Ohio Department of Developmental Disabilities

Division of Information Systems

DODD INCIDENT REPORT (ITS)

Incident Number			Group Name	
2021-009-0482			Butler	
Client Number	**Client Name**	**Gender**	**Waiver Type on Incident**	**Age at Discovery**
[redacted]	[redacted] LAUREN 350 KOLB DRIVE FAIRFIELD, OH 45014	F		34

Final Due Date	Incident Date	Discovery Date	Created Date	Fax 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/IID

Location: Non-County Operated Program Residence ICF/DD

Incident Provider:

0910027 TAKODA TRAILS

DODD INCIDENT REPORT (ITS)

Residential Provider:

0910027 TAKODA TRAILS

Adult Day/Employment Provider:

No Adult Day/Employment Provider

Notifications

9698260	Law:	11/30/2021
	Guardian:	11/30/2021
	County:	11/30/2021
	Administrator:	11/30/2021

Coroner

Notified: Accepted: Autopsy:

Rec. Closure
05/06/2022

Rec. Closure By
Campbell, Patrick

Incident Review Status
Closed

Closed Date
06/05/2022

Investigated By
Law Enforcement
Campbell, Patrick

Closed By
Chris E Young

Last Change By
Chris E Young

Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
De Satin Curtis	PPI	Direct Care Staff	No	0910027	TAKODA TRAILS
Unknown Unknown	PPI	Unknown	No	0910027	TAKODA TRAILS

Initial Report **12/01/2021** **3137532**

On 11/30/2021, it was reported to Holle Metz, SSA On-Call/BCBDD that a laceration was discovered to Lauren [redacted]'s 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 **12/01/2021** **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 **01/24/2022** **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 ODH by Ellie, they have completed the survey. IA wait outcome. Lauren injury is reported to be healing well. IA has visited the home and Lauren, Did a

Others

environmental check of the home, the provider has removed some broken items from the home such as a mirror frame and secured 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	3186055

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	3195913

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	05/06/2022	3201586

Q)List of persons interviewed and documents reviewed
A)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 Lagemann with Fairfield PD
Dr. Gary L. Utz, pathologist
Lisa K. Mannix 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, ADON with Takoda Trails
Vikki Perry, DSP with Takoda Trails
DeSatin Curtis, DSP/PPI with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kumi, DSP with Takoda Trails
Lynnette Whitaker, DON with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Noonan, Program director with Takoda Trails
Michelle Truett, QA RN with BCBDD
Kathy Tallon, QA RN with BCBDD

Documents Reviewed:

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
BM records

Q)Summary of interviews and documents reviewed
A)The 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 – (11 previous MUI's since 1999)
No MUI involving current staff noted in history.

One unanticipated 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 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.

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 Tumbleson, Resident Specialist 1/FC, 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

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 Tumbleson, PPI – Insufficient evidence.

On 5/8/06 Nina Rose, a nurse at Fairfield HS, reported to Cathy Hagins 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 harm 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 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 Schauer, 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 to 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 PICA behavior and are on visual range supervision. The other 5 are to be checked every 15 minutes. – Diane Simpson and Tanisha Thornhill, 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 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.

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 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.

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 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 10-29-2021) 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
I. 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

despite recommendation. I also have a gait belt, swimsuit

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, Mycotic Nails, Chronic Periodontitis,
Nonsenile Cataract, Anhidrosis, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes Impair Level.

Medications: Tylenol 160mg q4h/prn-elevated temperature, Diastat I 0mg PRN-seizures, Miralax 17gm QD-constipation, Claritin I 0mg qd-allergic rhinitis, Keppra I 000mg bid
seizures, Fluticasone Nasal Spray 50mcg qd-allergic rhinitis, Lamictal 100mg qd
seizures, Bactroban-Clotrimin Cream to G-Tube site bid-preventative.

MENTAL HEALTH/EMOTIONAL DEVELOPMENT
I function within profound range of mental retardation. I scored a I 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 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. This corner was blocked by pipes to 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 QIDP 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:

Others

Tanya stated photos were taken of Lauren's injury by Sandy Osterberger after she discovered the injury before she was went to the hospital on 11/30/2021.

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. 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 home, 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 Noonan, Program director with Takoda 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 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.

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.

Laurens'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 Laurens'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 Portaleos 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.

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 DeSatin 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 DeSatin's shift, several hours before Lauren received medical attention. DeSatin was the only employee in Lauren's House in the time frame the injury occurred.

Secondly, the wound would have bled significantly at the lime of the cut. DeSatin either caused the injury herself or someone else did, possibly a resident, but either way the end conclusion is DeSatin knows what happened and failed to seek medical attention for Lauren. In any medical event DeSatin 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 DeSatin 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 DeSatin knowing,

DeSatin was the only employee to have several inconsistencies in her statements to police. DeSatin 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 UI 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 – DeSatin 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 - DeSatin 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 DeSatin, 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:
DeSatin Curtis 11/30/2021 – At 6:30 am, I gave Lauren [redacted] a 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 (7:15-7:20 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 Osterberger. LPN – Reporter – 11/30/2021 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 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 7:40 am Home 5 – On above time and date this writer entered Laure[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 Katz, DSP 11/30/2021 – I picked up the shift for another staff that day so I did clock in till about 6:45 am came to the

home 5 about 6:47 am when I came in I DeSatin in the room with Lauren so at that time I though she had that group so I set 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 me 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 I'm 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 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 hose 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 Kumi, 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 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 DeSatin to clarify, the Detective stated she indicated all the individuals were asleep in bed. IA did compare DeSatin's witness statement and the s'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 Hacker, 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.

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 8 PM no signs or symptoms of distress noted.

11/30/2021 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 Osterberger]

11/30/2021 6 pm – Resident returned home with Dx of laceration of neck. 12 sutures D/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 in bed at this time shows no sign symptoms of distress. S.O.

12/1/21 1 am resting in bed quietly in bed rsp easy and unlabored. Arouses 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 96.9 B/P 133/106 HR 103 this nurse administered PRN Tylenol.

12/3/2021 10:15pm 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 pian 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 drolling excessively and blowing bubbles, not acting normal would 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 12:55 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 n/o x-ray Right hip and knee mobilex. 11am 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 calculus and cover with mepilex daily.

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

Review of medical reports:

EMS report
CFFD M33 ALS32 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 xl with

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. 4 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 sheer 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 Dechert Firefighter/Medic #90

(IA was not able to determine why she was taken to Westchester ER, instead of Mecry 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

From 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 or healing noted to extremities.
Patient undressed and fill skin assessment without other acute injuries noted.

Images form 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 MRDD, 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 Stanko, NP – Lac Repair preformed 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 IP's / MUIs for peers in home.

Peers on same side of home:

[redacted]ndently around living area. Demonstrate limited
[redacted]mple communication.

[redacted]

Others

[redacted]

[redacted]

Peers on other side of home:

[redacted]

[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
Tanya Vance, MUI investigator with Takoda Trails
Joyce Katz, DSP with Takoda Trails
Sandra "Sandy" Osterberger, LPN with Takoda Trails
Brian Petrak, ADON with Takoda Trails
Vikki Perry, DSP with Takoda Tails
DeSatin Curtis, DSP with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kumi, DSP with Takoda Trails
Lynnette Whitaker, DON 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 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.

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, MUI 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 DeSatin 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 DeSatin was not in the area. Lauren routinely keeps her head down. Joyce brought up she thought DeSatin was acting odd, when she came to her after seeing the injury she asked did you hear a big boom? When she asked why DeSatin 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 DeSatin 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 thing 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 Petrak, 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 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 Noonan, 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 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 out 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 MUI 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.

Others

Kathy Tallon, QA RN with BCBDD– Reviewed photos of injuries with Kathy, she contact 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 kite 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. Mannix 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 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.

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 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.

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 some 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 term her 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 boom” before telling her Lauren was injured. (The witness stated the big boom 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.

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 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 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 if 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 MUI for PPI:
No previous MUI's 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 shoved.

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

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 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 DeSatin 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 DeSatin is the primary suspect, the Detective also lists other possibilities such as individuals or stranger.

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. 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 tearing as a result.

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, 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

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 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 ambulating with no sign/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 DeSatin not cooperating with a previous incident, this was reviewed and was a UI.

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 Lauran 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.

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.

DeSatin 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 DeSatin 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 DeSatin 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 5/6/2022>

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 Holle 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 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 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, bean 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, 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 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 MUI 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 Lauran 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.

Others

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.
<Campbell, Patrick Added on 5/6/2022>

Cause And Contributing Factors	05/06/2022	3201588

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	3201589

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 10-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 sutures removed 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, 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.

(still need input from provider from their report.)
<Campbell, Patrick Added on 5/6/2022>

Question	05/12/2022	3203747

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:
(still need input from provider from their report.)

<Chris E Young Added on 5/12/2022>

Response	05/19/2022	3207091

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

Others

but they wanted to review it before with supervisor before submitting it. She did not indicate any additional prevention 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 E Young Added on 6/1/2022>

Response	06/02/2022	3212560

1. IA received providers report 6/2/2022.

The following was listed:

Prevention Measures:
Preventative 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 providers 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.
Desatin 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. Takoda Trails HR Dept.as well as this investigator, attempted to call Desatin 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 POC 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>

MUI Report

BUTLER COUNTY Board of DEVELOPMENTAL DISABILITIES

Date of Report: 5/4/2022

Individual: Lauren [redacted] Incident Number: 2021-009-0482
Investigator: Patrick Campbell Category: Alleged Physical Abuse, Significant Injury & Neglect

INITIAL STATEMENT:
On 11/30/2021, it was reported to Holle Metz, SSA On-Call/BCBDD that a laceration was discovered to Laure[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 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.

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 Lyons on 12/1/2021 >

LIST OF PERSONS INTERVIEWED AND DOCUMENTS REVIEWED
Interviews/Statements:
Lauren [redacted], Individual
[redacted], Individual
[redacted], Individual
[redacted], Individual
[redacted]Guardian
Tanya Vance, MUI investigator with Takoda Trails
Ellie King, Detective with Fairfield PD
Sgt. Pete Lagemann with Fairfield PD
Dr. Gary L. Utz, pathologist
Lisa K. Mannix 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, ADON with Takoda Trails

Vikki Perry, DSP with Takoda Trails
DeSatin Curtis, DSP/PPI with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kumi, DSP with Takoda Trails
Lynnette Whitaker, DON with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Noonan, Program director with Takoda Trails
Michelle Truett, QA RN with BCBDD
Kathy Tallon, QA RN with BCBDD

Documents Reviewed:
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
BM records

SUMMARY OF INTERVIEWS/DOCUMENTS REVIEWED

The 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 – (11 previous MUI's since 1999)
No MUI involving current staff noted in history.

One unanticipated 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 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.

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 Tumbleson, Resident Specialist 1/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 jerked 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 Tumbleson, PPI – Insufficient evidence.

On 5/8/06 Nina Rose, a nurse at Fairfield HS, reported to Cathy Hagins 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 harm 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 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 Schauer, 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 to 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 PICA behavior and are on visual range supervision. The other 5 are to be checked every 15 minutes. – Diane Simpson and Tanisha Thornhill, 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 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.

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 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.

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 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 10-29-2021) 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
I. 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 despite recommendation. I also have a gait belt, swimsuit

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, Mycotic Nails, Chronic Periodontitis,
Nonsenile Cataract, Anhidrosis, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes Impair Level.

Medications: Tylenol 160mg q4h/prn-elevated temperature, Diastat I 0mg PRN-seizures, Miralax 17gm QD-constipation, Claritin I 0mg qd-allergic rhinitis, Keppra I 000mg bid-
seizures, Fluticasone Nasal Spray 50mcg qd-allergic rhinitis, Lamictal 100mg qd-
seizures, Bactroban-Clotrimin Cream to G-Tube site bid-preventative.

MENTAL HEALTH/EMOTIONAL DEVELOPMENT
I function within profound range of mental retardation. I scored a I 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 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.

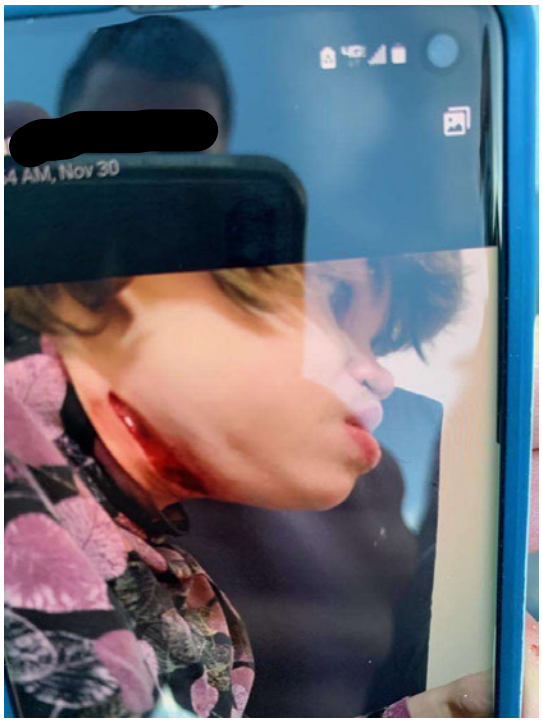
The outcome of reviewing the scene of the incident: IA visited the scene on 12/7/2021,

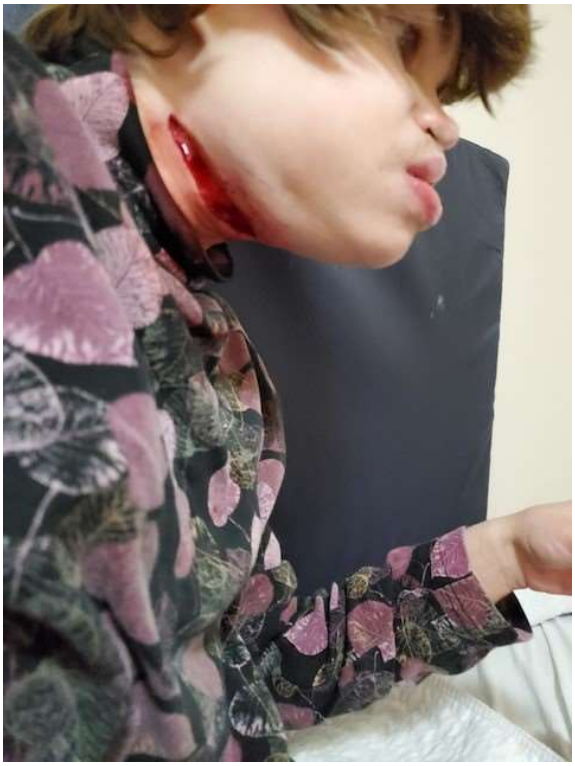
Tanya Vance was with IA, we looked over her room, the rooms on Lauren's hallway, kitchen, and dining room area. There were no obvious hazards in her room, The only hazards that were noted were in the bathroom down the hall with the adaptive tub, which had shelving in the corner that was just lying in the corner, with screws sticking out of them. This corner was blocked by pipes to 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 QIDP 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.

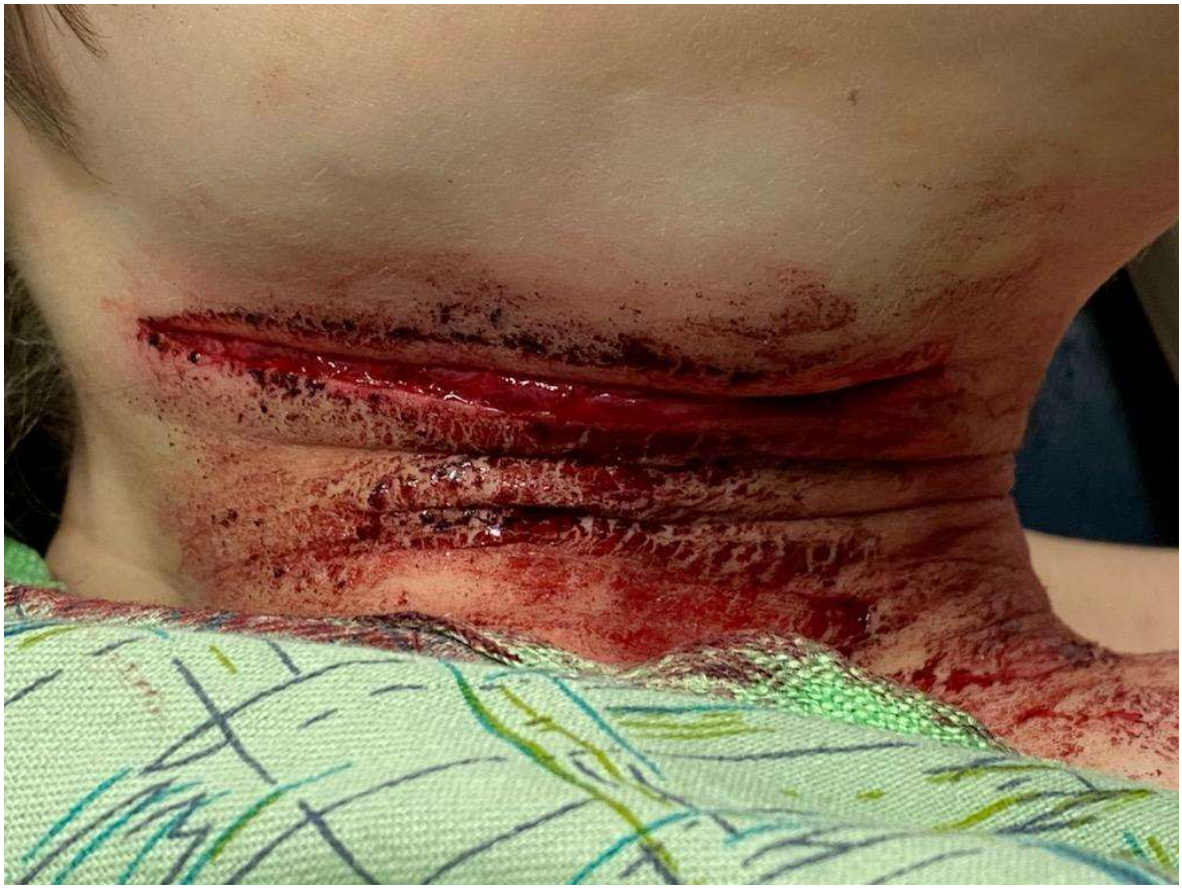
Review of physical evidence/photos:

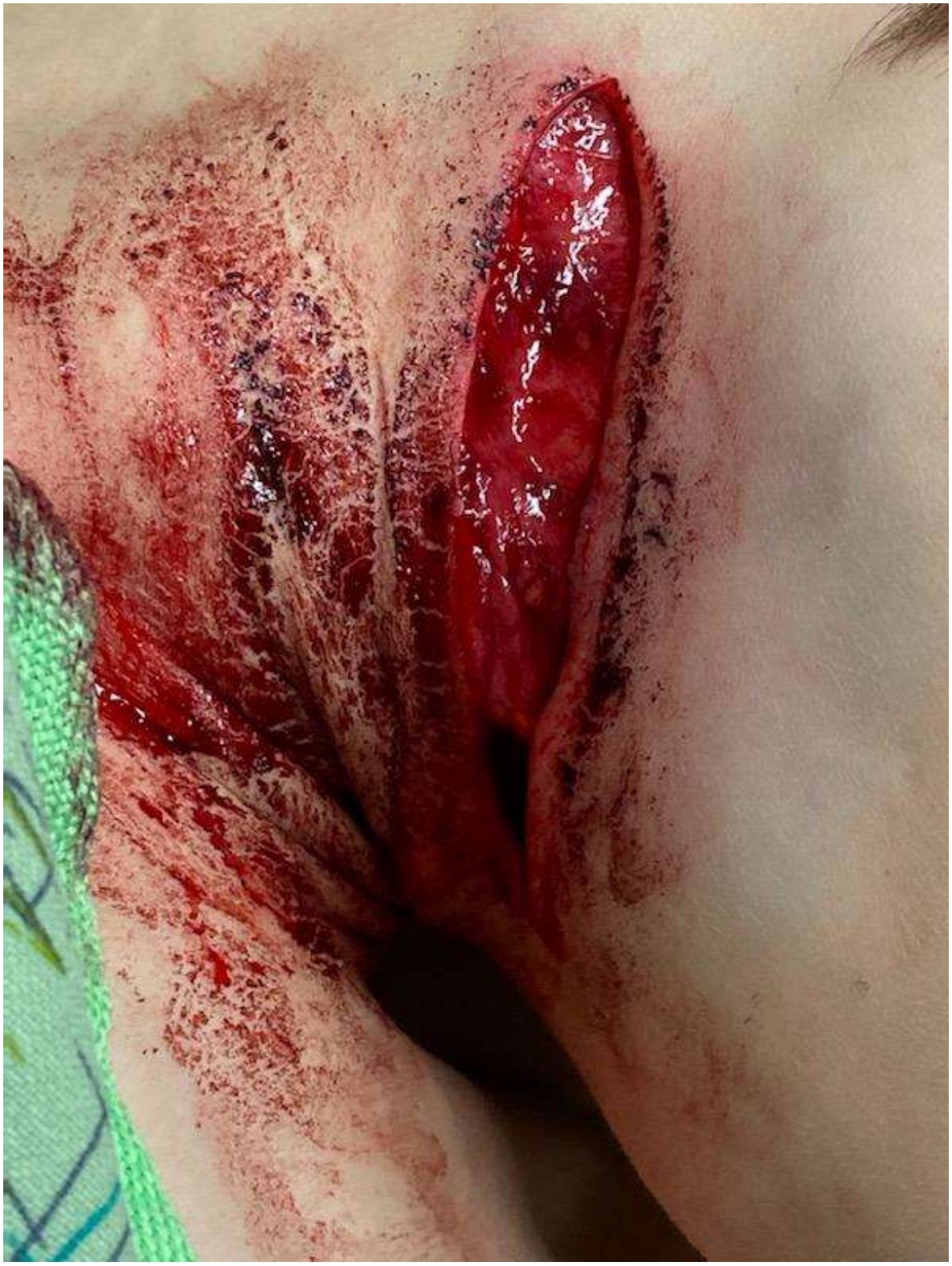




Tanya stated photos were taken of Lauren's injury by Sandy Osterberger after she discovered the injury before she was went to the hospital on 11/30/2021.

Photo's of blood after the incident was discovered.





Photos of injury from the hospital.

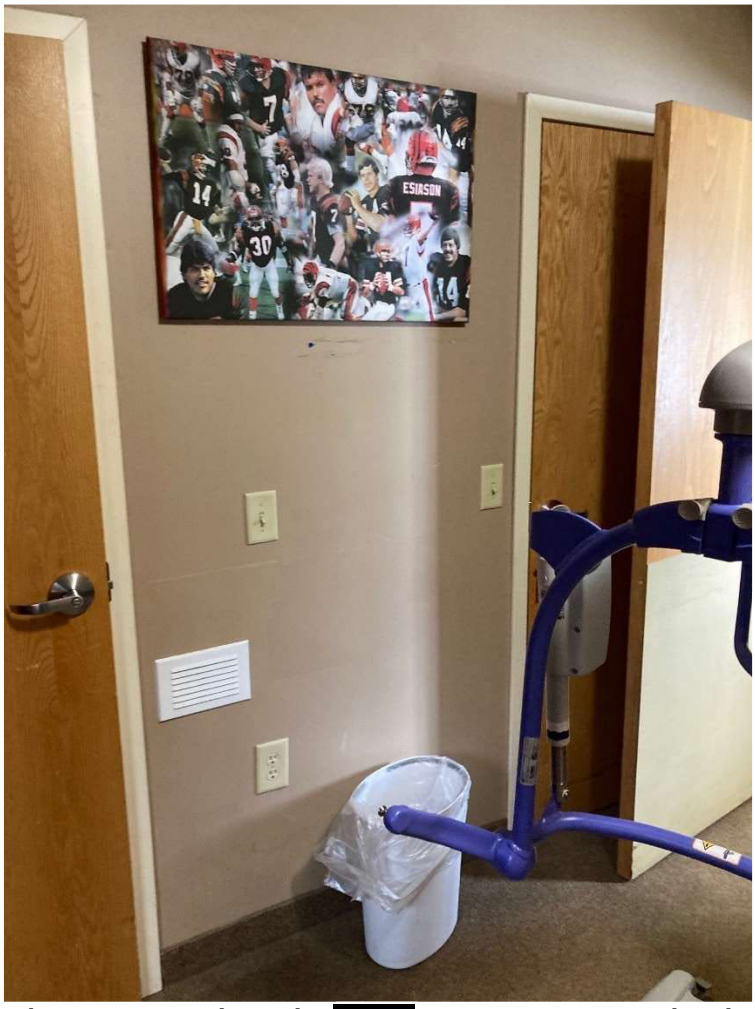

The mirror that was hanging on the wall in [redacted] room that was mentioned as broken. The frame is plastic and this was the part of the mirror that is broken. It was reported to have been broken for several/weeks prior to this incident. Brain Petrak. ADON came over and verified it was attached to 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 home, 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 Noonan, Program director with Takoda 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

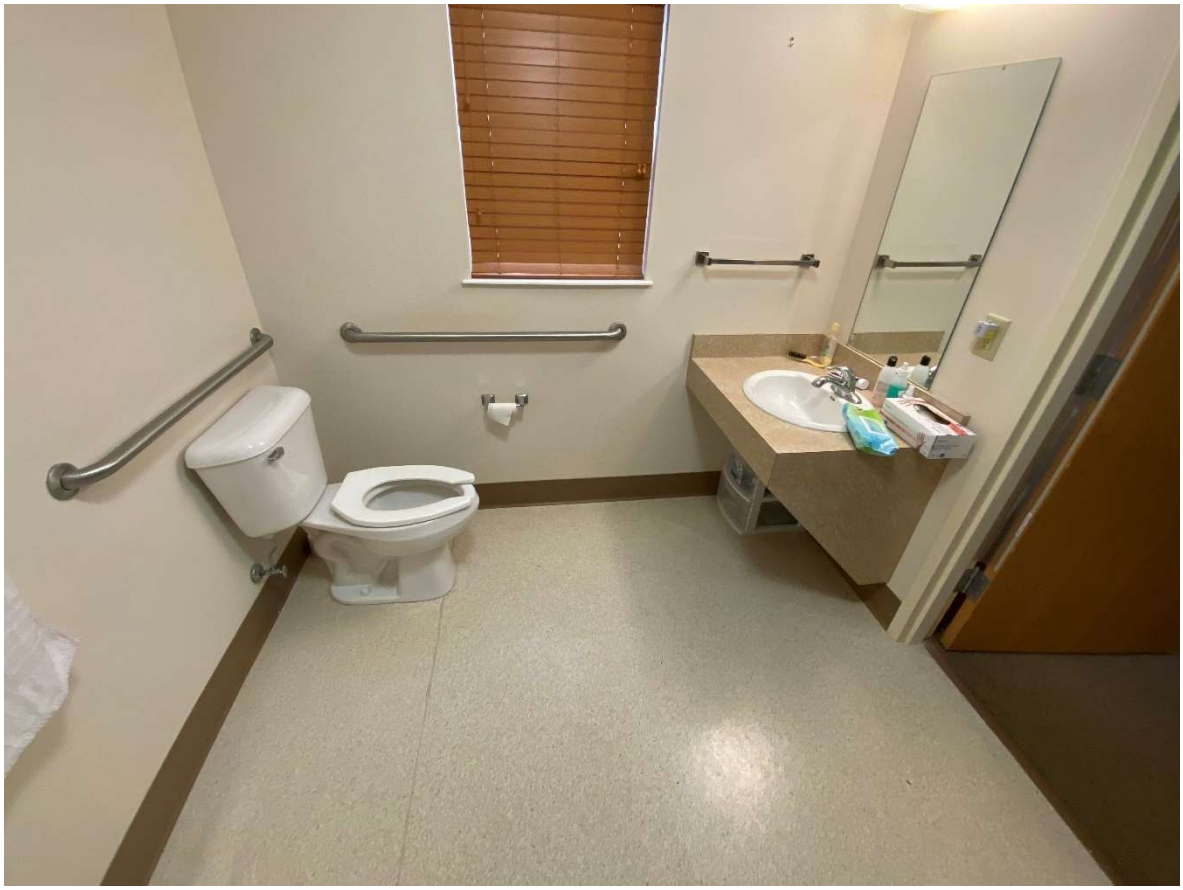
frame to be broken and no pieces off of the frame were found in any of the rooms, the mirror was originally found in [redacted] room.



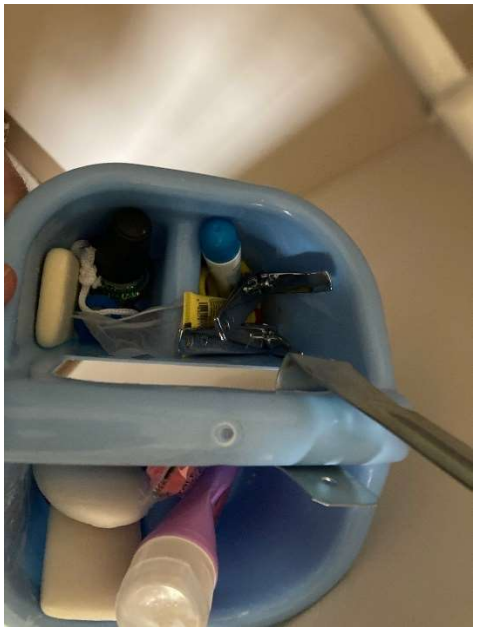
Where Mirror was located in [redacted] room. You can see in this photo the screw holes just below the poster on the wall.

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.

Laurens'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 Laurens'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 Portaleos 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.

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 DeSatin 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 DeSatin's shift, several hours before Lauren received medical attention. DeSatin was the only employee in Lauren's House in the time frame the injury occurred.

Secondly, the wound would have bled significantly at the lime of the cut. DeSatin either caused the injury herself or someone else did, possibly a resident, but either way the end conclusion is DeSatin knows what happened and failed to seek medical attention for Lauren. In any medical event DeSatin 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 DeSatin 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 DeSatin knowing,

DeSatin was the only employee to have several inconsistencies in her statements to police. DeSatin 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 UI 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 – DeSatin 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 - DeSatin 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 DeSatin, 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:
DeSatin Curtis 11/30/2021 – At 6:30 am, I gave Lauren [redacted] a 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 (7:15-7:20 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.

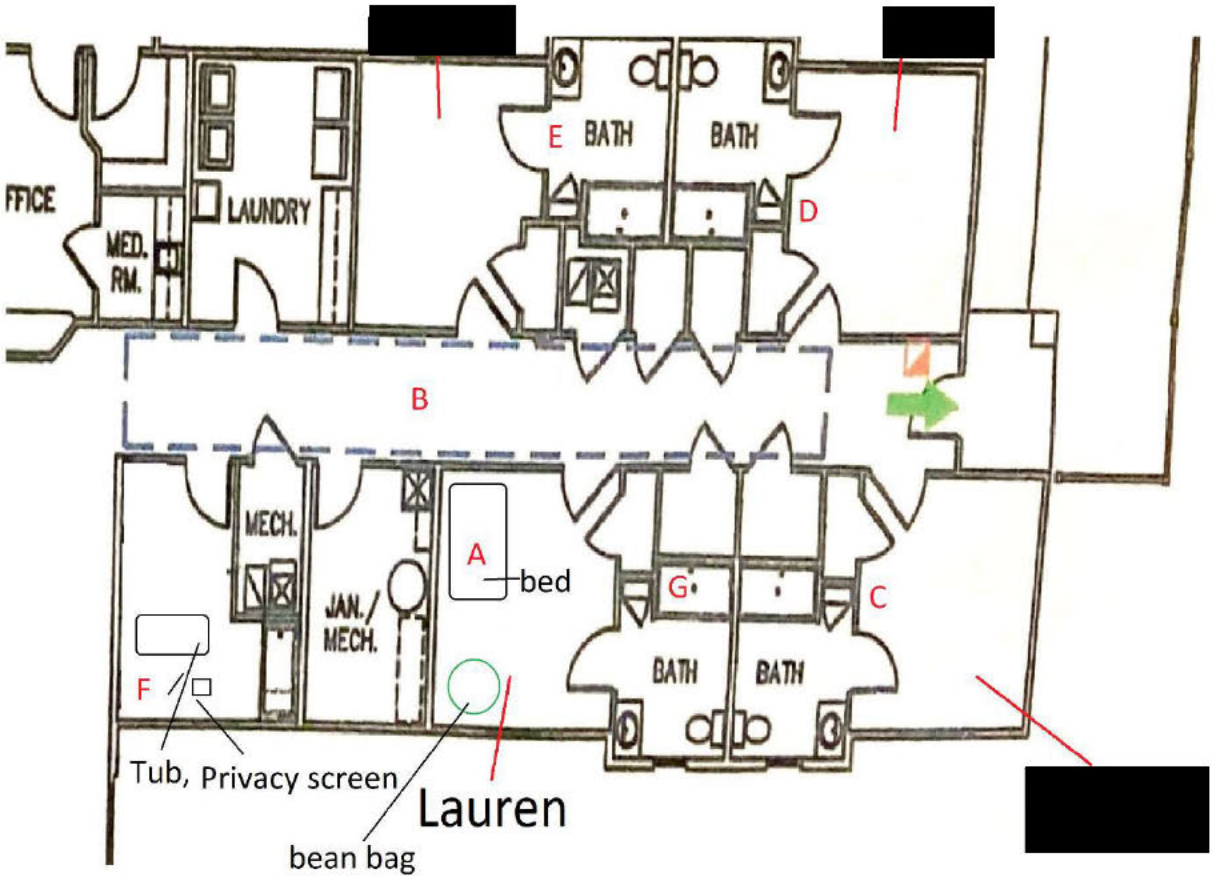
Sandy Osterberger. LPN – Reporter – 11/30/2021 7:45 am Home #5, When I went in to do residents meds and bolus resident was sitting on her bed. I approached her to hook up her tube and she lifted her head up and I seen a laceration on her neck. I yelled for Brian. We called 911. Resident sent to UC West 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 7:40 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 Katz, DSP 11/30/2021 – I picked up the shift for another staff that day so I did clock in till about 6:45 am came to the home 5 about 6:47 am when I came in I DeSatin in the room with Lauren so at that time I though she had that group so I set 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 me 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 I'm 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 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 hose was taped.

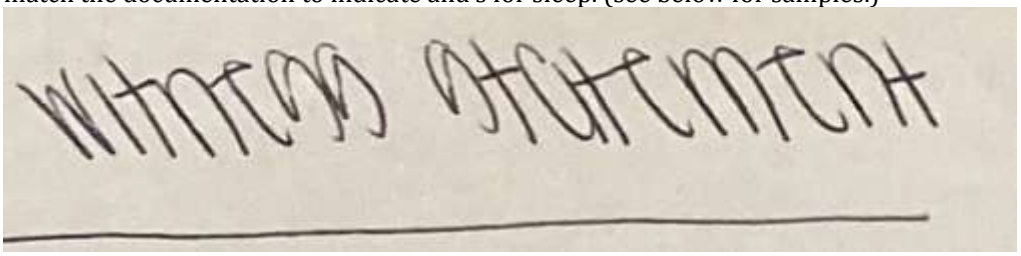
Two staff were on second shift from approximately 3:00 pm – 11:00 pm on 11/29/2021.
Vikki Perry, DSP was assigned to Lauren and stated that Lauren went to sleep after her shower, she did not observe any injuries. She stated that she did not do rounds with 3rd shift staff DeSatin Curtis, she had asked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

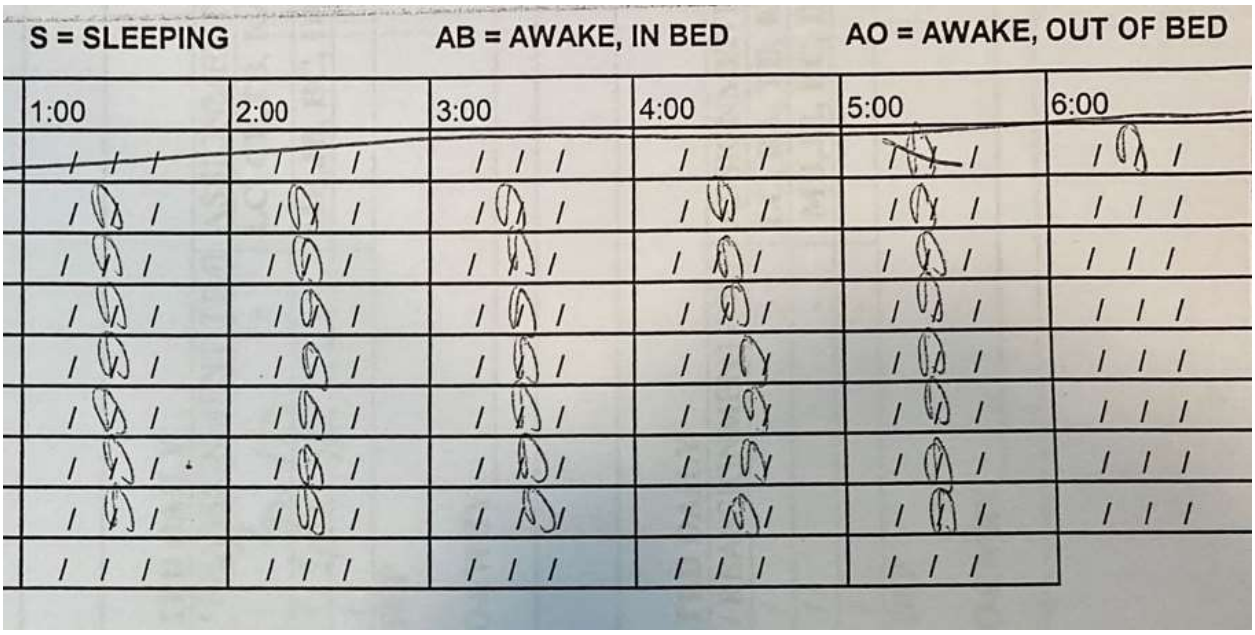
Prosper Kumi, DSP was the other second shift staff and did not observe any injuries.

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 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 DeSatin to clarify, the Detective stated she indicated all the individuals were asleep in bed. IA did compare DeSatin's witness statement and the s'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



S = SLEEPING AB = AWAKE, IN BED AO = AWAKE, OUT OF BED

1:00	2:00	3:00	4:00	5:00	6:00

From Home #5 sleep tracker, no staff signature or initials on the form.
Third shift nurse, Tracy Hacker, 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. 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 8 PM no signs or symptoms of distress noted.

11/30/2021 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 Osterberger]

11/30/2021 6 pm – Resident returned home with Dx of laceration of neck. 12 sutures D/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 in bed at this time shows no sign symptoms of distress. S.O.

12/1/21 1 am resting in bed quietly in bed rsp easy and unlabored. Arouses 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 96.9 B/P 133/106 HR 103 this nurse administered PRN Tylenol.

12/3/2021 10:15pm 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 pian 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 drolling excessively and blowing bubbles, not acting normal would 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 12:55 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 n/o x-ray Right hip and knee mobilex. 11am 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 calculus and cover with mepilex daily.

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

Review of medical reports:

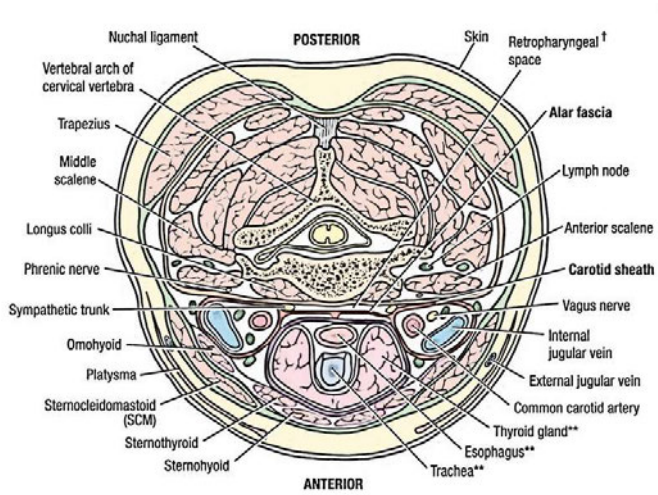
<u>EMS report</u>
CFFD M33 ALS32 emergent response to above location for a 34 y/o F with a laceration to her neck. Upon arrival, crew was met by facility staff who walked us to the Pt who presented sitting in her bed. There was very little blood noted. **Pt had a laceration approximately 4 inches long 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 xl with 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. 4 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 sheer drag and secured rails x2. Verbal report given to RN, transferred

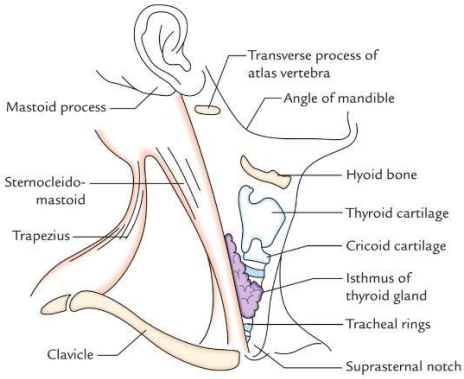
care of Pt to ED staff. Crew clear of hospital and returning to the city. Andrew Dechert Firefighter/Medic #90

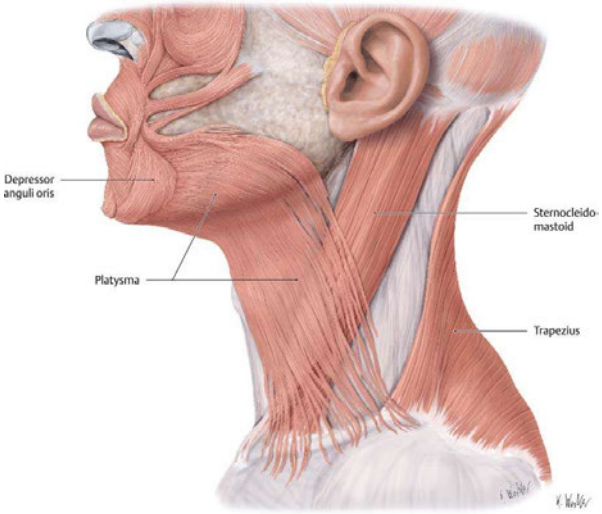
(IA was not able to determine why she was taken to Westchester ER, instead of Mecry ER which is closer but the EMS made the determination to do so, It was suggested that if Mercy's ER was very busy they may have been directed there, but this was is not known.)

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

From 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 or healing noted to extremities.
Patient undressed and fill skin assessment without other acute injuries noted.







Images form 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 MRDD, 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 Stanko, NP – Lac Repair preformed 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 IP's / MUIs for peers in home.

Peers on same side of home:

[redacted]

Peers on other side of home:

[redacted]

[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
Tanya Vance, MUI investigator with Takoda Trails
Joyce Katz, DSP with Takoda Trails
Sandra "Sandy" Osterberger, LPN with Takoda Trails
Brian Petrak, ADON with Takoda Trails
Vikki Perry, DSP with Takoda Tails
DeSatin Curtis, DSP with Takoda Trails
Tracy Hacker, LPN with Takoda Trails
Prosper Kumi, DSP with Takoda Trails
Lynnette Whitaker, DON with Takoda Trails
William Maynard, Administrator with Takoda Trails
Tammy Noonan, Program director with Takoda Trials

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 home, or were non ambulatory [redacted].

Tanya Vance, MUI 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 DeSatin 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 DeSatin was not in the area. Lauren routinely keeps her head down. Joyce brought up she thought DeSatin was acting odd, when she came to her after seeing the injury she asked did you hear a big boom? When she asked why DeSatin 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 DeSatin 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 thing 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 Petrak, 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 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 Noonan, 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 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 out 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 MUI 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. 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 thoughts or cause or what to look for, mainly a sharp object.

Kathy Tallon, QA RN with BCBDD– Reviewed photos of injuries with Kathy, she contact 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 kite 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. Mannix 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 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.

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 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.

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 some 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 term her 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 boom” before telling her Lauren was injured. (The witness stated the big boom 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 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 if 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 MUI for PPI:
No previous MUI's 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 shoved.

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

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 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 DeSatin 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 DeSatin is the primary suspect, the Detective also lists other possibilities such as individuals or stranger.

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. 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 tearing as a result.

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, 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 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 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 ambulating with no sign/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 DeSatin not cooperating with a previous incident, this was reviewed and was a UI.

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 Lauran 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.

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.

DeSatin 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 DeSatin 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 DeSatin 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 Holle Metz, 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 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 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 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, bean 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, 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 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 MUI 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 Lauran 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.

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 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 10-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 sutures removed 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, 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.

(still need input from provider from their report.)

DeSatin Curtis, DSP/PPI – Contacted IA after receiving PPI letter of notification. 5/14/2022 She wanted to know what they meant. I explained the letters, her copy of the alleged physical abuse, listed unsubstantiated for her, as the PPI was listed as unknown. But I had substantiated the physical abuse for the case. The alleged neglect was substantiated with her as PPI. 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.