical treatment Medication Errors		Abuse Category: (Check All Applicable) <input checked="" type="checkbox"/> A - Physical <input type="checkbox"/> B - Sexual <input type="checkbox"/> C - Theft <input type="checkbox"/> D - Fraud Death Category: (Check One) <input type="checkbox"/> A - Natural <input type="checkbox"/> B - Suicide <input type="checkbox"/> C - Homicide <input type="checkbox"/> D - Accident Fire or Damage Results: (Check All Applicable) <input type="checkbox"/> A - Injury to the individual (s) <input type="checkbox"/> B - Relocation of the individual (s) <input type="checkbox"/> C - Inability to provide services Law Enforcement Action: (Check One) <input type="checkbox"/> A - Arrest <input type="checkbox"/> B - Charges pressed <input type="checkbox"/> C - Criminal conviction <input type="checkbox"/> D - Incarceration
Notification: (Check All Applicable) <input checked="" type="checkbox"/> A - Local Law Enforcement Agency <input checked="" type="checkbox"/> B - ODMR/DD Office of Licensure <input type="checkbox"/> C - CDHS Children's Protective Services/Children's Services Bureau <input checked="" type="checkbox"/> D - Relative <input type="checkbox"/> E - Legal Guardian <input type="checkbox"/> F - Other: _____		Date Case Closed (mm/dd/yyyy)		
(Check All Applicable) <input type="checkbox"/> A - Staff suspended <input checked="" type="checkbox"/> B - Staff terminated <input type="checkbox"/> C - Other administrative actions taken <input type="checkbox"/> D - No administrative actions taken		<input checked="" type="checkbox"/> OI - Open - Information Pending <input type="checkbox"/> OC - Open - Information Complete <input type="checkbox"/> CL - Incident Case Closed		
Signature of MUI Reviewer Date <i>Jimmie Hardin 7/15/99</i>		Signature, Supervisor of MUI Reviewer Date <i>Michelle Angelo 7/15/99</i>		



000255824
LAUREN [REDACTED] Intake: JOSHUA OHAIR
MUI Case File 12/16/2010 11:29:20 AM

WITNESS STATEMENT FORM

*

STATE vs. _____ CASE NO. _____

Statement of Carol Schauer Address 4935 'D' Woodnedge Dr Apt D

AGE: 47 DOB: 10/20/51 SEX: Female SS#: [REDACTED]

EMPLOYER'S NAME: Abelides 4 and 1 Address _____

PHONE NUMBER: (Residence) _____ (Business) 423 5806

Statement taken by Det. B. Reese Date: 7-16-99 Time: 11:30 AM

I came to work about 5:15^p and got report from Alexia. After receiving report I went and checked on everyone on both sides of the building. Approx 6^p to 6⁴⁵^p I was busy with giving the twins their meds + disconnecting tube feedings so that the ^(one) twin + Blowgill could get their batns. Approx 7³⁰^p I started my med pass which took until about 9^p. During the med pass on the girls side I noticed an unusual noise + asked what the noise was + was told by Donna that it was [REDACTED] grinding her teeth. I believe that I gave [REDACTED] some Motrin after asking if she could possibly be in pain or discomfort and had Donna help me give her her meds. During the med pass Donna + Cheryl were working on the girls side + I was asked when/if I wanted to/going to feed hauser

INITIALS cap

At that time I stated whenever they were ready I would feed Lauren. During that time I got the supplies together & began to feed Lauren. I asked for Cheryl to raise Lauren up (back/head) so that she would be in an upright position. During this time there was conversation regarding how much Lauren seems to like Derrick & that she seemed to miss the attention that he gave her when he worked. I gave Lauren her meds then the tube feeding of pedisure then her water flush. After finishing with the feeding I checked around her nuckey pile to see if it required any oint. due to being rashey early. After that I uncoiled the tubing & threw out the syringe into the garbage along with the plastic bag. Prior to feeding Lauren I had to redirect [redacted] away from the door because he was opening it up. After feeding Lauren I proceeded to finish the med pass & checked on the 3 clients that were receiving tube feeding & making sure that they were all going ^{by getting them checked}. During this time I had made 2-3 attempts in getting [redacted] to take his meds (Usually I ask for help but no one was around when I went into his room). The first time I went into [redacted] room to give him his meds he had his hands to his face and I couldn't get him to move them so I left him & returned back to the room. The first time I was in the room I noted [redacted] to have a diaper on & he wasn't suppose to be wearing a diaper (attendy) because of tearing it apart so I removed the diaper. After the second or third attempt I finally got [redacted] to take his meds. After that essentially the med pass was over & I cleaned up after myself. Proceeded to go back to take a shower making sure that Lauren was out of the way.

and was letting to run. Shortly after that
Laurer was returned per Brenda to her
wife and was taken over to the girls
side. I was busy with whatever paperwork
etc that I had left to do & the aides were doing
their last rounds. About 10⁴⁰ Kim came into
work, I gave her report & then I left for
the evening. ep

I have read this statement consisting of 3 page(s), and I
understand it and it is true.

This statement was completed at 1135 AM., on the 16 day of
July, 1999.

WITNESS

WITNESS

Det. Barry F. Reese
James Hardin

Carol Dehaan

Signature of person giving
voluntary statement

ABILITIES FIRST FOUNDATION

DATE: 6/30/99
TO: JIM HARDIN
CC: DENNIS GRANT & KAREN SMITH
FROM: TERI
RE: INCIDENT

After the alleged incident was reported to me on Thursday 6/24/99, I noted that Carol Schauer was not on the schedule. I called her home twice, leaving messages to call me. I am in receipt of a note from Carol stating that she has a hectic schedule this week and will be out of town over the holiday weekend and will get in touch with me when she returns. I wish to give her the opportunity to speak to these allegations. Let me know what else I can do.

*Don
Zivich
(513) 423-5806*

6/30/99



*...is committed to providing
comprehensive services and
quality care to help children
and adults with special needs
put their "Abilities First".*

Abilities First Foundation
In Robert B. Gardner Center

FAXSIMILE TRANSMITTAL COVER SHEET

Date:

10/19/99

Time:

4:30 p

To:
Name

Joan

Firm

Address

FAX #

Phone #

From:
Name

Firm

Doty House Residential
Abilities First Foundation

City

Middletown, Ohio 45044

FAX #

(513) 727-3817

Phone # (513) 423-5808 (Nursing Station)

Number of Pages, Including Cover Sheet 3

Message:

Don't give to Jimmy unless he

Promises not to misplace them ☺



In The Robert B. Gardner Center
4710 Timber Trail Drive, Middletown, Ohio 45044-9912
513-423-9496/Fax 513-423-1717
<http://www.middletown.com/abilities.htm>

*Celebrating 40 Years of Loving Care
1958-1998*

July 8, 1999

Carol Schauer
4935 'D' Woodridge Drive
Middletown, OH 45044

Dear Carol,

I have left several messages at your home asking you to contact me. Since you have not done so, after you left me a note stating that you would, I am now writing this to you.

There were allegations made about your care toward a resident. Since the nature of the allegations were severe I have discharged you from Abilities First Foundation/Doty House Residential and you will not be eligible for re-hire. Due to the serious nature of the allegations, an MUI was made out and Community Support Services was brought in to investigate. Currently the investigation continues. If you wish more information on this matter please contact Community Support Services at 1-513-867-5914.

Regretfully,


Teri Eisele, Nursing Manager

Expanding the Doty House tradition of care

Beginnings, Community Employment Opportunities, Doty House and Hopewell Residential,
Language Preschool, STARS

**Discovering Abilities**

P.O. Box 376

Mason, Ohio 45040

~~(513) 459-7928~~

ABILITIES FIRST FOUNDATION

DATE: 6/30/99
TO: JIM HARDIN
CC: DENNIS GRANT & KAREN SMITH
FROM: TERI
RE: INCIDENT

After the alleged incident was reported to me on Thursday 6/24/99, I noted that Carol Schauer was not on the schedule. I called her home twice, leaving messages to call me. I am in receipt of a note from Carol stating that she has a hectic schedule this week and will be out of town over the holiday weekend and will get in touch with me when she returns. I wish to give her the opportunity to speak to these allegations. Let me know what else I can do.

A Program of Abilities First Foundation
6/30/99

4710 Timber Trail Drive • Middletown, OH 45044
(513) 423-9496

UNUSUAL INCIDENT REPORT FORM

DATE: 6-25-99 Time: 8³⁰-9⁰⁰ a.m. (p.m.) REPORT TAKEN BY: _____

CLIENT NAME: Lauren [REDACTED] S.C.: _____

ADDRESS: Abilities 1st Foundation
Middlebury
(If Fairfield Center, Indicate Bldg #)

REPORTED BY: Jerry Siles, AGENCY/FACILITY: Abilities 1st

PHONE: _____ HE/SHE WAS NOTIFIED BY: _____

THAT INCIDENT OCCURRED.

STAFF INVOLVED: _____

OTHERS NOTIFIED:	Law Enforcement	_____	If so, by whom:	_____	When:	_____
	BCHS - CSB	_____	If so, by whom:	_____	When:	_____
	BCHS - APS	_____	If so, by whom:	_____	When:	_____
	ODMRDD - CSS	<input checked="" type="checkbox"/>	If so, by whom:	<u>Joan</u>	When:	<u>6-28-99</u>
	ODMRDD - Licensure	_____	If so, by whom:	_____	When:	_____

DATE/TIME OF INCIDENT: 6-22-99

LOCATION OF INCIDENT: Abilities 1st Circle One: MUI UI-H UI

SEE PRIOR UI/MUI'S: Carol Skowron - was discharged last week no longer part of pool no re hire
Left before came back as no need bases
Lauren no harm done not appropriate

DESCRIPTION OF INCIDENT: Staff Reported Nurse grabbed Lauren by
the head & shook it hard. She also yelled at her

Lauren: DOB [REDACTED]
SS # [REDACTED]

034A/PCV

UNUSUAL INCIDENT REPORT FORM

DATE: 6/22/99 Time: _____ a.m./p.m. REPORT TAKEN BY: _____

CLIENT NAME: Lauren S.C.: _____

ADDRESS: Abilities 1st Foundation
Madison
(If Fairfield Center, Indicate Bldg #)

REPORTED BY: Jeri Easier, AGENCY/FACILITY: Abilities 1st

PHONE: _____ HE/SHE WAS NOTIFIED BY: _____

THAT INCIDENT OCCURRED.

STAFF INVOLVED: _____

OTHERS NOTIFIED:	Law Enforcement	<input checked="" type="checkbox"/>	If so, by whom:	<u>Jh</u>	When:	<u>7/7/99</u>
	BCHS - CSB	<input type="checkbox"/>	If so, by whom:	_____	When:	_____
	BCHS - APS	<input type="checkbox"/>	If so, by whom:	_____	When:	_____
	ODMRDD - CSS	<input checked="" type="checkbox"/>	If so, by whom:	<u>Jh</u>	When:	<u>7/7/99</u>
	ODMRDD - Licensure	<input checked="" type="checkbox"/>	If so, by whom:	<u>Jh</u>	When:	<u>7/7/99</u>

DATE/TIME OF INCIDENT: 6/22/99

LOCATION OF INCIDENT: Abilities 1st Foundation Circle One: MUI UI-H UI

SEE PRIOR UI/MUI'S: _____

DESCRIPTION OF INCIDENT: Staff reported a nurse (Carol) was physically & verbally abusive to Lauren. See written statements attached

WITNESS STATEMENT FORM

STATE vs. _____ CASE NO. _____

Statement of Carol Schauer Address 4935 'D' Woodnedge Dr Apt 1

AGE: 47 DOB: 10/20/51 SEX: Female SS# [REDACTED]

EMPLOYER'S NAME: Abelides Ford Address _____

PHONE NUMBER: (Residence) _____ (Business) 423 5801

Statement taken by Det. B. Reese Date: 7-16-99 Time: 11:30 AM

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INITIALS CS

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Laurer was returned per Brenda to her
wife and was taken over to the girls
side. I was busy with whatever paperwork
etc that I had left to do & the aides were doing
their last rounds. About 10⁴⁰ Kim came into
work, I gave her report & then I left for
the evening. ep

I have read this statement consisting of 3 page(s), and I
understand it and it is true.

This statement was completed at 1:35 AM., on the 16 day of
July, 1999.

WITNESS Det Barry F. Reese

WITNESS James H. Harkin

Cari Dehaan
Signature of person giving
voluntary statement

"ON-CALL" LOG

[illegible]

NOTE: Completed "On-Call Log" forms must be disseminated to service Coordinators on the next working day.

Date:

6/25/99

WITNESS STATEMENT FORM

STATE vs. _____ CASE NO. _____

Statement of _____ Address _____

AGE: _____ DOB: _____ SEX: _____ SS#: _____

EMPLOYER'S NAME: _____ Address _____

PHONE NUMBER: (Residence) _____ (Business) _____

Statement taken by _____ Date: _____ Time: _____

Monday Schedule meeting with those listed below
 Derrick Lucas, Maria Hail Jennifer
 Has seen interaction ~~between~~ with Lorraine where
 she kicked, hit, spit & hit her

Carol Schauer 423-4151 Monday ^{home} 3-7
 Tues 7p-7a
 Home by 8⁰⁰ Wed/Thurs off
 Fri 3-11

INITIALS _____

CONTRACT #0900010

BUTLER COUNTY BOARD OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
CASE MANAGEMENT SERVICES

1) LOCATION CODE	2) CONTACT CODE	3) SERVICE CODE	4) SERV NEEDS CODE
A. Hospital	G. With Individual	L. Needs Assessment	R. Housing/Placement
B. In Office	H. With Individual/Phone	M. Crisis Intervention	S. Interpersonal
C. Residential Fac/Home	I. With Essential Other	N. Information/Referral	T. Monitoring
D. Place of Employ/Day Prog/School	J. With Essential Other/Phone	O. U.I.R.	U. Comprehensive Evaluation
E. Transport of Client	K. Written	P. Service Monitoring	V. U.I.R. Follow-up
F. Other		Q. Service Coordinating	W. Crisis Resolution
			X. Other
			Y. Team Meeting

SERVICE PERIOD: 08/01/99 - 08/31/99

PRIMARY DIAG CODE: 03190

NAME: [REDACTED] LAUREN (1599)

MEDICAID: [REDACTED]

DOB: [REDACTED]

CASE MANAGER: *James E. Jordan*

DATE: 8-31-99

DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
08/17/99	01:21:00	01:48:00	B	J	O	V	2	Recieved call from Dennis Grant of Abilities 1st re the status of the case JHY on Lauren and the nurse, Carol. Updated him re Detective Reese intention. informed him that CSS would call detective Reese and get back with him. Called detective Reese re the Taskforce decision. He stated they felt in the absence of hard physical evidence ie bruises ect they would not pursue the case. He stated he plan to ask Carol to take a polygraph test but could not schedule it before Monday when the tester get's back from vacation. Called Dennis and informed him of this conversation.	

CONTRACT #0900010

BUTLER COUNTY BOARD OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
CASE MANAGEMENT SERVICES

1) LOCATION CODE	2) CONTACT CODE	3) SERVICE CODE	4) SERV NEEDS CODE
A. Hospital	G. With Individual	L. Needs Assessment	R. Housing/Placement
B. In Office	H. With Individual/Phone	M. Crisis Intervention	S. Interpersonal
C. Residential Fac/Home	I. With Essential Other	N. Information/Referral	T. Monitoring
D. Place of Employ/Day Prog/School	J. With Essential Other/Phone	O. U.I.R.	U. Comprehensive Evaluation
E. Transport of Client	K. Written	P. Service Monitoring	V. U.I.R. Follow-up
F. Other		Q. Service Coordinating	W. Crisis Resolution
			X. Other
			Y. Team Meeting

SERVICE PERIOD: 07/01/99 - 07/31/99

PRIMARY DIAG CODE: 03190

NAME: [REDACTED] LAUREN

(1599)

MEDICAID # [REDACTED]

DOB: [REDACTED]

CASE MANAGER:

James Harkin

DATE:

7-31-99

DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
07/21/99	08:00:00	09:12:00	F	I	O	V	5	Meeting with detective Reese to review the witnesses statement concerning JHJ the alleged physical and verbal abuse of Lauren. All in order. Some question still not answered is statement of LPN conflict with statements of the witnesses. This and other concerns not relivant to the allegations. Detective Reese stated again that he didn't think this case would be proscuted because he didn't see any criminal activity and CSS agreed. He stated he would present the case to the taskforce at 11:00am today. He would keep CSS informed. Requested he contact [REDACTED] and update him on current status of this case.	

CONTRACT #0900010

BUTLER COUNTY BOARD OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
CASE MANAGEMENT SERVICES

1) LOCATION CODE

- A. Hospital
- B. In Office
- C. Residential Fac/Home
- D. Place of Employ/Day
Prog/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. Written

3) SERVICE CODE

- L. Needs Assessment
- M. Crisis Intervention
- N. Information/Referral
- O. U.I.R.
- P. Service Monitoring
- Q. Service Coordinating

4) SERV NEEDS CODE

- R. Housing/Placement
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- T. Monitoring
- U. Comprehensive Evaluation
- V. U.I.R. Follow-up
- W. Crisis Resolution
- X. Other
- Y. Team Meeting

SERVICE PERIOD: 07/01/99 - 07/31/99

PRIMARY DIAG CODE: 03190

NAME: [REDACTED] LAUREN

(1599)

MEDICAID # [REDACTED]

DOB: [REDACTED]

CASE MANAGER: *James Harder*

DATE: 7-31-99

DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
07/16/99	09:15:00	01:00:00	F	I	O	V	15	Interviewed Carol Schauer at the Middletown P.D. re allegations concerning JHJ she and Lauren. Carol denied all allegation and offered to take a polygraph test to prove her innocent. See written statement for details of Carol's response to the allegation. In her verbal statement she mention that Donna Rush was assisting her while feeding Lauren. Detective Reese and CSS was not aware that Donna existed. Took a break and called Terry at duty house re Donna being on duty on the 22nd. She confirmed she was there and agreed to have her do a statement and be avialbe for interview on Monday. Detective Reese and CSS discussed the interview and Carol's willinesses to take the test. He stated there was no criminal act and he could justify giving her the test. We will meet at duty house on Monday to conclude this case.	
07/20/99	01:40:00	01:49:00	B	J	O	V	1	Returned call to Teri, DON at duty house. She stated she had the statement JHJ from donna and was preparing to fax it down. Explained that CSS and detective Reese would be there today to interview Donna and could pick up her statement at that time. She stated that Donna didn't see anything on the date in question but wrote about a lot of things she saw in the past. Informed her that the past would not be apliclicable for this incident but would be important in determining if Carol is being truthful in her verbal and written statement.	
07/20/99	02:20:00	04:55:00	F	I	O	V	10	Interviewed staff at Abilities First with detective Reese. The primary purpose was to get a visual of the area then interview staff to determinad where each of them were when they made their observations. Once this was done detective Reese was able to understand the statements better ie men side and women side and why some observations were made on the men side and others on the women side. At the conclusion of this session detective Reese and I agreed to meet in his office tomorrow at 8:00am to review the statement and all other evidence.	

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F. Other		Q. Service Coordinating	W. Crisis Resolution
			X. Other
			Y. Team Meeting

SERVICE PERIOD: 07/01/99 - 07/31/99

PRIMARY DIAG CODE: 03190

NAME: [REDACTED] LAUREN

(1599)

MEDICAID # [REDACTED]

DOB: [REDACTED]

CASE MANAGER: *Thomas Horden*

DATE: 7-31-99

DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
07/01/99	12:08:00	12:30:00	B	J	O	V	1	Returned call to [REDACTED] Lauren's father. He was very concerned about JHJ the incident involving Lauren and the nurse, Carol at doty house. He wanted child abuse charges filed against the nurse. He also expressed concern about Lauren's level of care. Informed him that CSS would file a report with Middletown PD but not sure if the would investigate or if the case would be prosecuted. He wanted to know if he could file a civil suite against doty house. Spoke with Peggy she said he could file charges on Lauren's behalf. Called Keith and informed him of conversation with Mr. [REDACTED] and updated him on this case	
07/07/99	03:00:00	04:00:00	F	I	O	V	4	Meeting at Middletown P.D. to file report of physical and verbal abuse with detective Fred Shoemaker. He was not in so left information with secetary and asked he call CSS.	JHJ
07/08/99	11:30:00	12:40:00	F	I	O	V	5	Attempted to see detective Fred Shoemaker of the Middletown P.D. to discussed information left for him on 7/8/99. Not in will try again.	JHJ
07/09/99	09:50:00	10:00:00	B	J	O	V	1	Returned call to Laurel re her conversation with [REDACTED] Expalined to JHJ her the status of this case ie report filed with Middletown P.D. but has not talked with the detective assigned to case. Explained that should police decide not to investigate case or to prosecute CSS would have to close this case.	
07/12/99	08:30:00	10:00:00	F	I	O	V	6	Meeting with Detective Bobby Reese re the allegation of physical and verbal abuse of Lauren. Called Doty House to get the SS # and D.O.B of the accused, Carol Schauer. Detective Reese called Carol. Not in, left message on machine for her to call him. He stated he would set up a meeting and call CSS. Asked what would happened if she didn't call today. He stated he would turn the case over to the task force. In any case he would keep CSS informed.	JHJ